# New York City Council Hearing

# Improving Maternal Health in New York City

## Committee on Hospitals

## Committee on Women and Gender Equity

**Wendy Wilcox, MD, MPH, MBA, FACOG**

**Chief Women's Health Officer, Chief of OB/GYN**

**NYC Health + Hospitals**

**October 23, 2025**

Good afternoon Chairwoman Narcisse, Chairwoman Louis and members of the Committee on Hospitals and Women and Gender Equity. I am Dr. Wendy Wilcox, Chief Women's Health Officer of NYC Health + Hospitals, and Chief of OB/GYN at NYC Health + Hospitals/Woodhull. In addition to these roles, I have been with the System for over 15 years, working at acute-care centers which include Jacobi, North Central Bronx, and Kings County in a clinical role. Maternal and women's health has been the foundation of my career. In addition to my clinical work, I serve as Co-Chair of the New York State Maternal Mortality Review Board and the Brooklyn Borough Maternal Health Task Force, and as a member of several statewide and national bodies dedicated to improving maternal outcomes and advancing birth equity.

At NYC Health + Hospitals (the System), we are particularly focused on helping to reduce the unacceptable maternal mortality rates among women of color in New York City. NYC Health + Hospitals is a leader in providing quality, culturally responsive health care services that address the disparities and race-based health care gaps that have historically and disproportionately affected the diverse population of patients we proudly serve. This past year, NYC Health + Hospitals/Bellevue, Elmhurst, Lincoln, and Woodhull were recognized by U.S. News & World Report 2025 Best Hospitals for Maternity Care.

Addressing the maternal health crisis requires a multi-pronged approach: from focusing on preventative health care to addressing social detriments of health, there are various pathways to ensuring that maternal mortality and morbidity are addressed efficiently. Over the past two decades, NYC Health + Hospitals has made significant strides in improving maternal health outcomes, with a focus on reducing maternal mortality and addressing health inequities. In collaboration with the American College of Obstetricians and Gynecologists, all 11 hospitals in the System have participated in the Safe Motherhood Initiative, which developed safety protocols targeting the leading causes of maternal mortality in New York. This initiative has helped standardize best practices across the System, ensuring

better care and fewer complications during childbirth. In addition, in 2018, the health system launched six state-of-the-art simulation labs in trauma centers to allow obstetrical staff, including OB and anesthesia physicians, nurses, midwives, and physician assistants, to practice handling critical obstetric emergencies. While the simulation labs initially focused on the three top causes of maternal mortality, its success invited expansion over the recent years into covering topics including, cardiac resuscitation during pregnancy, obstetric hemorrhage, and shoulder dystocia, are crucial in reducing maternal mortality rates and preventing avoidable, potentially fatal complications.

That same year, NYC Health + Hospitals established the Maternal Home to provide comprehensive care for patients with complex pregnancy-related conditions. The Maternal Home offers support through a team of social workers, maternal care coordinators, doulas, and mental health professionals addressing both clinical and social determinants of health, improving access to necessary behavioral health services. Since its launch, the program has enrolled over 8,000 unique patients, supported over 60,000 births, and made over 27,000 referrals. By putting pregnant patients at the center of their care, results show the importance of prioritizing connected care teams throughout the pregnancy journey.

On October 14th of this year, the System formally announced The NYC Baby Boxes program at NYC Health + Hospitals/Jacobi, Lincoln, Elmhurst, and Kings County, where more than 7,000 babies are delivered each year. This program aims to support new parents by alleviating early financial stress and provide essential postpartum and newborn care supplies. In collaboration with the Mayor's Office and community partners, the contents of the baby boxes are designed to address the most common needs which are not covered by existing benefits to directly address stressors in the postpartum period. All babies born at these sites will receive a box during the pilot program. Sourced from local and Minority- and Women-Owned business enterprises. Items in each box, set to be distributed later this month, will include the following items for parent and baby:

- Two onesies
- Footie pajama
- Cap
- Burp cloth
- Swaddle blanket
- Bath towel
- Newborn diapers
- Baby wipes
- Two types of diaper rash cream
- Baby shampoo
- Nipple cream
- Nursing Pads
- Postpartum pads
- Breastmilk bags
- Resource guides

Since 2022, NYC Health + Hospitals has a contract with Natera, a cell-free DNA testing company, to support its prenatal screening program for two essential services. The first, Non-Invasive Prenatal Tests, enables clinicians to analyze fetal DNA and detect common chromosomal abnormalities. The second service, Carrier Screens, allows us to test parents' DNA before or during pregnancy to identify potential genetic mutations that could pose a risk for to the baby's health. Additionally, Health + Hospitals utilizes Triton, a tool that measures blood loss to prevent hemorrhaging, which is a leading cause of maternal mortality.

Health + Hospitals always strives to bring preventative care to patients, and this past August, our acute care site at Kings launched a Cardio-Obstetric program which aims to reduce maternal mortality and morbidity among women of color by focusing on heart disease during and after pregnancy. This program additionally focuses on targeting risk factors which include hypertension, obesity, and diabetes during the prenatal period as well through one year postpartum. We have also partnered with community-based organizations to promote health education and refer individuals to this program.

As part of NYC Health + Hospitals' Behavioral Health Blueprint, we highlight the System's commitment to providing comprehensive substance use care for New Yorkers, including pregnant individuals. The RISE Center, which stands for Recovery, Integrated Support, and Empowerment, is expected to open in 2026 at NYC Health + Hospitals/Lincoln. It will focus on early intervention to support healthy pregnancies and break the intergenerational cycle of substance use and dependency. Partnering with additional programs on site, our aim is to the RISE Center will serve pregnant and parenting people affected by substance use disorder and their children. Utilizing a family-centered model, we aim to provide a deeply welcoming and supportive services in one location. With wrap-around services on site, families will have access to childcare, food pantries, parenting education, referrals to treatment, and screenings.

Beyond programmatic development, Health + Hospitals is also revitalizing physical spaces to improve birthing options for pregnant people at Kings, South Brooklyn Health, and Woodhull. These updated designs include the creation of four new, private birthing rooms for low risk pregnancies, greater integration of doula and midwifery support, and reconfigured staff support areas to improve workflow and collaboration.

Moreover, all 11 hospitals have achieved Baby Friendly status, a certification that highlights their leadership in promoting and supporting breastfeeding, a key factor in improving maternal and infant

health. Our system's cesarean delivery rate also remains consistently below the state average, underscoring our success in reducing unnecessary interventions.

NYC Health + Hospitals remains committed to ensuring that all New Yorkers who embark on their pregnancy journey in our System continue to receive the highest standard of care. By providing patients with wrap-around services, innovative tools, and spaces safely and efficiently work with care team, we will continue to improve maternal health outcomes throughout New York City.

Thank you again for the opportunity to testify today on this critical topic. I'm happy to answer any questions.

**NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
Michelle Morse, MD, MPH
*Acting Health Commissioner*

Written Testimony

of

**New York City Department of Health and Mental Hygiene**

before the

**New York City Council**

**Committee on Women and Gender Equity**
**Committee on Hospitals**

On

# Oversight: Improving Maternal Health in New York City

October 23, 2025
250 Broadway, 8th Floor, Hearing Room 1
New York, NY

Thank you for the opportunity to submit written testimony on behalf of the New York City Department of Health and Mental Hygiene (Health Department) on our work to improve maternal health in NYC.

HealthyNYC is the City's vision for improving life expectancy and creating a healthier city for all. The Health Department is working with partners across the city to ensure New Yorkers can realize their full health potential, regardless of who they are, where they are from, and where they live. Supporting the health of women and people who give birth is a critical aspect of this work. Extreme racial disparities persist in maternal mortality. Black women and people who give birth are five times more likely than their white counterparts to die from pregnancy-associated causes. As part of HealthyNYC, we have set a goal to reduce maternal death rates among Black women and people who give birth by 10% by 2030.

Last month, the Health Department published an annual report on Maternal Mortality in NYC, in collaboration with New York City's Maternal Mortality Review Committee (MMRC) that highlighted concerning and urgent findings.

The report showed that the number of pregnancy-associated deaths increased by 13.7 percent, from 58 deaths in 2021 to 66 deaths in 2022- the highest number of pregnancy-associated deaths since 2016. Black non-Hispanic women and people who gave birth accounted for 42.4 percent of pregnancy-associated deaths, despite representing only 17.5 percent of live births. The leading cause of pregnancy-associated deaths in 2022 was mental health conditions, followed by cardiovascular conditions The report also includes recommendations for policy makers, hospital systems, and other stakeholders based on these findings.

The Health Department remains committed to reversing these sobering trends and eliminating these unjust racial disparities. We do so in part by providing a range of programs that support the health of families who are expecting or have young children. This includes the New Family Home Visits Initiative (NFHV), which provides citywide access to high-quality home visiting services for new families with a focus on maternal mental health, chronic disease, and early childhood development. NFHV prioritizes first-time families in Taskforce on Racial Equity and Inclusion (TRIE) neighborhoods, those who live in NYCHA in these neighborhoods, and those who are engaged with the Administration for Children's Services. We also support the Citywide Doula Initiative, which increases access to no-cost doula care to promote critical birth support at a sustainable wage for doulas.

Last month, we launched the City's first-ever pilot of the Neighborhood Stress-Free Zone (NSFZ) in Brownsville, Brooklyn. This initiative expands resources for maternal health education, social needs support, and connections to mental and behavioral health services. This is an important step forward as the Health Department advances its broader Maternal Home Collaborative, aimed at improving birth equity.

While we are proud of our work, there is so much more to be done. We look forward to continued partnership with the Council to improve maternal health and address associated racial disparities.

JUMAANE D. WILLIAMS

**STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS TO THE NEW YORK CITY COUNCIL COMMITTEES ON HOSPITALS + WOMEN AND GENDER EQUITY OCTOBER 23, 2025**

Good afternoon,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. I want to thank Chairs Narcisse and Louis, as well as the members of the Committees on Hospitals, and Women and Gender Equity for holding this important hearing.

In 2023, when maternal mortality rates were declining worldwide, the U.S. was one of only seven countries to report a significant increase in maternal mortality.[1] In New York State, severe maternal morbidity rates increased by 50% between 2017 and 2022, signifying a rise in life-threatening health conditions and complications during childbirth.[2] In New York City, during the period of 2016 to 2020, Black birthing New Yorkers were found four times more likely to die from pregnancy-associated causes than white non-Hispanic birthing people.[3] The COVID-19 pandemic had a rippling effect on our healthcare systems, affecting health outcomes across a range of issues, but years later, disparities in maternal health are continuously being exacerbated by discrimination and unequal access to quality healthcare, and culturally sensitive treatment.

Earlier this year, my office released a report on Black maternal mortality and the role of birthing centers; prior to that, in 2021, we released a report looking at the maternal health crisis in New York City and how it disproportionately negatively impacts Black and brown women as well as transgender and gender nonconforming individuals. Amongst the numerous recommendations made in these two reports, we called for more disaggregated data and a comprehensive plan for material mortality. All of the bills before this committee today aim at securing accurate and transparent data regarding adverse maternal health events. These resolutions call on the State Legislature to sign critical bills that would refine the way the NY Patient Occurrence Reporting and

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[1] https://www.commonwealthfund.org/publications/issue-briefs/2025/jul/maternal-mortality-united-states-2025

[2] https://www.health.ny.gov/community/adults/women/maternal_mortality/docs/factsheet_severe_maternal_morbidity_2017_2022.pdf

[3] https://www.nyc.gov/site/doh/data/data-sets/maternal-morbidity-mortality-surveillance.page

Tracking System (NYPORTS) records adverse maternal health events and further share that information with the NYC Maternal Mortality and Morbidity Review Committee. Since 2018, the committee has conducted multidisciplinary reviews of all pregnancy-associated deaths in New York City, starting with deaths occurring in 2016.[4] This data has been crucial in informing policy recommendations to eliminate preventable maternal mortality, and racial and ethnic disparities.

If our hospitals are to implement effective policies and eliminate these disparities, they must have access to this critical data. I hope to see these resolutions passed and these changes enacted by the State Legislature. Thank you.

[4] Ibid.

New York City Council Committee on Hospitals
*Jointly with the Committee on Women and Gender Equity*

**Testimony New York City Council Hearing on "Improving Maternal Health in NYC**
Patricia O. Loftman, CNM, LM, MS, FACNM
October 23, 2025

Greetings Chairpersons Narcisse and Louis and Committee Members Moya, Brewer, Gutierrez, Marmorato, Brooks-Powers, Paladino, Riley, Caban and Vernikov.

Thank you for this opportunity to provide testimony on Improving Maternal Health in NYC.

My name is Patricia Loftman. I am a Certified Nurse Midwife, the former Director of Midwifery Service at Harlem Hospital in New York City, a founding member of the New York City Maternal Mortality Review Committee (MMRC) in 2018 and a member of the newly created New York City Council Maternal Health Steering Committee. Of note, I share with you that I have missed two NYC MMRC meetings in 7 seven years. Consequently, I have extensive experience with the issue on which I testify today.

I speak in support of Resolution 1082-2025 (Deputy Speaker Ayala) - Resolution calling on the New York State Department of Health to confidentially share data regarding adverse maternal health events from the New York Patient Occurrence Reporting and Tracking System with the NYC MMRC.

Every year in NYC between 50-60 women and birthing people die from a pregnancy-associated death. Black non-Hispanic women are about five times more likely to experience a pregnancy-associated death than white women. As many of you know, The NYC DOHMH first convened the Maternal Mortality Review Committee in January 2018 and was then signed into local and state legislation through the New York City Council (Int. No. 914-A) and New York State legislation (S-1819)[1]. The NYC DOHMH provides operational support to the Committee, conducts data analysis and produces collaborative reports with the NYC MMRC. The NYC MMRC is an independent, diverse, multidisciplinary team, including 40 specialists with expertise in midwifery, family medicine, nursing, psychology and psychiatry, anesthesiology, maternal-fetal medicine, and obstetrics and gynecology; doula services and patient advocacy; social work; health systems; addiction treatment; and violence prevention. In total, 70% of members self-identify as Black or Hispanic women (the two groups most affected by these deaths), and 65% of members identify as clinical and 35% identify as nonclinical. We meet monthly to review each maternal death in NYC to understand the contributing factors leading to the death as well as opportunities for prevention. Since 2018, the NYC MMRC has reviewed almost 400 deaths (391).

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[1] See local law here: The New York City Council - File #: Int 1172-2016 See NYS law establishing the state and New York City Maternal Mortality Review Boards here: https://www.nysenate.gov/legislation/bills/2019/S1819

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According to the NYC and NYS legislation, two MMRCs were established. The NYC MMRC reviews deaths that occur in NYC. The NYC MMRC then shares data with the NYS MMRC. According to the NYS legislation

- The NY State MMRC should provide "information and assistance to the NYC MMRC for the performance of its functions".
- And the NYC MMRC "may request and shall receive upon request from any department, division, board, bureau, commission, local health departments or other agency of the state or political subdivision thereof or any public authority, as well as hospitals established pursuant to article twenty-eight of this chapter, birthing facilities, medical examiners, coroners and coroner physicians **and any other facility providing services** associated with maternal mortality such information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records **and any other information that will help the department under this section** to properly carry out its functions, powers and duties."

Since 2018, The NYC MMRC has requested access from the NY State MMRC and other NY State DOH representatives to a critical data source—the New York Patient Occurrence Reporting and Tracking System (NYPORTS). NYPORTS is a statewide mandatory reporting system that collects information from hospitals and diagnostic and treatment centers about adverse events, including data on maternal deaths and serious injuries. NYPORTS requires hospitals to report adverse events that were not the result of the natural course of an illness and caused an undesirable development in a patient's condition. Reporting must be done within 24 hours or one business day of becoming aware of the event and must include the date, nature, classification, and location of the event, as well as affected patients' medical record numbers. Severe incidents, like wrong-side, wrong-patient, or wrong-procedure surgery, unexpected deaths, and certain equipment malfunctions, have specific, stricter requirements, including an in-depth root cause analysis and corrective action plan, according to a New York State Department of Health document.

An expert NYS DOH committee assembles to conduct the Root Cause Analysis (RCA) and develop an action plan for the hospital or facility in response to a severe incident or unexpected death, including maternal deaths. For example, NYPORTS codes 911 and 912 are specific categories for reporting wrong-site, wrong-patient, and wrong-procedure medical events within New York's mandatory healthcare reporting system. These codes are used by NYPORTS to log errors that occur in hospitals and other treatment centers. These are then grouped into categories of root causes, such as, the level of the clinician providing care, was this an intern, patient to staff ratio, was there adequate staffing, the time of day or night, communication failures, noncompliance with existing procedures, inadequate orientation or training. Some of the categories might overlap within cases. We noted that most Code 911 and Code 912 events had at least three root causes (suggesting a specific and direct causal relationship), as well as multiple contributing

factors (e.g., "environmental conditions" increasing the chance of the adverse event). Complex cases had as many as 10 root causes.

In sum, this data source is critical to the NYC MMRC understanding of what occurred in the hospital and what was recommended as a corrective course of action after a maternal death occurred. The NY State MMRC already has access to this data and has presented it in past public forums. The NYC MMRC also requires access to this data. Access to NYPORTS[2] data would support the NYC MMRC's full understanding of hospital deaths and provide critical information on issues that may have affected the decedent's course of care that are not routinely documented in the medical records such as staffing. I am requesting on behalf of the NYC MMRC that the City Council assists us in gaining this access to this crucial data source to enable us to fully understand and make determinations and recommendations for the maternal deaths to enable us to give full justice and honor to the women and birthing people who have died and their families and communities who lost a loved one.

Common root causes of NYPORTS Code 911 and Code 912 cases include:

1. Communication failures.
2. Inadequately designed procedures/systems.
3. Noncompliance with existing procedures.
4. Team issues: informal norms, hierarchy problems.
5. Inadequate orientation and training.
6. Inaccurate/incomplete scheduling information.
7. Consent – availability, legibility, accuracy, and consistency with other documents.
8. Incomplete history and physical.
9. Inadequate patient identification and assessment.
10. Inadequate pre-operative/pre-procedural verification process.
11. Inconsistent, absence of, or unclear site marking.
12. Room set-up, positioning, prepping, and draping variation.
13. Lack of, or inadequate "time-out."
14. Failure to have complete information available (x-ray, lab, or pathology reports).
15. Failure to correlate available information.
16. Production/time pressures, including case urgency.
17. Lack of compliance monitoring of existing systems.

[2] https://www.health.ny.gov/facilities/hospital/nyports/

OFFICE OF THE BROOKLYN BOROUGH PRESIDENT

ANTONIO REYNOSO
Brooklyn Borough President

**City Council Committees on Hospitals and Women and Gender Equity**
**Oversight hearing: Improving Maternal Health in New York City**
**October 23, 2025**

Thank you, Chairs Louis and Narcisse and members of both committees, for holding this hearing today. My name is Lacey Tauber and I am here on behalf of Brooklyn Borough President Antonio Reynoso to endorse the Council's proposals supporting the collection of accurate and comprehensive data on maternal health outcomes, and to highlight solutions that utilize this data.

NYPORTS data on adverse events in healthcare settings is an important source of information for researchers seeking to improve patient safety and the quality of patient care. This is precisely the sort of work being done by the New York City Maternal Mortality Review Committee (MMRC), whose aim is to combat our city's unacceptable rates of maternal deaths and severe maternal morbidity. NYPORTS data is particularly beneficial because it is legally mandated and very timely. We also know from NYPORTS reports that among the deaths and serious injuries entered into this tracking system, obstetrics-related events are by far the most prevalent. [1,2] Additionally, given the number of health facilities in NYC, most of the NYPORTS-reported events occur in NYC. So it is smart for the City Council to put forward the resolutions being considered today, which call for this data to be regularly audited by the NYS DOH, and for NYPORTS to standardize and specify data variables related to severe maternal outcomes and make this data readily available to City researchers.

Ultimately, the purpose of collecting public health data is to inform choices about funding, programming, and regulations that aim to improve outcomes. What we already know from previous reports is that for the most devastating of adverse maternal health outcomes—pregnancy-associated deaths—the majority were preventable.[3] And from the DOHMH's last five-year report on pregnancy-associated mortality, we know that four of the five community districts with the highest rates of pregnancy-associated death are in Brooklyn. That is why Borough President Reynoso has made improving maternal health in Brooklyn one of his

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[1] New York State Department of Health. New York Patient Occurrence Reporting & Tracking System (NYPORTS), *Summary Statistics 2018 - 2022*.
[2] New York State Department of Health. New York Patient Occurrence Reporting & Tracking System (NYPORTS), *Summary Statistics 2023*.
[3] Maternal Mortality Review Committee, New York City Department of Health and Mental Hygiene. Pregnancy-Associated Mortality in New York City, 2016-2020. September 2024.

highest priorities. He thanks the Council for its ongoing work on this issue and hopes to continue to partner on the following solutions:

**Investing in Public Hospitals:** A 2024 NYS DOH report showed that a significant proportion of Brooklyn residents, especially those with commercial insurance, are electing to access care outside of Brooklyn. Those who do elect to stay in Brooklyn for perinatal care are not going to our public hospitals.[4] There is no reason Brooklyn's public hospitals should fall behind, and it must start from proper investment in fair wages and adequate staffing for maternal and mental health.

**Investing in Midwifery Care:** Research has shown that midwives can play a critical in role in reducing maternal death rates.[5] The midwifery model of care is structured in a personalized and holistic way that has been shown to improve patient satisfaction when compared to obstetric care provided by physicians.[6] Maternity care provided by midwives has also been associated with improved birth outcomes such as fewer C-sections, lower preterm birth rates, lower episiotomy rates, and higher breastfeeding rates.[7]

However, Woodhull is the only public Brooklyn hospital that has centered midwives in obstetric care. In 2022, 71.8% of its births were attended by a licensed midwife, while this number was drastically lower at Kings County Hospital and South Brooklyn Hospital at 4.6% and 14.2% respectively.[8] The Borough President wants to partner with the Council to expand midwifery care and ensure that midwives hold leadership positions at their hospitals.

**Expanding the Perinatal Mental Health Workforce:** Mental health conditions are the single leading underlying cause of pregnancy-associated deaths in NYC. This year, Borough President Reynoso was proud to announce a partnership with Brooklyn College to design and implement an Advanced Certificate in Perinatal Mental Health. This program is the first of its kind and seeks to prepare healthcare, mental health, and early intervention professionals to support expectant and new mothers who are experiencing mental distress. Creating an informed maternal health workforce that can work with parents during the vulnerable perinatal period is critical, and we encourage the City Council to support initiatives that expand the perinatal mental health workforce.

Thank you again for the opportunity to testify today.

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[4] New York State Depart of Health. Report on the New York State Department of Health's Study of Healthcare System Inequities and Perinatal Access in Brooklyn, New York. January 2024.
[5] P. Mimi Niles and Laurie Zephyrin. How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis. (Commonwealth Fund, May 2023).
[6] Vedam, S. et. al. "The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States." (Reproductive Health, June 11, 2019).
[7] Carlson, N.S. et. al. "Influence of midwifery presence in United States centers on labor care and outcomes of low-risk parous women: A Consortium on Safe Labor study." (Birth, September 2019).
[8] Health Data NY—Hospital Maternity Information. (Accessed October 15, 2025).

New York State NURSES ASSOCIATION an affiliate of National Nurses United AFL-CIO

# New York City Council Committee Oversight Hearing by the Committees on Hospitals and on Women and Gender Equity:

## Improving Maternal Health in New York City

## Testimony by the New York State Nurses Association

**Submitted by: Judith Cutchin, DNP, RN, NYSNA First Vice President**

**250 Broadway - 8th Floor - Hearing Room 1**
**Thursday, October 23, 2025, at 1:00 PM**

My name is Judith Cutchin, DNP, RN. I am an elected First Vice President of the NYSNA Board of Directors have worked for more than 30 years at NYC H+H/Woodhull as an RN.

NYNSA represents more than 42,000 frontline nurses for collective bargaining and is firmly committed to equal, high-quality, healthcare coverage for all New Yorkers without regard to their social background, legal status or ability to pay. NYSNA strongly supports action to address racial and socio-economic inequities in care, including persistent and unacceptably high maternal mortality and morbidity rates for poorer mothers and for women of color.

The statistics on maternal mortality and morbidity are widely known and recognized. In 2023, for example, the U.S. average maternal mortality rate was 18.6 deaths per 100,000 live births, but the mortality rate for black women (50.3) was more than three times higher than the rate for white women (14.5).

New York has made some progress toward addressing the maternal health crisis, improving total maternal mortality rates for 2022 to slightly lower than the national average. This progress, however, has not addressed the shocking underlying racial inequities in maternal care in New York, where the maternal mortality rate for black women is *worse* than the national average, with mortality rates of black mothers that are *five* times higher than that for white mothers.

Indeed, the situation is so bad that the State DOH acknowledges that disproportionately high Black maternal mortality and morbidity levels are “indicative of long-standing heath disparities resulting from inequitable care and systemic racism.”

We also know that maternal harm and racial disparities in maternal outcomes can be identified and corrected. The NY State Maternal Mortality Review Board and the CDC estimate that 70% to 80% of documented maternal deaths were preventable with proper access to care, bias free diagnosis and treatment, and timely intervention.

We also note that the Trump administration's policies and budget cuts will worsen the situation, with millions of women of child-bearing age losing Medicaid or ACA exchange health coverage, reductions in the availability of SNAP food benefits, and other cuts to vital services that make women healthier before and during their pregnancies.

In this context it is critical that the NY City government agencies and the New York City Maternal Mortality and Morbidity Review Committee have the information they need to fully capture the scope of the problem, the circumstances and causes leading to maternal deaths and illness, and the data to inform local efforts to reduce maternal mortality and to eliminate the unconscionable racial gap in maternal outcomes.

The proposed batch of bills to improve data collection and analysis under consideration by the Council include:

- **Resolution 1082** (2025), calling on the NYS DOH to share data that it collects from the NY Patient Occurrence Reporting System (NYPORTS) with the NYC Maternal Mortality and Morbidity Review Committee;

- **Resolution 1085** (2025), calling on the NYC H+H system to provide more detailed and standardized reporting on maternal deaths or harm, including at least for 30 days post-partum;

- **Resolution 1086** (2025), calling on the State DOH to create more specific criteria to fully report and track maternal mortality and morbidity by using standardized definitions of adverse events reportable to the NYPORTS system that will capture unreported maternal harms; and,

- **Resolution 1087** (2025), calling on the State DOH to audit and enforce timely and robust reporting of instances of maternal mortality and morbidity, particularly by NY City area hospitals that account for most births but have the lowest rates of compliance with reporting requirements.

Neither the State nor the City will be able to effectively reduce maternal mortality and morbidity rates if they do not know the extent of the problem or have a clear understanding of the causes of too high rates of maternal harm in general and of the disparities in care and outcomes faced by black mothers in particular.

Poor maternal health outcomes constitute a public health crisis and should be addressed with the urgency and decisiveness that they deserve. That is why better data collection and tracking of maternal harm is needed.

NYSNA urges the City Council to pass **Resolutions 1082, 1085, 1086 and 1087.**

# New York City Council

## Committee on Hospitals
## Committee on Women and Gender Equity

Hearing Testimony:
Improving Maternal Health in NYC

Beth McGovern, Associate Vice President

**GREATER NEW YORK HOSPITAL ASSOCIATION**

Chairs Narcisse, Louis, and members of the Committee on Hospitals and Committee on Women and Gender Equity, my name is Beth McGovern, Associate Vice President, Quality and Clinical Initiatives at Greater New York Hospital Association (GNYHA). I am also a registered nurse with a Doctorate of Nursing Practice and certification in Inpatient Obstetrics. GNYHA proudly represents all hospitals in New York City, both not-for-profit and public, and hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

Thank you for the opportunity to speak with you today about maternal health. This year, my organization had the privilege of serving on Speaker Adams's Maternal Health Steering Committee alongside other important maternal health advocates. Today, I would like to detail our member hospitals' efforts to improve care for pregnant people and their newborns, reduce maternal mortality and morbidity, and end the racial disparities in these areas.

Studies show that Black and Brown people die or experience severe complications at higher rates than White people during and after pregnancy. Black people are 5.3 times more likely to die in childbirth than White people in New York City. [1] These racial disparities exist regardless of socioeconomic status, health insurance, education, behaviors, and employment status.

From 2018 to 2022, there were an estimated 27.1 pregnancy-related deaths per 100,000 live births[2] in New York State, which is unacceptably high. New York's hospitals are committed to addressing it, as well as the root causes of these disparities: poverty, discrimination, and systemic and structural racism. Addressing this problem will become more difficult as deep funding cuts that result from the recently enacted Federal One Big Beautiful Bill Act (OBBBA) begin to take effect over the next few years. It is therefore imperative that we all work together to protect hospitals and the pregnant and birthing people they serve.

## The State of Maternal Care

It is critically important for hospitals to provide quality maternal and perinatal care and ensure all birthing people have access to it. Hospitals are among the largest providers of perinatal care in New York via prenatal ambulatory care well visits (inside and outside the hospital setting), labor and delivery care, and postnatal follow-up care. This is particularly true for Medicaid beneficiaries and uninsured individuals. In 2024, 181,806 babies were born in NYS hospitals: 94,967 of those births were billed to Medicaid and 77,176 to commercial insurance; 5,552 were uninsured. Of that total, 93,474 babies were born in New York City (53,948 were billed to Medicaid and 36,755 to commercial insurance; 1,957 were uninsured).[3]

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[1] New York City Department of Health and Mental Hygiene, "Pregnancy-Associated Mortality in New York City, 2022." Available at: https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf

[2] Includes deaths that occur during pregnancy or within one year from the end of pregnancy that are caused by a pregnancy complication, a chain of events initiated by pregnancy, or an aggravation of an unrelated condition by the pregnancy. New York City Department of Health and Mental Hygiene, "Pregnancy-Associated Mortality in New York City, 2022." Available at: https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf

[3] Source: NYS Institutional Cost Reports (ICR).

Hospitals face many challenges to the provision of maternal and perinatal care and keep labor and delivery units open, especially for financially struggling community and safety net hospitals that serve the most vulnerable communities and populations—including Black and Brown people who experience poorer outcomes than White people. These issues and proposed solutions are detailed below:

- ***Social Determinants of Health*.** Birthing people can face many obstacles that impact their physical and emotional health. These can include health-related social needs (HRSNs), such as housing inadequacy, food insecurity, lack of childcare, limited employment opportunities and training, transportation inadequacy, systemic racism, and much more. Investing in and improving the wider social safety net would help address these societal problems and improve health outcomes across the State. While hospitals provide the highest quality patient care, they can ultimately only control what happens within their four walls. In fact, most pregnancy-associated deaths occur outside of the hospital and after the end of pregnancy. According to recent data from the New York City Department of Health and Mental Hygiene (DOHMH), 62.1% of these deaths occur between seven days and one year after the end of pregnancy.[4] To that end, the State government established Social Care Networks under New York's 1115 Medicaid waiver to connect health care providers to community-based organizations to address patients' HRSNs. GNYHA supported this program and helps to brief our member hospitals on new information and connect them with relevant community-based organizations.
- ***Medicaid Rate Inadequacy*.** Around 30 hospitals across the State are on a NYS Department of Health (DOH) "watch list" for closure, primarily in high-need areas like New York City. The primary reason for their financial condition is inadequate Medicaid reimbursement, which was frozen for 10 years and still does not come close to covering the cost of providing care. GNYHA has tirelessly advocated for greater investments in the Medicaid program to bolster the State's entire health care system, but because of the OBBBA, which was passed into law earlier this year, we expect every hospital to face massive funding cuts, which will imperil critically important services. GNYHA and our allies are working to mitigate the fallout to shore up safety net and community hospitals and the patients they serve, including birthing people.
- ***Health Insurance Coverage Gaps*.** Around 95% of New Yorkers have insurance coverage, which is among the highest rates in the country. For years, GNYHA worked to expand the Essential Plan, increase New York State of Health subsidies so more people can afford insurance, and provide greater outreach to Medicaid-eligible individuals who haven't signed up for coverage. Unfortunately, the OBBBA will undo some of these efforts by restricting Essential Plan eligibility, rolling back subsidies, and implementing Medicaid work requirements, among a litany of other harmful policies. GNYHA will continue to work with the City, State, and New York's Congressional delegation to mitigate these terrible policies to preserve coverage for as many people, including new and expecting mothers.
  In past years, we have supported enhancing access to care for birthing people by extending

[4] New York City Department of Health and Mental Hygiene, "Pregnancy-Associated Mortality in New York City, 2022." Available at: https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf

the Medicaid coverage period to one year after the last day of pregnancy to cover the post-partum phase of childbirth, known as the fourth trimester (which lasts up to 12 weeks post-delivery). This is a period of great vulnerability to both physical and emotional complications. We are glad that in 2023, the State expanded post-partum Medicaid coverage, which will improve the long-term health and well-being of the entire family.

- ***Medical Liability Reform*.** New York has the highest medical liability costs in the country, and this broken system makes it harder to provide care to New Yorkers. Perinatal care is no exception: obstetric providers pay some of the highest medical liability costs of any provider group, making it difficult for them to practice in less commercially lucrative areas and for hospitals to provide perinatal services. This is one of the reasons hospitals experiencing financial difficulties often reduce labor and delivery services. The impending financial devastation from the OBBBA makes it imperative that the State address this problem by enacting comprehensive medical liability reform and supporting and expanding programs like the Medical Indemnity Fund, a landmark reform that covers the ongoing medical costs of neurologically impaired infants. For example, the State Legislature could pass S.2228, which would provide medical malpractice insurance premium reductions for physicians and midwives who complete professional education courses that address risk management strategies in obstetrics and midwifery. This would help relieve the exorbitant costs of obstetrics services and improve access to obstetrics care.

## Improving Maternal Care

Hospitals constantly coordinate with government, community groups, not-for-profits, professional organizations, and others to improve perinatal care and reduce maternal mortality and morbidity. Several organizations—including the US Department of Health and Human Services, The Joint Commission, DOH, DOHMH, and the American College of Obstetricians and Gynecologists (ACOG)—have issued recommendations in this area that GNYHA and our members are implementing. Some notable efforts are described below:[5]

- ***Safe Motherhood Initiative.*** The Safe Motherhood Initiative is a statewide collaborative dedicated to improving maternal health outcomes by addressing the leading causes of maternal mortality and morbidity, including obstetric hemorrhage, severe hypertension, venous thromboembolism, maternal sepsis, and cardiac conditions in obstetric care. Recent efforts have been expanded to include perinatal mental health conditions and substance use disorder. The initiative partners with hospitals to develop and implement standardized protocols for managing obstetric emergencies. Through the adoption of evidence-based Maternal Safety Bundles, hospitals have achieved measurable improvements in the timely recognition and treatment of maternal complications. GNYHA, in collaboration with its member hospitals, ACOG, and the Perinatal Quality Collaborative of New York State, continues to engage birthing hospitals across the State in implementing these best practices.

[5] Many of these programs grew out of the efforts of New York City and State Task Forces to reduce maternal mortality and racial disparities, which included a broad group of stakeholders, including hospitals and GNYHA, clinicians, researchers, community organizations, and a 2018 DOH-sponsored listening tour across New York State designed to enable Black and Brown women to share their experiences with the health care system.

To date, 100% of regional perinatal centers and more than 70% of other birthing hospitals in New York State have actively participated in bundle implementation.

- ***New York Perinatal Quality Collaborative NTSV Cesarean Reduction Project.*** The New York Perinatal Quality Collaborative (NYSPQC), led by DOH, is committed to improving maternal and infant outcomes through data-driven, equity-centered quality improvement initiatives. The Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Reduction Project focuses on safely reducing primary cesarean births among first-time mothers with low-risk pregnancies while addressing the racial and ethnic disparities that persist in cesarean delivery rates and maternal outcomes. This project builds upon the foundation of the ***New York State Birth Equity Improvement Project (BEIP)***, a statewide initiative designed to reduce inequities in maternal health care and outcomes. By extending BEIP's framework, the NTSV project integrates an explicit equity lens into every phase of implementation, encouraging hospitals to analyze NTSV cesarean rates by race, ethnicity, and social determinants of health; engage community partners and patients with lived experience; and strengthen practices that foster respectful, person-centered maternity care. Participating hospitals implement evidence-based strategies to promote safe vaginal births, such as standardized labor management practices, enhanced patient education, shared decision-making, and consistent use of labor support techniques. The project also helps hospitals review implicit bias within clinical decision-making and communication processes, ensuring that quality improvement efforts are aligned with equity goals. The project emphasizes data collection and transparent performance monitoring to identify practice variation, address inequities, and sustain progress over time. GNYHA collaborates with the NYSPQC and member hospitals to promote engagement, facilitate peer learning, and share best practices that advance both the quality and equity of obstetric care. Through these collective efforts, hospitals have achieved measurable reductions in NTSV cesarean birth rates, strengthened adherence to labor management guidelines, and improved patient trust and experience.
- ***Hospital Doula Friendliness Project.*** The Hospital Doula Friendliness Project, sponsored by DOHMH, aims to promote equitable, patient-centered maternity care by strengthening collaboration between hospitals and community-based doulas. The initiative helps hospitals create environments that recognize and integrate doulas as essential members of the birthing care team. Participating hospitals receive guidance and technical assistance to assess current policies, identify barriers to doula access, and implement strategies that enhance communication, respect, and inclusion of doulas in labor and delivery settings. Through this work, hospitals are improving patient experiences, advancing birth equity, and fostering trust between health care providers and birthing communities. GNYHA collaborates with DOHMH and member hospitals to support engagement in the project and to promote best practices that sustain doula-friendly hospital cultures citywide.
- ***Maternal Mortality Review Boards (MMRBs).*** Examining cases of maternal mortality and morbidity is key to improving patient care and birth outcomes and reducing racial disparities. The State Legislature passed GNYHA-supported legislation in 2019, convening a group of experts for this purpose (New York City has its own MMRB as specified in State law). This multidisciplinary team, which includes clinicians and experts from GNYHA member

hospitals, reviews maternal death data, identifies the causes of poor outcomes, and shares evidence-based best practices to prevent them in the future. The MMRB focuses on quality improvement, reviewing outcomes of care, conducting peer reviews, and collaborating on process improvements. The New York City Maternal Mortality Review Committee (MMRC) recently produced its annual report, "Pregnancy-Associated Mortality in New York City, 2022." Its key findings include:[6]

- 66 pregnancy-associated deaths (citywide deaths during or within a year of pregnancy)
- 32 deaths were found to be pregnancy-related (death from pregnancy complications)
- Mental health conditions, cardiovascular conditions, and cancer and homicide were the leading causes of pregnancy-associated death
- White, non-Hispanic women comprised 16.7% of pregnancy-associated deaths and 36% of live births, whereas Black, non-Hispanic women comprised 42.4% of deaths and 17.4% of live births, and Hispanic women comprised 28.8% of deaths and 29.4% of births
- Majority (78%) of deaths occurred to individuals with Medicaid as their health insurance, (13% for those with private insurance)

Other MMRC findings include:

- Black, non-Hispanic women had a pregnancy-related mortality rate 5.3 times higher than White, non-Hispanic women
- 25% of pregnancy-related deaths occurred during pregnancy
- The most common pregnancy outcome among pregnancy-associated deaths was a live birth (48.5%). Of these, 17 live births were vaginal and 15 were cesarean.
- The most common social and emotional stressors among pregnancy-related deaths were recent trauma (57.6%), history of domestic violence (37.9%), and unemployment (34.9%)

## Conclusion

Thank you for the opportunity to testify before the City Council on this important issue. GNYHA and our member hospitals will continue to work with government, health care providers, community groups, and others to improve maternal health across New York. We welcome the City Council joining our efforts to protect New York's health care system and the patients it serves during this difficult and tumultuous time by mitigating the immensely harmful effects of the OBBBA. Although we have collectively made progress on this issue, there is still much more work to do.

[6] New York City Department of Health and Mental Hygiene, "Pregnancy Associated Mortality in New York City, 2022." Available at: https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2025.pdf

**Testimony of Sarah March, LMHC, CASAC**
**Program Director, Young Mothers Program**
**Samaritan Daytop Village**
**Before the New York City Council Hearing on Improving Maternal Health**

Good morning, Chair Lee, Chair Louis, and members of the Council,

My name is Sarah March, and I serve as Program Director of the Young Mothers Program (YMP) at Samaritan Daytop Village. For more than a decade, I've had the privilege of supporting pregnant and parenting women navigating substance use and mental-health challenges — women whose experiences are too often left out of our city's maternal-health conversation.

First, I want to thank the Council for its leadership on maternal health and for the new funding supporting the Young Mothers Program. This investment acknowledges that improving maternal outcomes must include support for mothers facing behavioral-health and substance-use challenges.

Across New York City, behavioral-health factors remain a leading driver of poor maternal outcomes.

- Overdose is now a leading cause of maternal mortality, rising by more than 80% in recent years.
- Black women are nearly ten times more likely to die from pregnancy-related causes than white women, and Latinas twice as likely to experience severe complications.
- One in five women experiences postpartum depression, yet only half receive treatment.

Beyond these numbers lies a deeper barrier: stigma. Too many mothers fear that seeking help for depression or addiction will lead to judgment or family separation. If we want to save lives, we must create a system where mothers are met with compassion, not punishment.

We commend the Adams administration for its recent initiatives advancing maternal health.

First, the family-focused substance-use disorder clinic at Lincoln Hospital represents a critical step in integrating addiction and mental-health treatment into maternal care. As the City expands these efforts, we urge Health + Hospitals and DOHMH to partner with community-based programs like YMP. We bring decades of expertise, culturally responsive care, and lived experience that can strengthen clinical systems and ensure no mother falls through the cracks.

Second, the CRIB (Creating Real Impact at Birth) pilot—connecting 300 pregnant New Yorkers to housing subsidies before childbirth—is an important recognition that housing stability is health care. We see firsthand how essential this is: too many of our graduates leave treatment ready to rebuild their lives, only to return to shelter because of a lack of affordable housing. We urge the city to expand the CRIB pilot so that every mother completing treatment has a safe, stable home to continue her recovery.

For over fifty years, Samaritan Daytop's Young Mothers Program has provided comprehensive, family-centered treatment for women with co-occurring mental-health and substance-use disorders while keeping mothers and children together.
Our services include trauma-informed therapy, postpartum-depression treatment, peer recovery and parenting supports, early-childhood education, and housing and employment assistance.

Recognized by SAMHSA as one of only two national models for maternal behavioral health, YMP has demonstrated that when we invest in this group of women, entire families and communities thrive.

Improving maternal health requires addressing behavioral health, stigma, and housing together. With the Council's partnership, we can continue to meet mothers where they are—helping them recover, stay with their children, and build stable futures.

On behalf of Samaritan Daytop Village and the families we serve, thank you for your commitment to maternal health and equity. With your continued support, New York City can become a national model for maternal-health care that truly serves all mothers.

Thank you for your time and leadership.

Sarah March, LMHC, CASAC
Program Director, Young Mothers Program
Samaritan Daytop Village

City Council Hearing on Disability

My name is Eman Rimawi-Doster and I wear many hats in the disabled community.One of the hats I wear is as Executive Director of Diversity Includes Disability, which supports disabled leaders, including artists and performers of all kinds. I myself am an artist, actor, model, photographer and creator when I'm not working on organizing and policy.

The more disabled my body has become over the years, the less accessible I find many roles are. I was recently on Dexter Resurrection and for some reason they cut me from the final episode. Not sure why. I was also on FX's The Beauty, which hasn't been released yet but I'm waiting to see if I'm actually in the episode they filmed.

More importantly, there needs to be more funding opportunities for projects run by disabled people, who are involved in the arts, want to participate but keep getting denied funding and opportunities.

MOPD wasn't entirely honest. Years ago, I along with a number of other Black and Brown disabled women, were not only not helped but given suggestions that weren't jobs at all. There are nearly 1 million people with disabilities in this city. "Helping" less than 200 people when there are so many people who are looking for jobs. Yes, they need more funding and yes, they need more staff. Also, they themselves need more equity training on not discriminating against people with disabilities and identities they don't understand or aren't educated on. They never stay for the public testimony, they tout small numbers when the need is great, they make excuses when they don't actually want to do it.
I appreciated all of your questions. Especially Councilmember Hanif's questions, because she was around the last time MOPD shared THE SAME numbers, several years ago!

As a fellow advocate Gian Pedulla says often, Low expectations lead to low outcomes.

In addition to my aforementioned comments, when I was being considered for MOPD, one of the parts of my 10-point plan for MOPD was to incorporate wheelchair repair into the office. While I didn't get accepted as Commissioner, I did continue my work on getting wheelchair repair to people and my friend Stefan Henry, the Executive Director of Level the Curve, and a wheelchair user, are working on a proposal to start a wheelchair repair. And we sometimes get pushback from people when we ask for support!

As Councilmember Dinowitz stated, suggesting things is great, but mandating is better (I'm paraphrasing). We have spoken several times about document accessibility. I recently realized that a few offices upstate are now providing accessible document submission, which is amazing and makes it easier for people like me to get them documents, but also review what their determinations are. That needs to be available in NYC as well.

Lastly, with the cuts headed our way, I worry about children with disabilities in our schools and their parents. I'm actually working with a few organizations outside of NYC to bring disability equity training to parents and young children, so that we can set them up to succeed.

I'm happy to meet with you all on any and all of these Introductions and Resolutions, as well as lend my expertise to all of these incredible projects.

Thank you so much,

Eman Rimawi-Doster
[redacted]
www.diversityincludesdisability.org

City Council hearing on hospitals and maternal care

Good afternoon. My name is Eman Rimawi-Doster. I was invited to this hearing and I wasn't sure if I'd have time to come but I did come and watched, even though I wasn't going to share live.

I heard a lot of great information during this hearing but I didn't hear anything about accessibility and training for these medical providers for birthing people with disabilities.

I'm both Black and Palestinian. I have lupus, a heart issue, blood clotting issue, nerve damage and I'm a double amputee. I've also lost 3 pregnancies. My second pregnancy caused me to become an amputee, and the doctors at Bellevue didn't listen to me in time, which caused the blood clots to turn my feet black. My 3rd pregnancy was caught at 6 weeks, which caused my heart doctors and rheumatologist to suggest that I get a D and C, rather than being pregnant longer, because they didn't think I, or my baby would survive. The gynecologist that I saw after my procedure was incredibly nasty and insensitive towards me and he had no care for me whatsoever. That was at New York Presbyterian.

Not only do these trainings need to require cultural sensitivity, but it also needs to include disability sensitivity! I've spoken to a number of birthing people with disabilities who have been treated awful in NYC. This needs to be done in an intersectional way. I also hope that the languages used also include ASL.

Since I have had lupus active in my body for 26 years, I've had a long life with disability and chronic illness, I've seen and experienced all kinds of disrespect and disregard for my life and my health. I've been in hospitals in Queens and Manhattan and I've experienced this more times than I can count.

MOPD should have been at this hearing and I'm stunned and appalled that they aren't. The Commissioner is a disabled mother. Why isn't she there?!

If you have any further questions or comments, please reach out.

Thank you so much,

Eman Rimawi-Doster, 347-362-1114
www.diversityincludesdisability.org

1199SEIU
United Healthcare Workers East

# Testimony- NYC Council Oversight Hearing "Improving Maternal Health in New York City"

- Committee on Hospitals
- Committee Women & Gender Equity

Good Afternoon Members of the City Council,

On behalf of 1199SEIU's 300,000 New York members, I would first like to thank the City Council Committees on Hospitals and Women & Gender Equity for holding this hearing on this extremely important issue of maternal health in this city.

The issue of maternal mortality and morbidity – particularly among women of color - has increasingly become an issue for New York, especially in the City. New York State ranked 30th in the nation in its maternal mortality rate, and this rate has been on the rise over the past two decades [1].

According to the NYC Department of Health, pregnancy-associated mortality ratios in NYC have remained steady for the past two decades for some demographics, while rising for others. From 2016 to 2020, Black non-Hispanic people were six times more likely to die of a pregnancy-related cause compared to white non-Hispanic people [2]. In 2022, 42.4% of all pregnancy related deaths in NYC were Black New Yorkers, while only accounting for 17.4% of live births that year [3].

As a union representing many women of color who work in healthcare, this issue is two-fold for 1199SEIU. The vast majority of our members are women of color, so many have or will experience the joy of childbirth along with the fear of knowing that they are at greater risk of complications. From issues of access to affordable prenatal and perinatal care, discriminatory and racist maternal care practices and limited support for postpartum mental health, we must do more to ensure the experience of giving birth is positive and safe for all demographics.

As healthcare workers, they face the daily challenge of providing care to low-income New Yorkers in settings that often struggle to recruit and retain needed staff and struggle to keep the doors open. With increasing divestment from healthcare, such as the $1 trillion the federal government just strip from Medicaid funding, workers are consistently being tasked to do more with less.

NEW YORK CITY PRINCIPAL HEADQUARTERS
498 7th Avenue
New York, NY 10018
(212) 582-1890
www.1199seiu.org

CAPITAL REGION
33 Tech Valley Drive, Suite 101
East Greenbush, NY 12061
Tel. (518) 396-2300
Fax (518) 992-5099

BALTIMORE, MARYLAND
611 North Eutaw Street
Baltimore, MD 21201
Tel. (410) 332-1199
Fax (410) 332-1291

MASSACHUSETTS
108 Myrtle Street, 4th Fl.
Quincy, MA 02171
Tel. (617) 284-1199
Fax (617) 474-7150

BUFFALO
2421 Main Street, Suite 100
Buffalo, NY 14214
Tel. (716) 982-0540
Fax (716) 876-0930

FLORIDA
2881 Corporate Way
Miramar, FL 33025
Tel. (305) 623-3000
Fax (305) 826-1604

GOUVERNEUR
93 E. Main St.
Gouverneur, NY 13642
Tel. (315) 287-9013
Fax (315) 287-7226

HICKSVILLE
100 Duffy Ave., Suite 300 West
Hicksville, NY 11801
Tel. (516) 542-1115
Fax (516) 542-0919

NEW JERSEY
555 Route 1 South, 3rd Fl., Suite 301A
Iselin, NJ 08830
Tel. (732) 287-8113
Fax (732) 287-8117

ROCHESTER
259 Monroe Ave., Suite 220
Rochester, NY 14607
Tel. (585) 244-0830
Fax (585) 244-0956

SYRACUSE
250 South Clinton Street, Suite 200
Syracuse, NY 13202
Tel. (315) 424-1743
Fax (315) 479-6716

WHITE PLAINS
10 Bank Street, 7th Floor, Ste.740
White Plains, NY 10606
Tel. (914) 993-6700
Fax (914) 993-6714

7.5 million New Yorkers rely on Medicaid to get health coverage, over 4 million are New York City residents. Medicaid covers a significant portion of healthcare services across the city, including 58% of all maternal and newborn care.

We appreciate the city and states commitment to this issue and acknowledge the emphasis on increasing access to programs that provide at-home care, such as midwives and doulas during childbirth. The resolutions introduced today are another step in the right direction to ensure we are prioritizing the health and wellness of pregnant people as they are going to give birth. Having correct data on any adverse maternal health events helps us identify patterns and needs.

The City also needs to continue prioritizing the growth of the healthcare workforce, specifically maternity care, so it looks more like the people being cared for. Providing adequate support to encourage low-income women and women of color to participate in workforce training is one way to increase diversity in the workers providing maternity care. We should also be putting an emphasis on recruitment of incumbent workers such as nurse aides, LPNs, and homecare workers, transitioning them into these very crucial maternal care roles.

1199SEIU's Training and Employment Funds runs a Career Pathways Training (CPT) program that works to support and empower New Yorkers to join the healthcare workforce by providing accessible, high-quality training and educational opportunities at no cost. This program is made possible from collaboration at the state level, federal funding and those on the ground committed to fighting to strengthen the healthcare workforces in our state and city. Programs like these are a great way to ensure that all New Yorkers, regardless of background or financial circumstances, have the tools, knowledge and resources necessary to pursue fulfilling careers in healthcare. Especially in those areas typically under resourced like psych and maternal health.

We appreciate the attention the City Council is bringing to this important issue and hope this commitment will continue to be reflected in permanent investments in maternal care for pregnant people around this city.

Looks great – maybe just shout out the Career Pathways Training program that the Funds is running with support from the Federal waiver as one strategy to support the workforce.

Contact:
Tori Newman Campbell
Legislative Coordinator
Tori.newman@1199.org

1. https://raisingnewyork.org/maternalhealth/
2. https://www.nyc.gov/site/doh/data/data-sets/maternal-morbidity-mortality-surveillance.page
3. https://www.politico.com/newsletters/weekly-new-york-health-care/2025/10/06/pregnancy-associated-deaths-in-new-york-city-are-up-slightly-new-report-finds-

VNS Health

Oversight Hearing on Improving Maternal Health in New York City:
VNS Health Testimony
October 23, 2025

Good afternoon Chair Narcisse, Chair Louis and members of the Committees on Hospitals and Women and Gender Equity. My name is [insert], and I am [insert] at VNS Health, New York's largest nonprofit home and community-based health care organization. Thank you for the opportunity to testify today.

**Who We Are and Our Commitment to Maternal Health**

For over 130 years, VNS Health has helped New Yorkers live, age, and heal where they feel most comfortable: at home and in their communities. Through our Bronx Nurse-Family Partnership (NFP) program, we provide critical support to low-income, first-time mothers from early pregnancy through their child's second birthday. Since launching in the Bronx in 2006, we have served over 7,600 families.

Our home nurses build trusted relationships with clients, helping them achieve healthy pregnancies, strengthen parenting skills, and reach education and employment goals. In 2024 alone, we served 761 families, completed over 8,100 nurse visits, and provided essentials like diapers, books, and formula to more than 300 families.

The Bronx NFP program plays an important role in improving maternal and infant health outcomes in communities facing some of the city's highest rates of poverty, preterm birth, and maternal morbidity. Our work is made possible in part by City Council Discretionary Funds, and we want to thank the Council for its continued commitment to supporting New York City's mothers and babies.

**Alignment with Maternal Health Resolutions**

Nurse home visiting is one of the most effective ways to improve maternal and infant health, but it works best alongside other system-level measures that strengthen the continuum of care. Data collection, accountability, and coordinated policies, like those advanced through these resolutions, are essential to ensuring that every mother receives the care and support she needs.

VNS Health supports Resolutions 1082, 1085, 1086, and 1087, which together seek to improve how maternal health data is collected, shared, and analyzed to strengthen outcomes for mothers citywide. These measures—focused on better data consistency, transparency, and oversight—are critical to understanding disparities, identifying preventable causes of maternal morbidity and mortality, and preventing poor outcomes before they occur.

VNS Health

As a home health agency, VNS Health has seen firsthand the impact that the creation of new occurrence codes can have on accurately treating, tracking, and addressing specific health issues and trends. We appreciate Resolution 1086's proposal to establish new occurrence codes to better identify adverse outcomes and support mothers across the city.

We also support the enactment of Resolution 1085, which expands the definition of adverse maternal health events to include events occurring up to 30 days post-partum. As an organization whose nurses work closely with mothers both before and after pregnancy, we know that adverse health issues do not always occur immediately after childbirth. This expanded definition will help ensure that maternal health outcomes are tracked more accurately and that families receive the follow-up care they need.

In addition, we are aligned with Resolution 1082, which strengthens data sharing between state and city partners, and Resolution 1087, which enhances data quality and completeness. Together, these policies will expand our collective understanding of maternal mortality and morbidity and enable faster, more coordinated responses to protect mothers.

While these proposed policies may add additional administrative responsibilities, we believe the resolutions represent sound public health practice and will ultimately strengthen New York's ability to identify risks early, close gaps in care, and save lives. We strongly support any initiatives that will better allocate resources, track maternal health outcomes, and improve healthcare for New York City's mothers.

**Conclusion**

We thank the City Council for its ongoing leadership and investment in maternal health, including our Bronx Nurse Family-Partnership work. We welcome the opportunity to partner with the city to ensure that every mother, no matter her neighborhood or income, has access to the support, information, and care she needs for a healthy pregnancy and a strong start for her child.

Thank you for the opportunity to provide testimony.

633 3rd Avenue
New York, NY 10013
PH 212.254.8900
FAX 212.260.6218
www.cssny.org

**David R. Jones**
President & Chief Executive Officer

**Steven L. Krause**
Executive Vice President &
Chief Operating Officer

October 23, 2025

Chair Farah N. Louis and Members of the Committee on Women and Gender Equity
Chair Marcedes Narcisse and Members of the Committee on Hospitals
New York City Council
City Hall
New York, NY 10007

**RE: Improving Maternal Health in New York City**

Dear Chair Louis, Chair Narcisse, and committee members,

The Community Service Society of New York (CSS) would like to thank the City Council for the opportunity to provide comments on opportunities to improve maternal health in New York City. CSS is an 180-year-old organization that aims to build a more equitable New York for low- and moderate-income individuals, assisting over 130,000 New Yorkers annually in accessing health care. We achieve this through a live-answer helpline and partnerships with over 50 community-based organizations operating in every county of New York State. Annually, CSS and its partners save consumers over $80 million in health care costs.

The September 2025 annual report on Pregnancy-Associated Mortality in New York City issued by the NYC Maternal Mortality Review Community (M3RC) showed that the number of pregnancy-associated deaths *increased* by 13.7 percent in 2022. In addition, the report showed that among those who died within a year of pregnancy, 42 percent were Black, despite Black New Yorkers only accounting for 17 percent of births that year. The committee also found that most deaths could have been prevented, indicating the urgency of regulatory intervention to improve outcomes and health equity.

In addition to disparities by race and ethnicity, maternal health outcomes in New York City vary by neighborhood. For example, between 2016 and 2020, the Crown Heights community district in Brooklyn reported a pregnancy-associated mortality ratio of 114.5 deaths per 100,000 live births (the second highest in New York City). The adjacent community district of Fort Greene/Brooklyn Heights reported only 47.8 pregnancy-associated deaths per 100,000

live births over the same time period.[1] These inequitable outcomes further underscore the need for regulatory intervention.

CSS supports the proposed initiatives to improve the reporting and tracking of adverse maternal health events in New York City, with minor adjustments to enhance transparency and ensure thorough data collection. CSS recommends three additional immediate actions the City can take to reduce maternal mortality and racial disparities in maternal outcomes.

I. **Res 1082-2025:** Resolution calling on the New York State Department of Health (NYSDOH) to confidentially share data regarding adverse maternal health events from the New York Patient Occurrence Reporting and Tracking System (NYPORTS) with the M3RC.

With a recommendation, CSS supports this initiative to improve access to data for the M3RC. Currently, NYPORTS is a State-run system, and NYSDOH does not provide NYPORTS data to the New York City Department of Health and Mental Hygiene (NYCDOHMH) or NYCDOHMH entities, including M3RC. Given the findings on preventable deaths included in the September 2025 M3RC report, it is critical that the City can access data on patient safety incidents, including surgical errors, medication errors, unexpected deaths, and near misses related to maternal care. With NYPORTS data, NYCDOHMH and M34C could develop a better understanding of the circumstances surrounding maternal deaths in New York City and develop actionable policies to address them.

Advocates have expressed concerns regarding a bill to regulate the sharing of health information (S929/A2141). The bill passed both chambers of the New York State Legislature this session and may complicate the NYSDOH's ability to share NYPORTS data with the M3RC.

*Recommendation:* CSS recommends that the City Council amend the resolution to request that the Legislature and Governor Hochul include a chapter amendment to explicitly allow data sharing between government entities before signing S929/A2141 into law.

**II. Res 1085-2025:** Resolution calling on New York City Health and Hospitals (H+H) facilities to report to NYPORTS on adverse maternal health events based on an expanded and standardized definition of adverse maternal health events, including adverse events at least 30 days postpartum.

With a recommendation, CSS supports the initiative to require H+H facilities to report to NYPORTS on adverse maternal health events, using an expanded and standardized definition of these events. Currently, there is no widely agreed-upon definition of maternal health, of what constitutes an adverse maternal health event, or the timeline in which an intervention or complication should be considered related to maternal health. Res 1085-2025 calls upon H+H to fill in this data gap and work with NYPORTS and maternal health advocates to standardize these

[1] Pregnancy-Associated Mortality in New York City, 2016-2020, Maternal Mortality Review Committee, New York City Department of Health and Mental Hygiene. September 2024. https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf.

definitions. CSS supports this initiative to ensure the State and City have the most accurate data possible to track adverse maternal health events.

The resolution specifies that the definition of adverse maternal health events should cover events at least 30 days postpartum. Nationally, 52 percent of maternal deaths occur postpartum.[2] According to the September 2025 M3RC report, the leading causes of late maternal deaths—occurring between six weeks and one year postpartum—are distinctly different from the leading causes of maternal deaths during and immediately after pregnancy. The M3RC report also includes many recommendations related to ensuring maternal health during the postpartum period.

There are three commonly used measures of maternal deaths: (1) pregnancy-associated mortality (deaths during pregnancy and up to one year postpartum); (2) pregnancy-related mortality (deaths during pregnancy and up to one year postpartum that are related to pregnancy); (3) and maternal mortality (deaths during pregnancy and up to 42 days postpartum that are related to pregnancy.

Collecting data on adverse maternal health events for up to a year postpartum provides critical information about racial inequities in maternal health outcomes. A 2021 NIH-funded study found that late maternal deaths were 3.5 times more likely among Black women than White women. It demonstrated that the risk of postpartum cardiomyopathy was six times higher among Black women, compared to White women.[3] For these reasons, only requiring data collection for adverse maternal health events for a minimum of 30 days postpartum risks missing critical data to understand the landscape of adverse maternal health events in New York City.

*Recommendations:* CSS has two recommendations. First, the City should amend the resolution to require H+H to track adverse maternal health events through one year postpartum to ensure pregnancy-associated and pregnancy-related events are captured in the NYPORTS data. To do so, the City should require H+H to track adverse maternal health events up to one year postpartum for any readmissions to the H+H system. If provided access to the NYPORTS data, the City should use death certificates, vital records linkage, and hospital discharge data to link any adverse maternal health events.

Second, CSS recommends that the City Council amend this definition to include adverse maternal health events at least one year postpartum for patients who are readmitted to the H+H system. In addition, the City should continue to use death certificates, vital records linkage, and hospital discharge data to identify pregnancy-associated deaths.

III. **Res 1086-2025:** Resolution calling on the NYSDOH to create a new and separate occurrence code for maternal mortality and standardize the definition of events reportable to the NYPORTS.

[2] Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries, The Commonwealth Fund. November 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.
[3] NIH-funded study highlights stark racial disparities in maternal deaths, NIH. August 2021. https://www.nih.gov/news-events/news-releases/nih-funded-study-highlights-stark-racial-disparities-maternal-deaths.

With a recommendation, CSS supports the initiative to call on NYSDOH to track maternal mortality using a separate code and to standardize events reported to NYPORTS. Currently, there are significant inconsistencies in NYPORTS reports of adverse medical events by facility, with rates up to 20 times greater between otherwise comparable hospitals in New York City. While maternal death is a category in NYPORTS, the language around classification is unclear and likely being interpreted differently across hospitals. The NYSDOH and M3RC classify a pregnancy-associated death as the death of a birthing person from any cause during pregnancy or within one year of the end of pregnancy, regardless of the outcome of the pregnancy. This definition differs from the State Maternal Mortality Review Board, aligned with the World Health Organization, which defines maternal death as the death of a birthing person while pregnant or within 42 days of termination of pregnancy.

*Recommendation:* CSS recommends that the City Council adopt the M3RC definition for a pregnancy-associated death to capture data up to a year postpartum for the reasons outlined in section II.

**IV. Res 1087-2025:** Resolution calling on the NYSDOH to conduct regular audits of NYPORTS data, and to require hospitals to fill in missing data retroactively.

With recommendations, CSS supports the initiative to call upon NYSDOH to audit NYPORTS data and require hospitals to fill in missing data. An audit of the NYPORTS data, with publicly available findings, has not been conducted since the 2009 New York State Comptroller's report. This report found that 84 percent of occurrences that were supposed to be reported within 24 hours, including deaths, were reported late. It also found that New York City hospitals, in particular, underreported medication administration errors.[4]

CSS recommends that the City Council, if given access to NYPORTS data by DOH, issue annual reports that break out NYPORTS findings and all data on maternal deaths by race and ethnicity. The 2025 M3RC report concerningly omits a table of the underlying causes of pregnancy-associated deaths by maternal race and ethnicity. This data, which has been included in previous NYCDOHMH/ M3RC reports on pregnancy-associated mortality, consistently shows variation in the cause of death by race and ethnicity. Specifically, while mental health conditions have been the leading overall cause of death, and the leading cause of death for White women, cardiovascular conditions have been the leading cause of death for Black women.[5] Given that the City has found that mental health conditions are the overall leading cause of death again, it is critical that the City release data to show if this finding holds across racial and ethnic groups.

*Recommendation:* CSS urges the City to return to its practice of publicly reporting data by race and ethnicity alongside underlying cases of pregnancy-associated deaths. This data

[4] "The High Costs of Weak Compliance With the New York State Hospital Adverse Event Reporting and Tracking System," Office of New York City Comptroller William C. Johnson. March 2009. https://comptroller.nyc.gov/wp-content/uploads/documents/03-09-09-nyports-policy-report.pdf.

[5] Pregnancy-Associated Mortality in New York City 2018-2020, Maternal Mortality Review Committee. Page 30. https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf.

should be publicly reported on the NYCDOHMH website and on the forthcoming website of the Office of Healthcare Accountability.

## V. Immediate actions the City can take to reduce maternal mortality and racial disparities in maternal outcomes.

Access to quality data is an essential step towards reducing maternal mortality in New York City. However, data collection and access are not enough to prevent maternal mortality. The 2025 M3RC report found that **86.4 percent of pregnancy-associated deaths had some chance of being prevented**. The City needs to act immediately to prevent maternal mortality and address racial disparities.

CSS has three additional recommendations for the City Council to consider.

### 1. Require that all patients who have given birth in New York City who are uninsured or have Medicaid coverage be discharged with an automatic blood pressure cuff.

According to the 2025 M3RC report, the second leading cause of pregnancy-associated deaths in New York City in 2022 was cardiovascular conditions. One national study found that cardiac conditions make up over half of postpartum deaths occurring between 43 days and one year after birth.[6]

NIH researchers found that the risk of postpartum cardiomyopathy is six times higher among Black women, compared to White women.[7] A previous NYC report includes a table of the underlying causes of pregnancy-associated deaths by maternal race and ethnicity from 2016 to 2020. While the report finds that the overall most common cause of pregnancy-associated death is mental health conditions, this does not hold for Black or Asian/Pacific Islander women. Mental health conditions are the most common cause of pregnancy-associated deaths among White-non-Hispanic women. For Black women, there was over double the proportion of pregnancy-associated deaths due to cardiovascular conditions as there was for White women, and it was the leading cause of death.[8]

A proven method to catch postpartum hypertension early is to send patients home with an automatic blood pressure monitor, instructions on blood pressure self-monitoring, and guidance on warning signs. A 2024 study found that using remote blood pressure measurement was cost-effective in 99 percent of simulations.[9] Another study of patients with postpartum hypertension found that remote monitoring led to decreased Emergency Department visits and readmission

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[6] Collier AY, Molina RL. Maternal Mortality in the United States: Updates on Trends, Causes, and Solutions. Neoreviews. 2019. https://pmc.ncbi.nlm.nih.gov/articles/PMC7377107/.

[7] [7] NIH-funded study highlights stark racial disparities in maternal deaths, NIH. August 2021. https://www.nih.gov/news-events/news-releases/nih-funded-study-highlights-stark-racial-disparities-maternal-deaths.

[8] Pregnancy-Associated Mortality in New York City 2018-2020, Maternal Mortality Review Committee. Page 30. https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2016-2020.pdf.

[9] Mei JY, et al. Remote blood pressure management for postpartum hypertension: a cost-effectiveness analysis. Am J Obstet Gynecol MFM. 2024 https://pmc.ncbi.nlm.nih.gov/articles/PMC12150216/.

rates by over 80 percent.[10] Patients in a home blood pressure monitoring program are significantly more likely to have blood pressure recorded within the first 10 days postpartum. Further, patients in the program are more likely to provide multiple blood pressure values which allows for improved clinical decision making.[11] The 2025 M3RC recommends the NYSOH and NYCDOHMH create a campaign to raise public awareness on postpartum warning signs, with a focus on cardiovascular disease and postpartum depression. While important, public awareness alone is not enough to prevent postpartum maternal mortality.

*Recommendation:* CSS recommends that the City ensure that blood pressure is remotely monitored for all people who give birth in New York City by sending them home with a blood pressure cuff.

2. **Require that all patients with Medicaid who have given birth in New York City be offered a pre-discharge scheduled home visit.**

As discussed above, racial disparities are particularly pronounced in postpartum maternal mortality, with cardiovascular conditions as a leading cause of death for Black women postpartum. The 2025 M3RC report includes a series of recommendations related to postpartum care. However, the report's recommendations focus on creating a network of maternal medical homes to coordinate postpartum care, not on home visits. It is essential to provide a variety of ways to access postpartum care.

Home visits have been shown to reduce Emergency Department visits in the first 12 weeks postpartum for low-income patients. This reduction in Emergency Department visits is cost-effective and may improve postpartum care delivery. Patients who receive a home visit are likely to have improved health literacy, education about what to expect in the postpartum period, and their health concerns triaged before they seek emergency care.[12]

*Recommendation:* CSS recommends that the City require hospitals to schedule a postpartum home visit for all patients with Medicaid before discharge.

3. **Leverage NYCDOHMH's surveillance systems to document and investigate "near misses" and preventable maternal deaths**

NYCDOHMH is one of the largest public health agencies in the world, with 220 years of experience, a $1.6 million annual budget, and over 7,000 employees. It has been on the forefront

[10] Mei, Jenny Y., et al. "Standardized clinical assessment and management plan to reduce readmissions for postpartum hypertension." Obstetrics & Gynecology 142.2 (2023): 384-392. https://journals.lww.com/greenjournal/fulltext/2023/08000/Standardized_Clinical_Assessment_and_Management.20.aspx. Hoppe, K., et al. "Telehealth with remote blood pressure monitoring compared with standard care for postpartum hypertension," American Journal of Obstetrics and Gynecology, Volume 223, Issue 4, 2020, Pages 585-588, https://www.sciencedirect.com/science/article/abs/pii/S0002937820305548.

[11] Corlin, T., et al. "Postpartum remote home blood pressure monitoring: the new frontier," AJOG Global Reports, Volume 3, Issue 3, 2023, https://www.sciencedirect.com/science/article/pii/S2666577823000928.

[12] Rokicki S, et al., "Home Visits and the Use of Routine and Emergency Postpartum Care Among Low-Income People: A Secondary Analysis of a Randomized Clinical Trial," JAMA Network Open. 2024. https://pmc.ncbi.nlm.nih.gov/articles/PMC11667346/#zoi241429r34.

of investigating, surveilling, and remediating major epidemics, including typhoid, multi-drug resistant tuberculosis, and M-Pox. As the nation's oldest municipal public health agency, NYCDOHMH serves a critical role in setting the standard of care for municipalities across the country.

Unfortunately, the maternal mortality frequency and racial disparities in maternal deaths have continued to worsen despite the steps the City has taken to address these crises. While the M3RC reviews and makes recommendations to prevent future deaths, the City needs to go further to leverage its surveillance expertise and public health authority to investigate and remediate maternal mortality as it has done with communicable diseases in the past.

Thank you for the opportunity for the public to comment on this matter. Should you have any questions, please do not hesitate to contact Mia Wagner at mwagner@cssny.org.

**Testimony of**
**NYU Langone's Together Growing Strong**
**to the**
**New York City Council**
**Committee on Hospitals and Committee on Women and Gender Equity**
**Oversight - Improving Maternal Health in New York City**
**October 23, 2025**

Thank you, Chairs Narcisse and Louise and members of the Committees on Hospitals and Women and Gender Equity for holding this important hearing. I am Bonnie Kerker, MPH, PhD, professor of population health and child and adolescent psychiatry at the NYU Grossman School of Medicine, and the director of Together Growing Strong at NYU Langone Health. I am pleased to provide testimony on the topic of improving maternal health in New York City as well as testimony in support of Resolution 1082-2025.

Together Growing Strong (TGS), housed in NYU Langone's Department of Population Health at the NYU Grossman School of Medicine, is a community-partnered initiative that aims to enhance the health, wellbeing, and development of young children and their families in Sunset Park, Brooklyn, from the prenatal period through age five. A large part of TGS focuses on enhancing pregnant and postpartum women's well-being, in partnership with the Family Health Centers at NYU Langone, one of the largest Federally Qualified Health Center networks in the nation. TGS weaves together a portfolio of evidence-based and evidence-informed clinical, educational, and community-based initiatives, including the following two programs to support mothers' mental health. Reach Out, Stand strong, Essentials for new mothers (ROSE) is an evidence-based postpartum depression prevention program that aims to prevent depression among postpartum women by increasing support and self-efficacy and decreasing stress. Bonded by Baby is 12-week program for caregivers of newborns to create strong social networks by providing a structured environment for parents to connect, share experiences, and receive expert guidance in weekly clinician-led group meetings. TGS delivers these programs in multiple languages and adapts the content to be culturally-sensitive through an iterative process of implementation, feedback, modification, and evaluation.

Maternal health is a critical issue that requires urgent attention, especially in New York City, where significant disparities persist. While it's imperative to continue to monitor and work to prevent maternal mortality, I support the New York State Department of Health confidentially sharing data regarding adverse maternal health events from the New York Patient Occurrence Reporting and Tracking System with the New York City Maternal Mortality and Morbidity

Review Committee, as proposed in Res 1082. Importantly, this would expand maternal health surveillance to include more morbidity events. Severe maternal morbidity (SMM) is an often-overlooked crisis that affects far more women than maternal deaths, and it carries profound health, social, and economic consequences.

For every maternal death, it is estimated that 50 to 100 women experience SMM—complications during pregnancy, childbirth, or postpartum that lead to serious, sometimes permanent health issues (Geller et al., 2018; Elci et al., 2025). The rate of SMM in the United States has more than doubled over the past two decades, growing from 74 per 10,000 hospitalizations in 1998 to 163 per 10,000 in 2010–2011 (Geller et al., 2018). Racial disparities are prevalent nationally and in New York City, with the highest rate of SMM reported among Black women, even after controlling for socio-economic status (Leonard et al., 2019; Howland et al., 2019). Further, women living in under-resourced areas and those with government insurance are disproportionately affected by SMM (Yu et al., 2024; Geddes-Barton et al., 2025; Elci et al., 2025), which is typically discussed as including pulmonary embolism, major obstetric hemorrhage, eclampsia and septicemic shock (Leitao et al., 2022).

These unexpected health outcomes impact women's long-term well-being and functioning, as well as the welfare of their families, children, and communities. SSM, for example, is associated with preterm birth, low birth weight, poor neonatal Apgar scores, and longer NICU stays (Geller et al., 2018). The burden of maternal morbidity does not end with childbirth—it impacts families and communities long after. Severe complications can prevent mothers from returning to work, contributing to their communities, or fully participating in family life. Addressing maternal morbidity is not only a matter of health equity—it is essential to the social and economic well-being of New York City as a whole. Understanding the prevalence of maternal morbidities in different communities can enable us to develop interventions and resources that not only improve quality of life for these individuals but also prevent morbidity from progressing to mortality.

Mental health is a particularly critical, yet often neglected, aspect of maternal morbidity—one that has a ripple effect on women, their children, and their families. Perinatal mental health conditions, including depression and anxiety, impact up to 20% of women during pregnancy and the postpartum period (Gimbel et al., 2024). Mental health treatment services are underfunded and far too scarce. Monitoring the prevalence of maternal mental health diagnoses can lead to the development of accessible and culturally relevant services that can prevent these conditions from progressing to more severe disease or death. Importantly, mental health conditions, including substance use disorders, have been identified by state Maternal Mortality Review Committees as the leading cause of preventable maternal mortality, accounting for nearly a quarter of maternal deaths in the United States (Wisner et al., 2024; Gimbel et al, 2024).

Effective and accessible mental health treatment in the perinatal period is critical not only for women but for their children as well, as untreated disease can compromise infant health and the ability of women to function and care for their children. Postpartum depression has been associated with insecure maternal-infant attachment, unsafe parenting practices, increased emergency care for infants, and poor cognitive and mental health outcomes in children (Field 2010; Murray et al. 2010; Misner et al., 2024). Left untreated, mental health conditions can further compromise families' ability to adapt and thrive during what should be a joyful life stage. By recognizing maternal mental health as a core component of maternal morbidity, New York City can help alleviate these burdens and protect future generations.

Broadening surveillance to expand the inclusion of maternal morbidity can improve outcomes for women and children alike. Identifying and reporting on morbidities creates opportunities to ensure that lifesaving interventions are available and accessible, which can prevent these conditions from progressing to mortalities. Including both physical and mental health morbidities in this surveillance can reduce disparities and build a healthier, stronger future for families across New York City.

Thank you for your time and commitment to addressing maternal health and morbidity, including mental health of pregnant and parenting women. NYU Grossman School of Medicine and NYU Langone Health are happy to work with the Council to improve Maternal Health in New York City.

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*Safe Relationships. Healthy Families. Supportive Community*

*500 7th Avenue 8th Floor*
*New York, NY 10018*
*212-742-1478*
www.shalomtaskforce.org – Info@shalomtaskforce.org

Good afternoon,

My name is Kim Susser. I am here on behalf of Shalom Task Force, an agency that has served the New York City Jewish community for over 30 years. Our mission is to combat domestic violence and foster healthy relationships through culturally competent direct legal services, youth and adult education, hotline services, and community engagement.

Shalom Task Force strongly supports Int. 1216, which would require the Office to End Gender-Based Violence to create and distribute posters that provide information about

a) how to identify signs of gender-based violence and
b) information about gender-based violence services available in the city, including free hotline services.

Such posters will be distributed to hair, nail, and skincare salons at no cost.

This bill follows the precedent of many existing requirements for businesses to display important public information—such as workers' rights, health regulations, and human trafficking -and expands that model to include critical, potentially life-saving resources.

For many within the Orthodox Jewish community, hair salons represent a unique and vital touchpoint. Married women in many factions of this community cover their hair in public, either by wearing a wig or scarf. As a result, salons are often one of the few spaces where they are uncovered and visible, sometimes revealing both physical and emotional signs of abuse.

STF regularly conducts trainings for salon staff and estheticians, many of whom have shared how they have become de facto therapists, case workers, or confidants for their clients. With visible signage in their workplaces, these professionals can easily direct clients to appropriate support services—helping survivors access care while allowing salon staff to maintain healthy professional boundaries.

Displaying signage in these settings provides a discreet and empowering opportunity for individuals to access information and help safely.

And, signs will serve an educational purpose as well. Many of our community members believe that only physical violence constitutes abuse. On our hotline, we callers often begin with statements such as, "He doesn't hit me" or "I'm not being abused' so I'm not sure you can help me."

In fact, a study conducted by the UJA Federation of New York during the 2020 pandemic found that one in three Jewish victims did not believe their situation was serious enough to seek help.

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*New York, NY 10018*
*212-742-1478*
www.shalomtaskforce.org – Info@shalomtaskforce.org

Raising awareness can bridge that gap in understanding and help survivors recognize that emotional, financial, and verbal abuse are also forms of gender-based violence.

Passing Int. 1216, the City Council can empower community members and local businesses to become part of a citywide safety net—ensuring that information, education, and hope are as accessible as a salon mirror.

Thank you for the opportunity to testify and for your continued commitment to addressing gender-based violence in all communities across New York City.

Testimony of NYU McSilver Institute for Poverty Policy and Research and
NYU Langone's Institute for Excellence in Health Equity
to the
New York City Council
Committee on Hospitals and Committee on Women and Gender Equity
Oversight - Improving Maternal Health in New York City
October 23, 2025

Thank you Chairs Narcisse and Louis and members of the Committees on Hospitals and Women and Gender Equity for holding this important hearing and for the opportunity to provide testimony on the topic of improving maternal health in New York City and in support of three resolutions (Res 1086, 1087, 1082). This testimony is submitted by Damali M. Wilson, PhD, MSN, Maternal Health Equity Fellow at the NYU McSilver Institute for Poverty Policy and Research and NYU Langone Health's Institute for Excellence in Health Equity; Rose Pierre-Louis, JD, Executive Director at the NYU McSilver Institute for Poverty Policy and Research; and Natasha Williams, EdD, MPH, Associate Professor at NYU Langone Health's Institute for Excellence in Health Equity. This hearing, and the proposed resolutions, are important steps towards more robust tracking and trending in our health care system, especially our maternal health system. According to the New York City Department of Health and Mental Hygiene (DOHMH), not only are pregnancy-associated mortality ratios worsening, but these maternal deaths are largely preventable.[1] Further, while death necessitates urgent action, for every maternal death in the United States, there are nearly 70 near-miss events (usually the sequelae of complications) which are also an urgent call to action.[2]

The McSilver Institute for Poverty Policy and Research (McSilver) at New York University is committed to generating knowledge about the root causes of poverty, developing evidence-based interventions to address its consequences, and rapidly translating research findings into action through policy and practice. The Institute currently maintains a large portfolio in health across the lifespan with an explicit focus on maternal health, including community awareness and legislation responding to the maternal health crisis. Additionally, McSilver is home to a training and technical assistance hub serving all mental health, substance use disorder, and child welfare agencies in New York State, as well as infant and early childhood mental health providers throughout New York City with a focus on bolstering the city's perinatal clinical and social support network.

The Institute for Excellence in Health Equity (IEHE) at NYU Langone seeks to achieve excellence in health equity research, clinical care, and medical education through development, implementation, and dissemination of evidence-based, community-centered solutions to optimize health and well-being. IEHE consists of a network of interdisciplinary health leaders who maintain a record of clinical, programmatic, and research experience prioritizing maternal health

outcomes among populations often skewed to health and social disadvantages. Included in the institute's extensive maternal health research is a multi-site, multimillion dollar, five-year study, funded by the National Institutes of Health (NIH), leveraging community health workers and digital health tools to adapt an evidenced-based intervention designed to incorporate lifestyle and nutrition counseling in improving maternal health across ambulatory clinics in New York City.

McSilver and IEHE have partnered in recent years to leverage collective expertise and resources to more pointedly address the maternal health crisis impacting our city and state. Together, the institutes are advancing a body of work that addresses the critical need to highlight and ameliorate disparities in maternal healthcare access, quality, and outcomes, particularly among underserved populations. We believe the proposed resolutions are in service to that goal and would welcome the opportunity to work with the Council by offering technical expertise and insight as these resolutions continue to move through the legislative process.

Res 1087-2025 (CM Schulman): This resolution calls on the New York State Department of Health to conduct regular audits of NYPORTS data, and to require hospitals to retroactively fill in missing data.

This resolution acknowledges the important potential of The New York Patient Occurrence Reporting and Tracking System (NYPORTS) as a robust reporting system that captures errors and adverse events to improve patient safety. The proposed layers of added accountability through auditing and addressing missing data can help reduce underreporting and inconsistencies. Enhanced reporting is essential for implementing prevention measures, bolstering clinical policies and procedures to improve quality, guiding professional training, and reducing healthcare costs (direct, indirect, and intangible) resulting from errors. We recommend the Council create standard procedures for reporting and auditing, establish well-defined reporting/auditing intervals, designate a person or team for support and oversight, and establish incentives or consequences if reporting standards are not met. These safeguards will support the intended goal of this resolution, and aid reporters in compliance.

Res 1086-2025 (CM Ossé): This resolution calls on the New York State Department of Health to create a new and separate occurrence code for maternal mortality, and standardize the definition of events reportable to the New York Patient Occurrence and Reporting Tracking System.

Standardization in definitions and severity in reporting is critical for ensuring transparency, rigor, and reproducibility. A foundation for this, specific to maternal health, exists, is used widely, and may serve as an exemplar for local implementation. In 2022, an international interdisciplinary group including midwives, clinicians, scientists, regulatory personnel, and patients published the rigorous, systematic process they undertook to develop standardized definitions for maternal adverse events, as well as a severity grading system.[3] Standardization

allows healthcare providers and maternal health stakeholders to better communicate around safety. This has implications for clinical care and research; for example, clinical trials including therapies and medications.

We recommend the Council to consider adaptation of standard definitions related to maternal mortality, morbidity, and adverse events. In doing so, NYPORTS can better integrate city and state reporting and data. A more comprehensive database allows for more detailed identification of system-level gaps and limitations, can more reliably inform allocation of resources, and offers a more nuanced system for tracking progress along the maternal health continuum. To ensure continued cohesion, we agree with alignment in the timeframe for what events qualify. According to analyses from the Commonwealth Fund, two-thirds of U.S. pregnancy-related deaths occur during the postpartum period: 35% between 1 to 42 days postpartum, and 30% between 43 to 365 days postpartum.[4] We endorse tracking during pregnancy through the first year after the end of pregnancy, as is the current practice of The New York State Department of Health and the New York City Maternal Mortality Review Committee (M3RC).

Res 1082-2025 (Deputy Speaker Ayala): A resolution calling on the New York State Department of Health to confidentially share data regarding adverse maternal health events from the New York Patient Occurrence Reporting and Tracking System with the New York City Maternal Mortality and Morbidity Review Committee.

Mortality is not the best or sole marker of the overall quality of maternity care and the safety of pregnant and postpartum individuals. As such, we fully support the alignment of NYS DOH, NYC DOHMH, and M3RC in NYPORTS reporting and bi-directional data sharing on adverse events. We also advocate for the development of an automated data sharing system. Standardization, systems integration, and transparency enable timely, coordinated efforts to: (1) identify trends and gaps that can reveal more specific targets in the maternal clinical and community care continuum, (2) avoid duplication of efforts, (3) improve cross-institutional communication through language, and (4) guide cross-sector prevention and early intervention strategies.

We again thank you and the Council for directing attention and legislation to the pressing issue of maternal health. We extend a standing offer to help members and staff however we can moving forward.

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[3] Spencer, R. N., Hecher, K., Norman, G., Marsal, K., Deprest, J., Flake, A., ... & David, A. L. (2022). Development of standard definitions and grading for maternal and fetal adverse event terminology. Prenatal Diagnosis, 42(1), 15-26.

[4] Gunja, M. Gumas, E.D., Masitha, R, & Zephyrin, L.C. (2024, June 4). Insights into the U.S. Maternal Mortality Crisis: An International Comparison. Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

## GMVA Lookback Window

The purpose of the GMVA Lookback Window is to give survivors a chance to file lawsuits for incidents that occurred before the nine-year statute of limitations was extended.

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## My Experience

These institutions—the very homes of these criminals—make no effort to notify victims when a serious event occurs. Instead, they focus on burying the evidence and moving staff around, fully aware that a possible crime has been committed against individuals and their children.

I learned about my situation through, of all things, a friend who happened to be a lawyer representing the criminal's husband in a divorce. A one-in-a-million chance. My wife screamed in the restaurant when we heard. We quickly drove up to Vermont to speak with my surviving son. The doctor who had seen my late son even asked if he might also have been a victim. All of it was brought to the surface again—not because the hospital reached out, but because they were more worried about the lawsuits to come than about notifying potential victims and their families.

The hospital knew all of this. Yet they chose to bury it rather than inform their patients. A simple phone call—off the record—or even a message through the patient portal would have been enough. They have all the contact information. But no—they chose instead to batten down the hatches.

If it hadn't been for that simple dinner with a friend, we would never have known. I get recall notices for my car all the time, warning me of potential safety issues. But a hospital can't bring itself to notify patients that *they* might have been harmed?

If hospitals and institutes are going to behave this way, I would argue there should be **no statute of limitations**. I was lucky enough to find out through a friend—others won't be. Victims deserve the chance for justice and compensation for crimes committed against them.

John H. Baldwin

10/16/2025

The Brooklyn Perinatal Network, Inc. (BPN)

Testimony to

New York City Council Committees on Hospitals and Women & Gender Equity

Oversight Hearing on "***Improving Maternal Health in New York City***"

On Thursday, October 23, 2025, at 1:00 PM in Hearing Room 1, 8th Floor, 250 Broadway.

Testimony Submitted in Writing

Thank you, Chairs Louis and Narcisse, Speaker Adams, and members of both committees, for holding this hearing today and for your ongoing dedication to improving maternal health and supporting the community-based organizations dedicated to these efforts throughout the city. My name is Ngozi Moses, and I am the Executive Director of The Brooklyn Perinatal Network, Inc. (BPN) which convenes the Brooklyn Coalition for Health Equity for Women and Families. BPN's mission is dedicated to improving Maternal and Child Health (**MCH**) outcomes through community collective work. Currently our major consistent MCH funding is provided by the NYC Council annual budget designations via the **MCHSI/Healthy Beginnings Initiative**, which supports our participation in the Citywide council-funded Healthy Women Healthy Futures (**HWHF**) Doula Program.

The Committee on Hospitals will also be hearing the following resolutions:

- Preconsidered Resolution (CM Schulman) - Resolution calling on the New York State Department of Health to conduct regular audits of NYPORTS data, and to require hospitals to retroactively fill in missing data.
- Preconsidered Resolution (CM Ossé) - Resolution calling on the New York State Department of Health to create a new and separate occurrence code for maternal mortality, and standardize the definition of events reportable to the New York Patient Occurrence and Reporting Tracking System
- Preconsidered Resolution (CM Narcisse) - Resolution calling on New York City Health and Hospitals facilities to report to NYPORTS on adverse maternal health events based on an expanded and standardized definition of adverse maternal health events, including adverse events at least 30 days post-partum.
- Preconsidered Resolution (Deputy Speaker Ayala) - Resolution calling on the New York State of Health to confidentially share data regarding adverse maternal health events from the New York Patient Occurrence Reporting and Tracking System with the New York City Maternal Mortality and Morbidity Review Committee

The resolutions proposed are a logical and proportional step towards helping to update and concretize local and statewide approaches to data collection to restore our collective efforts towards mitigating the prevalence of maternal mortality and adverse maternal health events, and improve the racial disparities that continue to be a crisis for our communities.

We support the goal of the council-funded collective work - clinical, behavioral, and social health efforts to empower community health service partners to engage robustly in a clear-eyed, multi-purposed delivery system that utilizes relevant and comprehensive data to maximize the quality of clients' experience while enhancing access, providing proportional support, and enriching opportunities for health education and unfettered self-determination. **To this end, these resolutions will help to**:

- Further clarify the categories of perinatal care concerns and help to measure frequency and causation.
- Help to better identify greatest areas of need for intervention
- Highlight best pathways to improve clinical care and related outcomes
- Inform improved design and implementation of community-based approaches to care
- Create efficiencies in the City's funding and resource allocations throughout various clinical and community sectors.

Recent BPN Coalition MCH Roundtables, in 2023 and 2024, focused on the need for integrating mental health / behavioral health services into the community-based level social health support service system. As a result, BPN has been created a Perinatal Health Pathway (PHP) care continuum approach to providing our services ,which is a community-based solution that blends Doula and CHW support , and includes direct access to perinatal mental health coaching, behavioral health services and other resources, offering a maternal village concept, that helps to streamline and address the need for easier access to perinatal, social, and mental wellness supports.

MCHSI/Healthy Beginnings financial support for the Citywide Healthy Women Healthy Futures Doula Program, enables BPN to recruit train and hire community doulas to provide birth and postpartum services, and engage in citywide collective advocacy with various partners, including with the NYC DOHMH Maternity Hospital Quality Improvement Initiative (MHQIN), in advising the utilization of Doula services and assisting the development of Doula Friendly Hospitals. Our Brooklyn HWHF Team has piloted voluntary perinatal depression, lactation, and pregnancy and infant loss training for the doula corps to help meet the full spectrum of needs of our community members. Because mental health is a primary underlying cause of pregnancy-associated deaths in

NYC, BPN has also chosen to allocate part of our funding towards behavioral health partnerships, working with local providers who offer several different modalities of support for perinatal clients and birth workers, and related mental health trainings for our birth workers.

BPN has over 35 years' experience with a primary focus on addressing Maternal and Child Health (MCH) disparities and improving related health and wellbeing outcomes in Brooklyn communities in collaboration with CBO, Clinical, Behavioral, and Social Healthcare partners, payors, policy makers, and community members, city and state DOH, and other departments addressing MCH. We use a dual approach of direct service and multi-level coalition building to help collectively streamline perinatal and child service delivery, inform policy making about needs, and pilot approaches to care in the borough and beyond. We serve North and Central Brooklyn and neighboring communities (including Brownsville, East NY, Flatbush, Crown Heights, Canarsie, Williamsburg-Bushwick) as well as individuals who travel from South Brooklyn to seek our services.

Our Executive Team and Senior Staff participate in various boroughs, city, and state maternal health task forces and advisory groups, and in perinatal clinical community partnerships aimed at improving the quality of care at local hospitals, including those in the NYC Health and Hospitals (H+H) network. For 25+ years, we have convened the Brooklyn Coalition for Health Equity for Women and Families. Members receive funding from City Council's Maternal Child Health Service Initiative (MCHSI)/Healthy Beginnings to support infant and maternal health-focused work. Collectively, we utilize the life course framework with an emphasis on the Period of Risk (PPOR) – covering preconception, pregnancy, postpartum, and interconception reproductive phases and into the early childhood period~~s~~ to help inform our direct service and collaborative work and, by extension, impact the maternal health data tracked by providers throughout the city.

Our funding has also been used to help coordinate regional maternal health work between multilevel stakeholders and to host collaborative events, such as our annual Community Maternal Health Forums and Roundtables.

Our work to identify pregnant, postpartum, inter-conception, preconception and parenting participants to receive screening and referrals for services to mitigate risks related to poor health and birth outcomes, including social determinants and emotional health challenges, is supported by funding from the Speaker's Initiative and Council Member Louis. BPN is co-located at and a community partner with the Department of Health in the Brownsville Neighborhood Health Centers' Neighborhood Stress Free

Zone pilot project, providing Social Care Network Screening, Navigation, and Enhanced Care Management to eligible perinatal clients.

The NYS Department of Health's Social Care Network provides an invaluable resource for all Medicaid-eligible clients to receive support with housing, food, and transportation needs, as well as other social health needs identified through screening for perinatal clients and their infants. This has already transformed the service landscape throughout NYC. Unfortunately, it leaves a gap in care for those who are not covered by Medicaid, including the uninsured and those with private insurance, all of whom are going to experience changes to their coverage in the coming months with the cuts to Medicaid, NYS Essential Care, and rate hikes for other insurance programs.

Our most recent funding to support Perinatal CHWs who helped to screen and mitigate social, behavioral, and other perinatal health needs has lapsed. Finding new ways to finance this work is challenging currently. Despite the ongoing need, many residents going through their perinatal journeys are and will experience a gap in care due to absence of CHWs to ensure the safety net they rely on. BPN and other CBOs with these competencies could benefit from further Council collaboration and support to help us build out a CBO-driven perinatal CHW corps that can partner with existing Doula services.

All our collaborative efforts are aimed at improving maternal health outcomes and overall community health and well-being. They are all impacted by the quality of an evidence base distilled from clinical data drawn from community provider sites including those operated by NYC Health and Hospitals. This relationship is vital to creating meaningful improvements for community health overall, as well as helping to reframe our perceptions about the scope of the challenges perinatal patients face and our understanding of and approaches towards improving related care experiences and outcomes. The resolutions mentioned above, as proposed, are a logical and proportional step towards helping to update and concretize local and statewide approaches to data collection to restore our collective efforts towards mitigating the prevalence of maternal mortality and adverse maternal health events, and improve the racial disparities that continue to be a crisis for our communities.

Should these resolutions pass, we look forward to learning more about their implementation and any potential CBO engagement that may benefit related outcomes in the coming months.

Submitted by

Ngozi Moses

Executive Director, Brooklyn Perinatal Network, Inc.

On behalf of the Brooklyn Coalition for Health Equity for Women and Families.

# THE COUNCIL
# THE CITY OF NEW YORK

*Appearance Card*

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

☐ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Dr. Wendy Wilcox

**Address:** Chief Women's Health Officer, Chief of OB/GYN

**I represent:** NYC HHH

**Address:** _____

# THE COUNCIL
# THE CITY OF NEW YORK

*Appearance Card*

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

☐ in favor ☐ in opposition

*Date:* 10/23/25 ALL HANDED

**(PLEASE PRINT)**

**Name:** Judith Cutchin

**Address:** [redacted] Corona 11368

**I represent:** NYS NYC Ave Brooklyn NYC

**Address:** 131 West 33rd 6th Floor

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*Appearance Card*

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

☑ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Patricia Loftman

**Address:** 788 Columbus Ave

**I represent:** NY Maternal Mortality Review Comm

**Address:** _____

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*Appearance Card*

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

☑ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Mia Wagner

**Address:** 84 Lafayette Ave, Brooklyn

**I represent:** Community Service Society

**Address:** _____

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*Appearance Card*

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☐ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Sarah Mann

**Address:** 119 W 10th Street

**I represent:** Samaritan Daytop Village

**Address:** Young Mothers Program

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I intend to appear and speak on Int. No. Reso 4113 4211 4138 4214 Res. No. _____

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*Date:* _____

**(PLEASE PRINT)**

**Name:** Lacey Tauber

**Address:** _____

**I represent:** Brooklyn Borough President Antonio Reynoso

**Address:** _____

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# THE CITY OF NEW YORK

*Appearance Card*

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☐ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Beth McGovern

**Address:** _____

**I represent:** Greater New York Hospital Association (GNYHA)

**Address:** _____

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*Appearance Card*

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

☐ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** Elizabeth Grellier

**Address:** 220 E 42nd Street

**I represent:** VNS Health

**Address:** _____

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# THE CITY OF NEW YORK

*Appearance Card*

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

☐ in favor ☐ in opposition

*Date:* _____

**(PLEASE PRINT)**

**Name:** [illegible]

**Address:** [redacted]

**I represent:** [illegible]

**Address:** _____

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