CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH JOINTLY WITH THE COMMITTEE ON HOSPITALS

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HONORABLE MERCEDES NARCISSE, CHAIRPERSON OF THE COMMITTEE ON HOSPITALS

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2 SERGEANT AT ARMS: Good morning, and welcome to
3 today's New York City Council hybrid hearing on the
4 Committee on Health jointly with the Committee on
5 Hospitals. At this time, please silence all
6 electronic devices. Thank you.
7 For those of you who may be viewing on Zoom, if
8 you wish to submit testimony, you may do so at
9 testimony@council.nyc.gov. I repeat,
10 testimony@council.nyc.gov. Thank you for your kind
11 cooperation. Chair, we are ready to begin.
12 [GAVEL]
13 CHAIRPERSON SCHULMAN: Good morning, everyone. I
14 am Council Member Lynn Schulman, Chair of the
15 Committee on Health. I'd like to start by thanking
16 the Co-Chair of this hearing, Council Member Narcisse
17 for joining me for this important discussion. I also
18 thank my colleagues for being present today. We have
19 been joined by Council Members Menin, Hudson,
20 Gutiérrez, Brooks-Powers, and Ariola.
21 Today, we'll be discussing maternal health,
22 mortality, and morbidity. Last Friday, while I was in
23 a briefing with Chair Narcisse discussing this
24 hearing, the Supreme Court issued an opinion to
25 overturn Roe v. Wade thereby reversing nearly 50

2 years of precedent and ending the federal
3 constitutional right to abortion. As a result of this
4 decision, half of US states are expected to ban
5 abortion. This decision will literally have deadly
6 consequences, consequences that will unfortunately
7 fall hardest on black women and birthing people who
8 already face a severe maternal mortality crisis.
9 Our country has a long history of discrimination
10 and structural inequality that is deep seeded within
11 the healthcare system. This decision will only
12 exacerbate this with forced pregnancy policies,
13 disproportionately affecting people of color,
14 immigrants, LGBTQIA+ individuals, young people, and
15 those who are poor.
16 Because of the Supreme Court's decision, our
17 right to control our own bodies and futures will
18 unfortunately depend on our economic status and where
19 we live. For folks who live in states that outlaw
20 abortion, New York will become a safe haven. And
21 while New York has more progressive laws protecting a
22 woman's right to an abortion, we must continue to do
23 work to improve maternal health outcomes. That is
24 what we are here to discuss today.
25

2 The ability to protect the health of mothers,
3 birthing people, and babies in childbirth, is a basic
4 measure of a society's development. However, more
5 people in the United States die of pregnancy-related
6 complications than in any other developed country.
7 And while the number of reported pregnancy-related
8 deaths has been declining in most of the world, in
9 the United States, the maternal mortality ratio has
10 increased compared to similar countries.
11 Across the United States, and in New York City,
12 maternal mortality disproportionately impacts black
13 women and birthing people with black people eight to
14 12 times more likely to die when giving birth than
15 their white counterparts. Research points to race
16 rather than educational attainment or income level of
17 the patient as the cause of such discrepancies.
18 This is not a new discovery. We have now known
19 for many years that black women and birthing people
20 face disproportionate rates of maternal mortality and
21 morbidity, and yet little progress has been made.
22 Today, I hope to hear from the administration and
23 our hospitals about how they are working to ensure
24 that we track relevant data and outcomes, make
25 assessments and reflect on healthcare decisions, and

2 understand and train on how bias and discrimination
3 play a role in the delivery of healthcare. Because at
4 the end of the day, everyone, regardless of zip code
5 you live in or who you are, should receive good
6 healthcare. And we need to work together to make that
7 a reality.
8 We will also be discussing a package of
9 legislation related to maternal health, mortality,
10 and morbidity. This includes Introduction number 508,
11 which I am proud to sponsor, which would require the
12 City to establish a Family Building Benefit for City
13 employees intended to cover some or all of the costs
14 of assisted reproduction and adoption for City
15 employees without conditioning reimbursement on an
16 infertility diagnosis. In implementing such benefits,
17 the City would be prohibited from discriminating on
18 the basis of marital or partnership status.
19 I also want to thank my colleagues for
20 introducing other important legislation and we look
21 forward to discussing your bills today. I look
22 forward to, examining all these crucial issues.
23 I want to thank the administration for being here
24 this morning. I also want to thank all of the
25 advocates who have been working tirelessly to improve

2 birthing outcomes in our City. Thank you to the
3 doulas and the midwives, many of whom I worked with
4 when I worked at Woodhull Hospital in Brooklyn, for
5 your work as well and for being strong advocates for
6 your patients and for being a very important part of
7 this dialogue.
8 I also want to thank the Committee Staff for
9 their work on this issue, Assistant Deputy Director
10 Sara Liss, Committee Counsel Harbani Ahuja, Policy
11 Analyst, Em Balkan, as well as my amazing team,
12 especially my Chief of Staff, Facia Class. I also
13 want to thank Kevin and Javier who are two staff
14 members who are here today with me.
15 Sadly, this is Em's last hearing with us at the
16 Council as they'll be moving on to pursue further
17 studies. I want to say a huge thank you to Em for all
18 their work over the last four years on the Health
19 Committee. You have had an enormous impact on the
20 Council's work in making the City healthier and more
21 equitable, and you will be truly missed. Thank you
22 again, and we know you will go on to do more amazing
23 work. And I also want to, on a personal note, say
24 that I worked with Em when I was a member of the
25 Speaker's staff a while back, and they are amazing.

2 On that note, I will turn it over to my wonderful
3 Co-Chair for today's hearing, Chair Narcisse for her
4 opening remarks.
5 CHAIRPERSON NARCISSE: Good morning, everyone. I
6 am Council Member Mercedes Narcisse, Chair of
7 Committee on Hospitals. I would like to start by
8 thanking the Co-Chair of this hearing, Council member
9 Schulman for this important discussion. I also thank
10 my colleagues for being present today.
11 Today, we will discuss maternal health,
12 mortality, and morbidity. This is a topic I care
13 greatly about, especially after having spent my
14 career as a nurse. Hundred of years of race-based
15 medicine coupled with systemic racism and other form
16 of oppressions have led to start disparate health
17 outcome faced by communities of color like myself,
18 and in particular, black indigenous and Hispanic
19 birthing people.
20 To reiterate some of the figures already shared
21 by my colleague, Chair Schulman, maternal mortality
22 disproportionately impact women of color and birthing
23 people, with black people eight to 12 times more
24 likely to die when giving birth than their white
25 counterpart in new York City. Studies have shown that

regardless of educational attainment and income, black women and birthing people are still more likely to die from childbirth than white people.

The fact that black women and birthing people are not receiving the care and resources they need to survive, um, during childbirth, is, is inexuse, I mean, inexcusable and morally reprehensible. Despite decades of work by advocates calling attention to these extremely important issues as well as years of Council hearings and action on this topic, I am here today because there remains more to be done.

I'm also here today to remind everyone that the field of gynecology itself is rooted in racism, and, of course, most of us probably remember that, and was only advanced because of the abuse of enslaved black women. After public outcry in response to the murders of George Floyd, Ahmaud Arbery, Breonna Taylor, and others, over 18 organizations signed a collect, collective action statement against racism in the field of obstetrics and gynecology. A portion of this statement acknowledged many examples of fundaments, I mean, foundational advances in the specialty of obstetrics and gynecology are rooted in racism and oppression.

For example, the mid-1800s, surgical experimentation of James Marion Sims was performed on enslaved black women including three women, Bestie, Lucy, and Anarcha, who underwent repetitive gynecology procedure without consent, and I believe, without anesthesiologist being there, too. This (INAUDIBLE) further highlights how deeply these injuries these run and how rooted healthcare is in race-based medicine and racism.

This hearing, which is taking place in the month of June, not too long after Juneteenth, and after the painful overturning of Roe versus Wade, 50 years, will examine how the City continues to strive to provide meaningful and incredible care for birthing people, particularly birthing people of color.

I thank Chair Schulman for already having discussed the impact of recent Supreme Court decision. We all know, I'm sorry, this is very emotional, yes. We all know that the dismantling of Roe versus Wade will disproportionately impact poor people, people in the south in Conservative state, and black other birthing people of color, the same people we should be striving to protect. High quality reproductive and maternal healthcare should be

2 accessible across the board and this decision has
3 sadly intro, tragically, set, set us apart. Yet, we
4 must continue to fight.
5 We are also discussing a package of important
6 legislation touching upon issues ranging from access
7 to doulas and midwives to proliferation of
8 information regarding the risks of C-sections. This
9 include race, resolution 201-2022, which I am proud
10 to sponsor, which calls on New York state to
11 establish full insurance coverage for fertility
12 treatment and fertility cuts across social economics,
13 racial ethnic, and religious lines. Cost is the
14 number one barrier to seeking family building
15 assistance. As 46$ of affected people lack insurance
16 coverage for treatment of infertility, this is
17 unacceptable.
18 Today, we must center ourself on the purpose of
19 the work, improving maternal health including
20 maternal health outcome and fertility. We must honor
21 and remember those who have lost due to, who have
22 lost due to pregnancy related causes, of which CDC
23 states that two thirds are preventable. We remember
24 them today, including those who may not have been
25 reported in the press.

2 We are also mindful of all those still with us
3 today who nearly died during giving birth. I’m also
4 mindful that given the Roe versus Wade decision, more
5 and more people will be at risk when accessing care
6 and giving birth in this country.
7 I’m sincerely grateful for the advocates, doulas,
8 midwives, and all other birthing professionals who
9 have been working to address maternal mortality and
10 morbidity for years. We cannot task you with fixing
11 this crisis alone. You have my commitment as a
12 partner in this work. And I look forward to hearing
13 from you and continue to work together.
14 I want to thank, thank the administration for
15 being here today and for their tireless work since
16 the pandemic begun. I also want to thank Chair
17 Schulman again, as well as the members of Hospitals
18 Committee and the Health Committee for joining.
19 I also thank the Committee staff for their work
20 on this issue, Committee Counsel Harbani Ahuja,
21 Policy Analyst, Em Balkan, as well as my amazing
22 staff including Saye Joseph, Frank Shea, and all my
23 staff.
24 As Chair Schulman mentioned, this is Em’s last
25 hearing with us. Em, you know we appreciate you. I

2 want to say huge thank you to you for all the work
3 you have done. You have been such a wealth of
4 knowledge and I appreciate all the work that you have
5 done for this Committee over the years. You are a
6 brilliant and wonderful person, and you will be
7 surely missed. We wish you so much success in your
8 future and hope our paths cross again. Thank you.
9 And for some that may wonder why I'm so
10 emotional, I've been a nurse for three decades. I
11 have heard so many that cannot have children today
12 because of where they had done their abortion. For
13 some, it's a religious or moral. Like I tell
14 everyone, I'm not a higher power since most of us
15 have faith. I'm not here to judge no one. But we have
16 the responsibility to do the right thing, especially
17 for those that's underprivileged, that we call, in
18 high-risk area. My district, 46 District, right now
19 we took the brunt of this pandemic. We don't have no
20 hospital, no community health centers nearby for
21 many, and we not doing preventive care. And now, we
22 have Roe versus Wade overturned. So, thank you and,
23 um, I appreciate your time. I will return it now to
24 my Co-Chair hearing, Chair Schulman.
25

2 CHAIRPERSON SCHULMAN: Thank you for those amazing
3 remarks, Chair Narcisse. Um, I want to, first I want
4 to acknowledge, we've been joined by Council Members
5 Rivera, Joseph, Velázquez, and Gutiérrez. And I also
6 want to hand it over to Council Member Menin for her
7 statement.
8 COUNCIL MEMBER MENIN: Thank you so much. I, first
9 of all, want to thank Chair Schulman and Chair
10 Narcisse for today's very important joint hearing.
11 Last Friday, we heard devastating and horrific news
12 with the Supreme Court striking down Roe v Wade. To
13 think that my daughter, and every single daughter
14 across this country has less rights than we had is
15 absolutely unconscionable. For women without abortion
16 access, they need hope, and they need our help. Our
17 message is clear, New York with stand firm to once
18 again be a safe haven for people who need access to
19 abortion.
20 Among the bills before the Committee today is my
21 legislation, Intro number 490, which would create an
22 Office of Sexual and Reproductive Health within the
23 Department of Health and Mental Hygiene. The
24 intention of the bill is to prepare our City for
25

2 increased demand for abortion and related
3 reproductive needs.
4 The Office would have three main goals. First, it
5 would provide outreach, education, and support on
6 sexual and reproductive health, particularly for low-
7 income individuals and people without health
8 insurance. Second, it would make referrals to
9 affordable and accessible services. And finally, it
10 would conduct research on sexual and reproductive
11 health disparities across the City. Establishing this
12 Office would ensure that the City remains vigilant
13 and proactive in helping New Yorkers access services,
14 testing, treatment, screenings, and health education.
15 According to the Center for Disease Control and
16 Prevention, the number of abortions reported in New
17 York City was 49,784 in 2019. Notably, 4,668 out of
18 state individuals sought out abortions. Since these
19 numbers will surely grow higher, this bill will refer
20 women to affordable and accessible providers.
21 In addition, this Office would also be
22 responsible for analyzing disparities in access for
23 sexual and reproductive services. Not everyone can
24 equally access reproductive services. Income,
25 neighborhood, and health insurance are all major

2 determinants for the quality of services requested.
3 Traveling to New York City requires a lot of funds,
4 particularly for people with few resources.
5 Meanwhile, New York City should be prepared for
6 states that limit travel for abortion. This new
7 Office can be a resource to help alleviate any
8 burdens for people travelling.
9 Lastly, the Office would also study disparities
10 across our City. The Center for Reproductive Rights
11 found that black and indigenous women are nearly
12 three times more likely to die from pregnancy related
13 complications than white women. This must change, and
14 an Office of Sexual and Reproductive Health can lower
15 this disparity.
16 I thank the Chairs for allowing me to speak and I
17 look forward to today's hearing.
18 CHAIRPERSON SCHULMAN: Thank you, Council Member.
19 And now, I'm going to hand it over to Council Member
20 Hudson for her statement.
21 COUNCIL MEMBER HUDSON: Thank you. Uh, and good
22 morning. I'd first like to thank Chairs Schulman and
23 Narcisse for holding this important hearing today on
24 maternal health, mortality, and morbidity. I'd like
25 to briefly speak on my bill, Introduction 478.

2 Introduction 478 co-prime sponsored by Council Member
3 Jennifer Gutiérrez, would require Department of
4 Health and Mental Hygiene to conduct an education
5 outreach campaign about the services offered by
6 doulas and midwives, to increase awareness of efforts
7 to improve access to such services, and share
8 information about free and low-cost resources related
9 to such services. It would also require DOHMH to
10 submit a report describing the methods of outreach
11 used to comply with this section.
12 As we know, black folks are the most at risk of
13 mortality and morbidity issues when giving birth, and
14 controlling for income, education, and other factors.
15 Studies show that black women are more likely than
16 their white counterparts to give birth at hospitals
17 with high rates of maternal morbidity, and up to 12
18 times more likely to die from pregnancy related
19 issues than white women. And black women are more
20 likely to die from conditions like hemorrhages and
21 preeclampsia. Simply put, this is an issue of racism
22 and implicit racial bias.
23 My home Borough of Brooklyn has the highest
24 number of pregnancy-associate and pregnancy-related
25 deaths. One clear way to reduce this gap is to

2 provide doula access to more people. Studies show
3 that a vast majority of women report that a doula
4 helped them feel more empowered to speak up for their
5 needs and better communicate them.
6 This bill, coupled with my colleague's, uh,
7 Council Member Gutierrez's bill to create a pilot
8 program to train doulas and provide no-cost doula
9 services across the City, will help reduce the
10 maternal health disparity by increasing access and
11 awareness of doulas and midwives. I urge the
12 Committee on Health to swiftly pass these bills and
13 the Council to pass them so all black folks giving
14 birth can have an advocate for their health standing
15 by their side the entire way. Thank you.
16 CHAIRPERSON SCHULMAN: Thank you, Council Member
17 Hudson. Now, I'm going to ask the Committee Counsel
18 to swear in the administration.
19 COMMITTEE COUNSEL AHUJA: Thank you, Chair. Um,
20 members of the administration, if you could please
21 raise your right hands. Do you affirm to tell the
22 truth, the whole truth, and nothing but the truth in
23 your testimony before this Committee and to respond
24 honestly to Council Member questions? Thank you.
25

2 Um, when you begin, just please state your name
3 for the record. Thank you.
4 CHIEF MEDICAL OFFICER MORSE: Good morning, Chair
5 Schulman and Narcisse and Members of the Committees.
6 I am Dr. Michelle Morse, Chief Medical Officer and
7 Deputy Commissioner for the Center for Health Equity
8 and Community Wellness at the New York City Health
9 Department. And I'm joined here today by my
10 colleagues Laura Louison, Assistant Commissioner, Dr.
11 Tara Stein, Medical Director, both from the
12 Department's Bureau of Maternal, Infant and
13 Reproductive Health. I am also joined by our
14 colleague, Dr. Machelle Allen, Chief Medical Officer
15 at New York City Health and Hospitals, Dan Pollak,
16 First Deputy Commissioner, and Claire Levitt, Deputy
17 Commissioner from the Mayor's Office of Labor
18 Relations.
19 On behalf of the administration, we thank you for
20 the opportunity to speak today on the important issue
21 of maternal health, sexual health, and birth equity.
22 We want to first acknowledge the Supreme Court's
23 decision to overturn Roe v Wade and with it, the US
24 constitutional right to a safe abortion, a right that
25 was in place for half a century, and the profound and

2 devastating impact this will have on health in this
3 country.
4 The City is committed to ensure all people have
5 access to the appropriate resources to make an
6 informed decision about their body. We plan to
7 address abortion access in detail at the reproductive
8 health hearing later this week.
9 Maternal mortality is a grave and urgent issue
10 with persistent racial and ethnic inequities in our
11 nation. And New York City is unfortunately no
12 exception. Although we have seen a statistically
13 significant decline in the maternal mortality rate
14 since 2001 in New York City, unacceptable inequities
15 among racial and ethnic groups remain.
16 In New York City, the average maternal mortality
17 rate among black pregnant people is more than nine
18 times the rate of white pregnant people. Our review
19 of pregnancy related deaths indicates that the vast
20 majority of these deaths of black people were
21 preventable. The Borough that accounted for the most
22 pregnancy associated deaths was Brooklyn, followed by
23 the Bronx.
24 Before proceeding further, I want to acknowledge
25 the heartbreaking injustice and human impact

2 represented in these statistics. As a practicing
3 physician myself, I know that every person who dies
4 during childbirth is a parent, a sibling, a child, a
5 friend, a community member, and that their sudden and
6 tragic absence from the lives of their loved ones and
7 in many cases their newborns, in unacceptable. Every
8 loss is a profound tragedy with ripple effects in our
9 communities. When a mother dies, no community is ever
10 the same.
11 We are compelled to action as a City to address
12 this crisis and reduce preventable birth-related
13 deaths and eliminate the unacceptable injustices that
14 these deaths represent.
15 Birth inequities are driven by racism and bias in
16 government, in medicine, in education, in housing,
17 and in economic policies amongst many others, and the
18 downstream effects of these intersecting systems of
19 oppression will take years and even generations to
20 undo. Differential access to power and resources has
21 created these health inequities and it requires the
22 investment of resources and deliberate corrective
23 actions to repair. It requires a true anti-racism
24 approach.
25

2 Our work is grounded in data with a focus on
3 outcomes among black and Latina people who are
4 pregnant or may become pregnant. We use that data to
5 drive and design the programs, strategies, and
6 policies that will support individuals' access to the
7 supports they need for healthy pregnancies,
8 reproductive health, and parenting.
9 We support families through the new Family Home
10 Visit Initiative, a range of linked home-visiting
11 programs, including the nurse family partnership,
12 newborn home visiting, City-wide doula initiative,
13 and the By My Side Birth Support program. We support
14 programs that support systems change in partnership
15 with hospitals, clinicians, and community-based
16 organizations throughout New York City including the
17 Maternal Mortality, Morbidity, and Review Committee,
18 the Maternity Hospital Quality Improvement Network,
19 the New York City, City Breastfeeding Hospital
20 Collaborative, Centering Pregnancy, Centering
21 Parenting, By My Side Birth Support Program, our
22 midwifery initiative, and our Department's Birth
23 Equity working group
24 I'd like to share a little bit more about some of
25 these initiatives that are relevant to our

2 conversation today. In 2018, the Health Department
3 established the New York City Maternal Morbidity and
4 Mortality Review Committee, referred to as the MMRC.
5 The Committee meets monthly to conduct a multi-
6 disciplinary expert review of each maternal death in
7 New York City from both clinical and social
8 determinants of health perspectives. The MMRC has 31
9 diverse, multidisciplinary members from all five
10 Boroughs and includes community activists, doulas,
11 midwives, nurses, specialists, case managers, public
12 health workers, and others.
13 And the end of every calendar year, the Committee
14 reviews and decides upon key recommendations which,
15 if enacted, would improve the care of pregnant
16 people. We then publish these in an annual report.
17 The goal of the MMRC is to reduce preventable
18 maternal deaths by gaining a holistic understanding
19 of each maternal death to determine the cause, assess
20 preventability, and identify contributing factors,
21 actionable recommendations, to prevent future
22 tragedies. The Committee’s recommendations address
23 systems, facility, provider, and patient-level
24 factors.
25

2 Another flagship initiative from the Health
3 Department is the newly expanded New Family Home
4 Visit Initiative which expands access to home
5 visiting programs and community resources to an
6 estimated additional 22,000 newly eligible families.
7 The New Family Home Visit Initiative offers a range
8 of evidence-based home visiting services through
9 trained healthcare workers and clinical providers
10 such as social workers, nurses, and lactation
11 consultants. This includes breastfeeding support,
12 creating a safe home, mental health screenings, and
13 connections to social services.
14 The Initiative has been supporting the expansion,
15 this Initiative has been supported by the expansion
16 of the Newborn Home Visiting Program, the Nurse
17 Family Partnership, Power of Two, and the City-wide
18 Doula Initiative. The program is open to first time
19 families in the Task Force for Racial Inclusion and
20 Equity, also known as TRIE neighborhoods, also those
21 who live in NYCHA and TRIE neighborhoods and those
22 who are engaged with child welfare.
23 I want to highlight our Nurse Family Partnership
24 Program which is one of the home visiting programs
25 included in the New Family Home Visit Initiative. NFP

2 is a long-standing evidence-based home visiting
3 program that connects first time expectant parents
4 with trained nurses to promote healthy pregnancy
5 outcomes, child development, and economic
6 independence. New mothers who participate in the NFP
7 experience lower rates of hypertension, decreases in
8 tobacco use, and lowered risk of pre-term birth.
9 The Department has also long acknowledged and
10 embraced the role of doulas in improving maternal
11 health and birth equity, and several Council Members
12 have already referenced doula initiatives. The
13 expanded City-wide Doula Initiative that was just
14 launched provides doula support both at home and in
15 the clinical setting with three prenatal visits,
16 support during labor and delivery, and four post-
17 partum visits. Clients who give birth at home receive
18 the same number of visits. This program includes
19 screening and referrals for family needs and
20 stressors such as food insecurity.
21 The City-wide Doula Initiative ensures that the
22 model of care is consistent across our City and that
23 uniform data is collected for a rigorous evaluation
24 of the doula services provided through this
25 Initiative.

2 We also know by evidence and research, that
3 doulas lead to fewer cesarian sections, healthier
4 birth weights, lower rates of depression, and
5 increased rates of breastfeeding, as well as, perhaps
6 most importantly, increased satisfaction amongst the
7 people who receive their care.
8 The Health Department has developed a series of
9 public awareness campaigns to promote City-wide
10 understanding of healthy pregnancies, reproductive
11 health, and parenting. To gain community input on
12 these campaigns, we conducted listening sessions with
13 community members as well as focus groups with health
14 care providers. These campaigns include safe and
15 respectful care aimed at community residents and
16 healthcare providers to educate New Yorkers about
17 their rights and options before, during and after
18 pregnancy, and to promote the standards for
19 respectful care. This is just a sample of some of the
20 programs and work, all of which demonstrate our
21 fierce commitment to this issue.
22 We must hold all levels of government and
23 healthcare accountable to make health equity a
24 reality for all New Yorkers. That is precisely what
25 the City is trying to do. The work we do at the

2 Health Department is grounded in science, equity, and
3 compassion. We are committed to focusing on improving
4 the overall health of New Yorkers and in ending
5 racial and ethnic inequities in health outcomes. We
6 envision a world where all New Yorkers live healthy,
7 fulfilling, sexual and reproductive lives, where all
8 children are born, born healthy, nurtured, and love,
9 and where all births are safe. And we're committed to
10 making that vision a reality.
11 Turning to the legislation being heard today, the
12 bills in this package cover a wide range of
13 protections for pregnant people and those who may
14 become pregnant. We are grateful to Council for
15 bringing further attention to these critical issues.
16 The City supports the intent of Introductions 86,
17 409, 472, 478, 482, 490, 508, and 509, and we look
18 forward to discussing the specifics with Council
19 after the hearing.
20 Introduction 86 would require the Health
21 Department to educate about City standards for
22 healthcare proxy forms, patient rights, and
23 respectful care at birth. We support the intent of
24 this bill.
25

2 As mentioned earlier, the Health Department
3 developed standards for respectful care at birth
4 through careful engagement with community
5 stakeholders. We currently provide education about
6 the standards at birth facilities and in other
7 facilities used by people of reproductive age. We
8 believe this bill would be most impactful as a joint
9 strategy to provide reproductive health resources in
10 multiple languages that are safe and accessible for
11 New Yorkers.
12 Introduction 409 would require the Department to
13 post an annual summary of vital statistics regarding
14 maternal mortality in New York City on its website
15 and we are pleased to report that these reports are
16 online, under our special reports section on our New
17 York City Health Department website.
18 Introduction 472 establishes a pilot program to
19 train doulas and provide doula services to residents
20 in all five Boroughs. We are pleased to report that
21 the Department does run a City-wide doula initiative
22 and that was detailed in my earlier testimony. We
23 look forward to discussing this program with Council.
24 Introduction 478 would require the Health
25 Department to provide outreach and education on the

2 benefits and services provided by doulas and
3 midwives. We are aligned with the intent of this
4 bill. In fact, the Health Department supports a
5 funded outreach and education campaign for doulas and
6 midwives. Currently, the Health Department's City-
7 wide Doula Initiative has an outreach and education
8 campaign in TRIE neighborhoods showing the benefits
9 of doula services and offers a paid doula
10 apprenticeship for local community residents.
11 Introduction 482 requires the Department to
12 report on polycystic ovarian syndrome and
13 endometriosis. We have operational concerns with this
14 bill, as the Department lacks a feasible mechanism to
15 collect this data. We are eager to discuss the bill
16 further with you after the hearing to better
17 understand the intent and work with you to meet your
18 goals to address these and other related women's
19 health issues.
20 And Introduction 490 codifies an Office of Sexual
21 and Reproductive Health with the, within the Health
22 Department. Fortunately, our Bureau of Maternal,
23 Infant, and Reproductive Health exists within the
24 Health Department's organizational structure, and we
25

2 are pleased to have the opportunity to talk about
3 some of our work with you today at this hearing.
4 Our teams undertake tireless and often unsung
5 work for New Yorkers every day and we really
6 appreciate your time today to share some of this
7 information. We look forward to working with Council
8 in partnership on this topic. And my colleagues and I
9 are happy to take your questions. Thank you.
10 CHAIRPERSON SCHULMAN: Thank you very much. Um,
11 before we do questions, uh, Council Member Gutiérrez
12 would like to make a statement.
13 COUNCIL MEMBER GUTIÉRREZ: Thank you, Chair
14 Schulman and Narcisse. Doulas and midwives are
15 critical for improving maternal health outcomes. When
16 women use doulas during pregnancy and birth, they are
17 two times less likely to have birth complications and
18 four times less likely to have a low-birth-weight
19 baby. The World Health Organization recommends that
20 every birthing person should have access to a doula.
21 They have a very special skillset.
22 I was lucky enough to have a positive birth
23 experience with a midwife and a doula that resulted
24 in a healthy baby and my own wellbeing, but for too
25 many, this is not the common experience. Currently,

2 the program is limited to six zip codes and eight
3 vendors hoping to reach 500 people by the end of
4 June. There are about 17,000 births per month in New
5 York City. We need to start the expansion of this
6 program yesterday, which means we need more doulas in
7 the pipeline now.

8 I do appreciate the Mayor's attention to this
9 issue and his plans to expand on the current program.
10 The state of maternal mortality is a crisis that must
11 be addressed as soon as possible. Women are going to
12 keep having babies every day and that's not slowing
13 down to wait for a program's expansion or the funding
14 to come through.

15 In 2017, there were 58 deaths associated with
16 pregnancy. 40% of the deaths were black women and 28%
17 were Latina, 28% were in Brooklyn, and 20, 21% were
18 in Queens. Just 9% were in Manhattan. Black New
19 Yorkers are more than twice as likely than white New
20 Yorkers to have severe complications in childbirth
21 and eight times more likely to die from pregnancy-
22 related causes. Doulas and midwives are a known
23 solution to this problem. They are ancestral. They
24 are indigenous. And they are not new or innovative
25 ones.

2 The bills introduced by my colleagues make
3 important steps to increase the visibility of life-
4 saving birthing options and access to data on
5 maternal mortality and morbidity. These bills are
6 vital steps towards understanding the crisis we have
7 in our City towards teaching people what their
8 options are. I am certainly excited to support them
9 and see them through.
10 I'm proud, I'm also proud to have my bill heard
11 today and ensure that not only women have more
12 support during birth but also that we can create
13 well-paying employment opportunities in the
14 caregiving space, and especially for women of color
15 to support their communities. Thank you.
16 CHAIRPERSON SCHULMAN: Thank you, Council Member
17 Gutiérrez. I'm going to turn to OLR, um, Office of
18 Labor Relations, I'm sorry, to, to give your
19 testimony.
20 FIRST DEPUTY COMMISSIONER POLLAK: No problem.
21 Thank you, Council Member. Good morning, Chair
22 Schulman and Chair Narcisse and Members of the
23 Committees. As my colleague mentioned, my name is
24 Daniel Pollak and I'm the First deputy Commissioner
25 at the Office of Labor Relations and I'm here with my

2 colleague Claire Levitt, the Deputy Commissioner for
3 Healthcare Strategy at the Office of Labor Relations.
4 Thank you for the opportunity to testify today.
5 We're here to discuss Intro 508 which would
6 require the City to establish family building
7 benefits for City employees intended to cover some or
8 all of the costs of assisted reproduction and
9 adoption for City employees. Before going into the
10 specifics of the current and proposed benefits, we
11 want to provide some brief background for context. As
12 you may be aware, since 1967, the City has been
13 obligated under the New York State Public Employees'
14 Fair Employee Act, commonly known as the Taylor Law,
15 to bargain health benefits with its municipal unions.
16 The benefits that are the subject of Intro 508,
17 like other health benefits and fringe benefits, are
18 mandatory subjects of collective bargaining under the
19 Taylor Law. This means the City must negotiate these
20 matters with its unions and these benefits cannot be
21 imposed by local law. Experience has also shown that
22 the City and its unions working together can and do
23 negotiate significant improvements in employee
24 benefits, including health benefits.
25

2 I now would like to take the opportunity to
3 summarize our current relevant benefits related to
4 fertility. For context, the City spends over $11
5 billion a year on its health benefits for employees,
6 dependents, uh, I apologize. I will, uh, I'll take it
7 off.
8 Alright. I apologize. Uh, would you like me to go
9 back at all? Alright. Um, as I mentioned, the City
10 spends over $11 billion a year currently for health
11 benefits for employees, dependents, and retirees. To
12 put the enormity of that expense into context, it's
13 over 10% of the City budget of $101 billion. In
14 accordance with state requirements, the New York City
15 Health Benefit Program covers the following benefits
16 related to infertility: intra-uterine insemination
17 known as IUI, three cycles of invitro fertilization,
18 IVF, medication including prescription drugs and
19 injectable medications, egg preservation where the
20 patient is undergoing treatment like chemotherapy
21 that would affect the viability of the eggs.
22 Additionally, through our primary employee health
23 plan, the City utilizes WINFertility, an organization
24 that supports families with infertility issues.
25 WINFertility helps families navigate the system with

2 nurse case managers that ensure that the highest
3 clinical standards are met. We believe that our
4 fertility benefits are very strong, and we currently
5 spend over $100 million a year on fertility benefits
6 for City employees.
7 Our fertility benefits, like all of our health
8 benefits are limited to City employees and their
9 dependents. For example, we cover IVF, invitro
10 fertilization for people covered by the health plan,
11 not for surrogates who are neither employees nor
12 dependents. As we understand, this is the case for
13 practically every other employer provided health
14 insurance.
15 Moreover, as recent State Department of Financial
16 Services guidelines, uh, guidance explains, while New
17 York insurance law was amended in 2019 to ensure that
18 existing coverage was afforded for individuals who
19 were unable to conceive due to their sexual
20 orientation or gender identity, the (INAUDIBLE)
21 change did not address surrogacy arrangements or
22 require coverage for services that are not, not
23 otherwise mandated to be covered under the insurance
24 law.
25

2 The Office of Labor Relations strongly believes
3 that all City employees deserve high quality and
4 equitable healthcare. As we have for many years, we
5 will continue to work with our municipal unions to
6 make appropriate modifications and enhancements to
7 our health plan in the best interest of employees and
8 taxpayers. Thank you for the opportunity to testify
9 and we'll be happy to answer any questions you might
10 have. Thank you.
11 CHAIRPERSON SCHULMAN: Thank you very much. Could
12 we also get a copy of your testimony as well?
13 FIRST DEPUTY COMMISSIONER POLLAK: Uh, yes. I
14 believe I provided it earlier to the, to the Sergeant
15 at Arms.
16 CHAIRPERSON SCHULMAN: Okay. Oh. Thank you.
17 Alright. So, I'm going to start asking, um, some
18 questions and then I'll turn it over to my Chair and
19 we'll have, um, some of my colleagues who also will
20 be asking questions.
21 So, the first one I'm going to ask is, how will
22 the overturning, um, I'm going to remove this a
23 minute. How will the overturning of Roe v Wade impact
24 maternal health mortality and morbidity? Shall we
25

2 expect more people coming to New York City to receive
3 maternal healthcare? Whoever wants to take it.
4 CHIEF MEDICAL OFFICER MORSE: Thank you,
5 Chairperson, for that really important question. We
6 are very concerned about the impact that the overturn
7 of Roe v Wade will have on access to abortion care
8 across the country. However, we really want to
9 reiterate that in New York City, abortion is legal.
10 And we are very concerned, however, that there, there
11 will be impacts on people of color and people who are
12 poor, in particular, in states where abortion is not
13 legal.
14 I'm going to pass to my colleague, uh, Laura
15 Louison, to share some additional comments.
16 ASSISTANT COMMISSIONER LOUISON: Thank you, Dr.
17 Morse. I want to reiterate what Dr. Morse said that
18 abortion is still legal in New York. And we do
19 anticipate that there will be increased demand for
20 abortion services following this decision. The Health
21 Department is working actively with our national and
22 local partners, including our colleagues at Health
23 and Hospitals, other private healthcare facilities in
24 the City, advocates, and community based
25

organizations to prepare for this. And we've been preparing for this since the leaked opinion.

Um, we are working to protect existing access and we are excited to stand with the Mayor in his announcement to ensure that New Yorkers and those who travel to our care can access abortion care by providing accurate information to the public and to providers and supporting expansion of services in collaboration with clinicians.

CHAIRPERSON SCHULMAN: How can we ensure that we provide safe, equitable, and sufficient care to those in need from other states? Because I think that what's being, um, planned is that there's going to be a great influx.

ASSISTANT COMMISSIONER LOUISON: Thank you, Council Member. You are correct. We are, we do anticipate that there will be an influx. It's hard to calculate what the, what the actual numbers will be, but we have been actively preparing for that for the past two months. Um, you know, I want to reiterate again that it is safe and legal in New York, and we also note that not all New Yorkers right now can easily access abortion services currently.

2 And so, to ensure access for both new Yorkers and
3 for those who travel to our city as a safe haven, we
4 have to ensure that people have accurate information
5 about how and when to access care and how to pay for
6 that care. All people need to be able to obtain
7 abortion regardless of their ability to pay for
8 services or to pay for the associated costs with
9 receiving an abortion like childcare or
10 transportation.
11 CHAIRPERSON SCHULMAN: How are we going to get
12 information to them? Do we, are we going to work with
13 the hotel industry, if people are going to come here,
14 stay there? Are people going to stay with relatives
15 and friends and all that? How are we going to get
16 that information out there to people?
17 ASSISTANT COMMISSIONER LOUISON: That’s a great
18 question, and we anticipate that people will probably
19 pursue a number of different strategies. We are
20 working closely with community-based organizations
21 and advocates to better understand the landscape of
22 what that travel might look like on a national level
23 and also within our state. Um, and we are also
24 working right now on a communications campaign to
25

2 ensure that people have accurate information about
3 how and where to access services.
4 CHAIRPERSON SCHULMAN: Is there a written plan
5 that's being put together or is there one? And if
6 there is, can we get a copy of it at some point, or
7 you can share it with the Council? Because I think
8 it's very important for us to know that, too, cause
9 we can also help to be ambassadors for that.
10 ASSISTANT COMMISSIONER LOUISON: Absolutely, yes,
11 Councilor, critical ambassadors in that. We are
12 working on that plan and that timeline now and are
13 happy to follow up with Council.
14 CHAIRPERSON SCHULMAN: Okay. Thank you. Um, so
15 DOHMH's Center for Health Equality addresses health
16 inequities and provides data on maternal mortality.
17 The Race to Justice Initiative is also particularly
18 noteworthy as it is an internal reform effort
19 committed to better addressing racial health gaps and
20 improving health outcomes for all New Yorkers. Can
21 you describe the education and training provided to
22 staff and how this helps address health disparities?
23 CHIEF MEDICAL OFFICER MORSE: Thank you again,
24 Council Member, for this question. Uh, excuse me,
25 Chair, for this question. Um, what I can say is that

2 we are very, um, proud of the work that our Center
3 for Health Equity and Community Wellness has done. It
4 was established in 2014 under former Commissioner
5 Bassett and then was actually expanded in 2019. Um,
6 it is in fact the, the division that I lead. There
7 are multiple areas of work within our division. Um,
8 and we do work that is focused on, uh, various areas.
9 Some of work is focused on place-based approaches
10 through our action centers which house community-
11 based organizations, Health Department staff, and
12 other team members to be able to really invest in the
13 communities that we know have experienced
14 disinvestment.

15 We also have strategies around community health
16 workers, um, as was already described, doulas, and we
17 do do, uh, lots of different trainings for health
18 equity for both our staff internally as well as our
19 community-based partners.

20 So, in summary, uh, I would say our work over the
21 Center has grown significantly since the Center was
22 established in 2015. And that includes the work, uh,
23 of the Race to Justice team. Um, and we would be
24 happy to share more details with you about the
25 Center's work in follow up to the hearing.

2 CHAIRPERSON SCHULMAN: Okay. Race to Justice
3 includes efforts to create a workforce that most
4 closely reflects diversity in New York City. Can you
5 explain what those efforts entail?
6 CHIEF MEDICAL OFFICER MORSE: Thank you for that
7 question, uh, Chair. Yes, the, the Race to Justice
8 initiative that the Health Department leads, um, are
9 focused on multiple different areas to advance anti
10 racism and health equity. Some of those efforts do
11 include, um, specific work around increasing, um,
12 people of color in both Health Department and in
13 healthcare delivery organizations and institutions.
14 Some of those efforts are really focused on how
15 we work with our human resources colleagues to
16 recruit, um, and to make sure the recruitment
17 materials we use are reaching communities that may
18 not always be reached. Um, and we also do multiple
19 efforts again, uh, internally within the Health
20 Department to make sure that there are teams across
21 all of our divisions that are experts in, uh, both
22 racial justice and health equity who can help make
23 sure that there's not only one team centrally, but
24 multiple teams across multiple divisions to be able
25 to advance this work.

2 CHAIRPERSON SCHULMAN: Thank you. I'm going to, I
3 have to skip out for one second, um, for something
4 urgent. Um, Chair Narcisse is going to take over the
5 questioning for now. Thank you.
6 CHAIRPERSON NARCISSE: Thank you. Um, one other
7 thing that I have people come, doulas complaining
8 during the height of the pandemic, that, um, it was a
9 choice between, between them or the partner in the
10 room. How could be put some, um, policy or some
11 enforcement over that to make sure that doula can
12 participate in the room when they need, when the
13 mother, maternal person need them the most?
14 CHIEF MEDICAL OFFICER MORSE: Thank you so much,
15 Chair Narcisse, for that question. Um, we are aligned
16 with you 100% on wanting to make sure that doulas are
17 welcomed in hospitals and healthcare settings, and
18 that hospitals, um, health workers in hospitals and
19 others understand the role that doulas play, the
20 critical role that doulas play in accompanying
21 birthing people, so we are very aligned, uh, with you
22 on that.
23 In fact, during the COVID pandemic, in fact, we
24 had, uh, not only relationships and partnerships with
25 community based organizations who were advocating to

2 make sure that doulas could still be in the room to
3 support birthing people, uh, but we also worked, uh,
4 actually with multiple other partners to ensure that
5 hospitals understood how they could, um, be
6 respectful of doulas and make sure that doulas again
7 were, were in, involved and included.
8 Um, the final thing that I'll mention is that we
9 also had a perinatal task force during COVID. And
10 that task force specifically focused on what you're
11 describing, on making recommendations and ensuring
12 that doulas could be, uh, present, um, for birthing
13 people, um, uh, throughout the COVID pandemic.
14 CHAIRPERSON NARCISSE: Sorry that I had to mention
15 that before I come back to where, um, CM Schulman who
16 is Chairperson was at. Research suggests that
17 solutions to addressing maternal mortality lies
18 outside of hospital walls. Has the Center for Health
19 Equity worked with outside agency on the, internal,
20 um, reform efforts?
21 CHIEF MEDICAL OFFICER MORSE: Thank you so much
22 for that question. Um, and yes, uh, it's very, very
23 important to mention that the large majority of
24 maternal deaths do occur in the rear following
25 delivery, um, and that a smaller portion, or about a

quarter of them, occur in the hospital and during pregnancy. So, we agree with you, Chair Narcisse, that this is incredibly important that the whole entire life course is supported, um, and that work happens both within the hospitals and very importantly outside of hospitals as well to ensure birth equity and to ensure that, um, all women, and, and pregnant people have access to the care they deserve.

To your question about how the Center for Health Equity has worked with other agencies, it's a really important question. In fact, we have family wellness suites located in our action centers. And the work of those family-wellness suites, uh, is in relationship and in partnership with many different other City agencies including, um, ACS and Health and Hospitals amongst other. Um, so we have, uh, developed those kinds of partnerships and we do seek to continue to engage other agencies in our work.

Um, I should also mention that, um, behavioral health, um, overdose and suicide are unfortunately very, very, uh, common causes of death in the year following pregnancy. And we continue also to work

with other partners in the behavioral health world to address that.

CHAIRPERSON NARCISSE: So, um, can the, the family can see the baby as well when they come in? Can, can they be in the room?

CHIEF MEDICAL OFFICER MORSE: Um, Chair Narcisse, I’m sorry, can you clarify the question?

CHAIRPERSON NARCISSE: Can they be in the room to, I mean, can they, when they come, can the family comes in the room as well?

CHIEF MEDICAL OFFICER MORSE: Um, I, do you mean in the hospital?

CHAIRPERSON NARCISSE: In the hospital setting.

CHIEF MEDICAL OFFICER MORSE: Okay. Um, I think for that question, I’m going to pass to my colleague Dr. Machelle Allen from health and Hospitals.

CHIEF MEDICAL OFFICER ALLEN: So, first of all I want to say that I really appreciate this hearing for bringing these issues to light. I also want to say that I’m very proud to be sitting next to Dr. Michelle Morse whose reputation preceded her, who fought for diversity and equity and inclusion before there was a DEI to the point that she was threatened

2 in her previous employment based on her vociferous
3 and passionate.
4 CHAIRPERSON NARCISSE: It's hard for me to hear
5 because the mic is kind of far.
6 CHIEF MEDICAL OFFICER ALLEN: I am saying thank
7 you to the Council.
8 CHAIRPERSON NARCISSE: Bring it down a little bit.
9 Just bring the mic down, just bring the head, yeah, a
10 little closer, yeah.
11 CHIEF MEDICAL OFFICER ALLEN: Thank you for having
12 this hearing. Um, I've been an obstetrician for 40
13 years and I appreciate the spotlight on maternal
14 morbidity and mortality, and I also was saying what
15 an honor it is to sit here Doctor, next to Doctor
16 Michelle Morse who was committed and passionate about
17 diversity, equity, and inclusion before there was a
18 DEI to the point she was actually threatened in her
19 job and her life based on her commitment to these
20 issues.
21 To speak about the visitation rights during the
22 pandemic, H and H actually allowed the family as well
23 as a, a support person to be with the patient
24 throughout her labor and delivery. This was our
25 commitment. It was the Health Department's

2 commitment. And after the baby was born, as you know,
3 in our hospitals, we have rooming in so in the room
4 you have the mother and the baby, and the, and one
5 visitor was allowed.
6 CHAIRPERSON NARCISSE: Thank you. Uh, most deaths
7 occur within one year after giving birth? What can we
8 do better to address the parent's health? For
9 example, when babies go for their six-month visit,
10 can we do better to ensure the parent receive care
11 to?
12 CHIEF MEDICAL OFFICER ALLEN: One of the things
13 that we have done at Health and Hospitals is co-
14 located the post-partum visit with the well-baby
15 visit. When you look at how we as moms comply with
16 our own healthcare, we are much better in taking care
17 of our children than ourselves. So, you look at the
18 post-partum no show rates, they are high. Our
19 compliance, our ability to make those visits for
20 various reasons is difficult. But if you look at the
21 compliance with the well-baby visit, that four- or
22 five-week visit, after the baby is born, that's a 98%
23 compliance. So, we have started in Health and
24 Hospitals to co-locate and coincide the post-partum
25 visit with the well-baby visit, so when the mom or

2 the dad brings the baby, the mom will show up, blood
3 pressure, if she had gestational diabetes, how her,
4 how's her diabetes doing. And the whole purpose of
5 this is to get the woman back into primary care.
6 I think for most of us in our reproductive years,
7 our gynecologist is our primary care physician, which
8 is fine. But we really need to detect those things
9 that cause maternal morbidity before the woman
10 becomes pregnant, so we've also implemented with,
11 within Health and Hospitals in the primary care
12 visit, a pregnancy intention question. Are you
13 planning on becoming pregnant? And if you are, then
14 the referral is made to the gyn clinic so you can
15 have prenatal, conceptual counseling. If you're not
16 planning on becoming pregnant, then we will refer you
17 to gyn for the appropriate effective contraception of
18 your choice.
19 The whole point of that, if the woman is in
20 prenatal care, if she's in primary care and she has
21 diabetes, hypertension, if we can get that in control
22 before she conceives, I think it would make a big
23 dent in how we do during the pregnancy, and the
24 pregnancy outcome.
25

2 CHAIRPERSON NARCISSE: I'm in total, I'm in total
3 agreement with that one because one of the things
4 that we have, especially in the black and brown
5 community, is diabetes, hypertension, that are
6 underlying that are never being addressed. And that's
7 by the time the person getting to give birth,
8 preeclampsia and all, that's, um, that's great. Thank
9 you for that.
10 Um, I have some other question. Just bear with me
11 one second. So, what is the population, before I get
12 to the other question, what's the population like
13 with say, what's the percentage of your population
14 of, um, mothers that end up with, I know last time we
15 said the, the numbers cannot be told, I want to know
16 for each hospital for example, how many of, um,
17 mortality that you have. Is that possible that you
18 have that on the record, especially when they come to
19 H and H, I would like to know.
20 CHIEF MEDICAL OFFICER MORSE: Thank you,
21 Chairperson, for that question. Um, one of the many
22 programs that we run at the New York City Health
23 Department is the Maternity Hospital Quality
24 Improvement Network and that network, uh, was
25 launched in 2018. And one of the things that that

2 network does, is it really works with hospitals
3 around their data on severe maternal morbidity and
4 mortality. We also do publish, every year, a report
5 that describes maternal mortality, um, and it
6 describes that information, uh, by Borough and by
7 race and ethnicity. And that is another source of
8 really important data to make sure that we are able
9 to follow the trends over time, um, across hospitals
10 across the City.
11 CHAIRPERSON NARCISSE: So, what's the number
12 specifically?
13 CHIEF MEDICAL OFFICER MORSE: Which, um?
14 CHAIRPERSON NARCISSE: For the H and H, that for
15 mortality that you have, maternal mortality.
16 CHIEF MEDICAL OFFICER MORSE: For, for Health and
17 Hospitals, I'll, I'll pass to Dr. Allen.
18 CHIEF MEDICAL OFFICER ALLEN: I don't have those
19 numbers with me today, but I would be happy to share
20 with, them with you after the Committee hearing.
21 CHAIRPERSON NARCISSE: Thank you. Um, black women
22 and birthing people are eight times, we mentioned
23 that eight times to twelve times more likely to die
24 from pregnancy related death than white women and
25 birthing people in, in, in New York City.

2 Additionally, they are, according to DOHMH, data set,
3 um, um, for severe maternal morbidity rate among
4 black, non-Latina women was three times that of white
5 non-Latina women. Research has shown that regardless
6 of education and other factors, black people are more
7 likely to die or nearly die from giving childbirth,
8 right. Can you discuss why we see these disparities?
9 CHIEF MEDICAL OFFICER MORSE: Thank you again, uh,
10 Chair Narcisse, for this question. Um, this is very
11 fundamental to the worth, the work that the Health
12 Department is doing, is really understanding, to your
13 point, the upstream causes as well as making sure
14 that we're working hand in hand with hospitals and
15 healthcare delivery institutions as public health.
16 And, in fact, my job as Chief Medical Officer in
17 large part is related to making sure those
18 partnerships work so that we can do more prevention
19 work. Your point about the fact that these racial
20 inequities in birth outcomes are huge and persistent
21 and unjust is critically important. In fact, the
22 Board of Health for the New York City Health
23 Department declared racism a public health crisis in
24 October of 2021. And that resolution that was passed
25 by the Board of Health was a landmark resolution that

2 not only described many of the drivers of those
3 racial inequities in birth outcomes, but it also
4 requires the Health Department to report twice per
5 year to the Board of Health and to explain the
6 progress that we're making in addressing those root
7 causes.
8 There are a series of nine actions that the Board
9 of Health resolution has required that the Health
10 Department take, and much of the work and programs
11 that I presented in my testimony today are in line
12 with the resolution and the accountability that we
13 have to addressing racism as a public health crisis.
14 CHAIRPERSON NARCISSE: Thank you. I'll pass it on
15 to, oh. (INAUDIBLE) Schulman, which. Okay, um, the
16 severe maternal morbidity rate was also notable high
17 among women who were, I mean, Puerto Rican, um, and
18 of other Latina origin. Can you speak to the
19 disparities as well?
20 CHIEF MEDICAL OFFICER MORSE: Yes, thank you so
21 much for that question. Um, and one of the things, I
22 want to pass to my colleague Dr. Tara Stein to talk a
23 little bit more about that question specifically, but
24 I do want to start by saying that one of our key
25 priorities in terms of ensuring access to healthcare

2 is also ensuring that that access to that healthcare
3 is in the language that's preferred by the person
4 who's seeking the care. Um, and we do know that lack
5 of access to language services is a driver of health
6 outcomes and it's something that we prioritize very
7 much in our work at the Health Department. I'm going
8 to pass to my colleague Dr. Stein to share some more.
9 CHAIRPERSON NARCISSE: But before I have, I have
10 this number here, the data, so, 272 per 10,000
11 deliveries when we're talking about the Latina
12 origin. That's a lot. And 248.5 per 10,000
13 deliveries.
14 CHIEF MEDICAL OFFICER MORSE: Yes, Chair Narcisse.
15 We are aligned with you in that we think that the
16 rates, uh, of inequities are too high and that the
17 racial inequities have to be reduced. Um, I do want
18 to ask my colleague Dr. Stein to speak a little more
19 specifically to the numbers you just mentioned.
20 CHAIRPERSON NARCISSE: Yeah, but I, I don't want
21 to confuse you. The one, the 272 was from Puerto
22 Rican descent specifically, and the others is from
23 248.5 is just Latina origin. Go ahead, thank you.
24 MEDICAL DIRECTOR STEIN: Thank you so much, uh,
25 Dr. Morse. And thank you, uh, Council Members and,

2 uh, Chairperson Narcisse for this important question
3 and calling our attention, um, to these issues that
4 face the birthing and parenting people of New York
5 City. We at the Department of Health are aligned with
6 you and are, your passion and commitment to making
7 sure every New Yorker has the ability to become
8 pregnant and parent those children when they want
9 them. Um, as a family physician myself, I am, uh,
10 firmly committed to ensuring all people have access
11 to this care and healthy deliveries.
12 We do rigorous review of all maternal death
13 events in the City. And we are committed to
14 identifying the root causes, and often times we do
15 find there are systemic causes. As Dr. Morse said,
16 um, racism is a public health crisis. And we need to
17 continue to identify and work with those root causes
18 when every tragic death occurs so that we can
19 recommit our programs and our priorities to
20 identifying and improving the outcomes in the
21 populations that need it most intensely, and to focus
22 our programmatic work to align our, itself with the
23 data as we identify it.
24 So, these numbers are, are critical. They're
25 devastating. We, um, we recognize the impact that

2 this has on specific communities and we're always
3 looking to partner, um, with community-based
4 organizations in specific groups to make sure that
5 those who need the care can get it. Thank you.
6 CHAIRPERSON NARCISSE: Thank, thank you. In
7 addition to discrimination in hospital settings and
8 care, what other factors contribute to racial
9 disparities in maternal health? And what are DOHMH,
10 and MH, and H and H doing to address them? How does
11 implicit bias come into play in the hospital setting?
12 CHIEF MEDICAL OFFICER MORSE: Thank you for that
13 question, and we do appreciate you getting at the
14 upstream causes. Um, and as Dr. Stein mentioned, I
15 think specifically we also know that inequities in
16 housing, for example, we know that there is a history
17 of redlining which is a policy of our federal
18 government that led to really different housing
19 access and housing conditions across our entire
20 nation.
21 Housing is a social determinant of health, and
22 it's a, a, a determinant that impacts, um, health
23 outcomes and birthing outcomes for pregnant people
24 across the City. And it is racialized, it is driven,
25 in many ways in terms of access to stable housing, by

2 systems and policies that, unfortunately, are rooted
3 in racism. So, we know that housing, education, um,
4 transportation, um, stable work, um, and economic
5 stability, these are all different determinants that
6 really influence the success of, the success of our
7 programs, and also, of course, the ability of a
8 pregnant person to have a healthy, um, pregnancy.
9 Um, in terms of implicit bias, it's a phenomenal
10 question. In fact, a lot of the research out there
11 shows that more trainings, uh, on implicit bias can
12 impact the perceptions of clinicians, um, around
13 their own understanding of how racism operates and
14 how other systems of bias operate. Um, one of the
15 pieces of the Maternal Health Quality Improvement
16 Network, uh, program that I mentioned, is, uh,
17 implicit bias training.
18 In fact, we can report, and we are happy to
19 report, that over 1,000 health providers have been
20 trained in health equity, anti-racism and implicit
21 bias as a part of the MHQIN. Sorry, it's very long,
22 Maternity Hospital Quality Improvement Network, um,
23 when the cohort was launched in 2018 and just
24 finished the first cohort in December of 2021. So,
25 over that time period, 1,000 providers were trained

2 in that area. And I'd like to pass to Dr. Allen to
3 add some more comments.
4 CHIEF MEDICAL OFFICER ALLEN: So, there's a lot of
5 research, not a lot of research, but we are starting
6 to look at the role of stress, intergenerational
7 stress, and its impact on the pregnancy. So,
8 research, we do have some research in the behavioral
9 health field looking at survivors of the holocaust
10 and how that stress of the holocaust has been passed
11 down through generations from the survivors of the
12 holocaust. And we're beginning to look at that, as
13 well as the impact of slavery in the 400 years of
14 oppression in this country and what impact, long-term
15 impact. And, as you know, if you correct for
16 education, for social class, for economic class, both
17 maternal mortality and infant mortality still has a
18 disparity between races, white and black races.
19 That having been said, I would like to share with
20 you some of the work that's being done at Health and
21 Hospitals to address diversity, implicit bias
22 training, and training about bias as well. Many of
23 you may be familiar with our simulation program where
24 we simulate the complications, the rare but
25 devastating complications that occur in pregnancy,

shoulder dystocia, post-partum hemorrhage, cardiac arrest.

We've also started a simulation training for bias. How do we train providers to ask questions and provide care and become aware of their own internal unconscious biases? So, we've just developed a curriculum and we've just started to roll it out.

In addition to that, in our Human Resources Department, we have an Office of Diversity, Inclusion, and Equity. We have eLearning modules. We have an introduction to unconscious bias. We have a business imperative of diversity of inclusion. Over 20,000 employees have completed these trainings since January 2000. We also have an Employee Voices Sessions, anonymous conversations with employees on the topic of implicit bias and racism. They're designed to give the employees a safe place to share or learn in concrete action steps to mitigate the bias. We've held six of these sessions in the last quarter.

We also host a variety of virtual workplace inclusion workshops year-round that include the following topics: diversity and inclusion in the healthcare setting, interreligious awareness for

2 patient centered care, having essential
3 conversations. This gives the tools and techniques
4 for having essential conversations on the topic of
5 racial equity. How to be an inclusive colleague, how
6 to be an upstander. Those are just a sample of some
7 of the trainings that we have for our staff
8 throughout H and H.
9 In terms of diversifying the workforce, because
10 you, the data is actually very clear that patients do
11 better if they have a provider that looks like them
12 or shares the same culture. But developing a pipeline
13 and pathway with medical schools so that we can
14 identify young students of color who are interested
15 in science, technology, math. We've just started a
16 Mosaic program with Morehouse University of Puerto
17 Rico. And we're very, working very closely with CUNY,
18 so that our workforce in Health and Hospitals can
19 look like our patient population, and hopefully make
20 a difference in the outcomes across the board, not
21 just in obstetrics and gynecology, but internal
22 medicine, surgery, etc., just to share how we're
23 thinking and what we're doing to make a difference.
24 CHAIRPERSON NARCISSE: Thank you. Um, what do you
25 think of doula program, Doctor?

2 CHIEF MEDICAL OFFICER ALLEN: So, I have a two-
3 and-a-half-year-old granddaughter who's the apple of
4 my eye, whose mom, my daughter, had a doula whom she
5 identified during her pregnancy who, thank God, was
6 with her during the labor and delivery and visited
7 her at home post-partum. So, I'm an advocate, a
8 personal advocate, and proponent of the support that
9 doulas provide.
10 CHAIRPERSON NARCISSE: Um, yes, I heard you, Doc.
11 Social determinants are crucial. Can you please
12 elaborate on how the Mayor's doula program provides
13 support to people in need of assistance with housing,
14 food, um, domestic violence and other social needs?
15 CHIEF MEDICAL OFFICER MORSE: Thank you for that
16 question, Chair Narcisse. Um, we are again, just
17 very, very honored that we have the support from this
18 administration to expand our doula programs.
19 Initially, they were only in Brooklyn, and now with
20 the City-wide doula initiative, we have been able to
21 expand doula support services to all five Boroughs
22 across the City, which is a very exciting expansion.
23 We also are very happy to report that already,
24 since this initiative has been launched, we have able
25 to actually train over 200 doulas. We're having a

2 Mike Pence moment. Um, we have over 200 doulas that
3 have been trained already in health equity, birth
4 equity, and several other topics including mental
5 health, um, addressing mental health, uh, as a part
6 of the City-wide doula initiative.
7 One of the key parts of this program is, as you
8 described, how to, um, screen and refer, um, patients
9 who might have food insecurity or other social
10 determinants of health concerns as a part of the
11 program. And I just want to say that that has been a
12 part of our doula work since the Health Department
13 launched it in 2010, actually. Um, and a part of the
14 work that our action centers do, um, in Brooklyn, in
15 Upper Manhattan, and in the Bronx, is actually to
16 help to refer community members to the social
17 services that they need based on what they come to us
18 asking for.
19 So, the piece around, uh, connecting community
20 members, including pregnant people, um, to health and
21 social services is very central to our approach at
22 the Health Department. And I'm so thankful that
23 you're raising awareness about it because we see that
24 as one of the ways that we get to birth equity. And,
25 Dr. Allen, uh, please do add.

2 CHIEF MEDICAL OFFICER ALLEN: I just want to share
3 with you that we've actually have started a pilot
4 program at a couple of our facilities where we're
5 actively referring the pregnant people who are
6 interested, to the doula services in their community.
7 We actively refer to Ancient Song, By My Side, and
8 we've been doing this actually through a number of
9 facilities, but this is a more rigorous pilot. We're
10 actually tracking the outcomes, how the women do.
11 CHAIRPERSON NARCISSE: Thank you. Do you think
12 that maternal health is a public health issue that we
13 have on our hands?
14 CHIEF MEDICAL OFFICER MORSE: Thank you so much,
15 uh, Chair Narcisse. Um, we see this as, uh, both a
16 public health and a healthcare, uh, issue for sure.
17 Um, and again, in my role as Chief Medical Officer, a
18 big part of what I hope to do and what I am, uh,
19 being held accountable to do, is help make to sure
20 that there is a seamless connection and partnership
21 between our healthcare delivery institutions like
22 Health and Hospitals and us at the Public Health
23 Department. So, we do see this as a public health
24 issue, and we, uh, are thankful that this Council,
25 uh, is also seeing it in that way.

2 CHAIRPERSON NARCISSE: Thank you. So why does the
3 US not treating maternal health as a public health
4 catastrophe that it is? What do you think? Rather to
5 make it, you know, it's nothing, and just not
6 developing anything to change it. What do you think?
7 And especially in our communities, black and brown
8 communities.
9 CHIEF MEDICAL OFFICER MORSE: Um, Chair Narcisse,
10 I think it's a very, very good question. I, uh, in my
11 role at the New York City health Department, I, I,
12 um, would probably not comment so much on the
13 national concerns, but I will say, um, one, you.
14 CHAIRPERSON NARCISSE: But national concern, we
15 need to have it especially after Roe versus Wade,
16 come on.
17 CHIEF MEDICAL OFFICER MORSE: Yes, I agree with
18 you.
19 CHAIRPERSON NARCISSE: You have to pay attention
20 to national.
21 CHIEF MEDICAL OFFICER MORSE: We certainly do pay
22 attention to the national trends. Uh, I just can't
23 speak to, um, the federal level about, uh, what, what
24 they are specifically focusing on. Um, but I will
25 say, um, that the CDC also, uh, declared racism a

2 public health crisis, and so, I do hope to see, um,
3 more work from the CDC.
4 In fact, they have launched, uh, a few years ago,
5 an, an, an ongoing campaign called Hear Her and that
6 campaign is specifically about making sure that
7 providers and other community members also have the
8 information they need to make sure that, uh, people
9 who are pregnant, uh, know their rights and get the
10 care that they deserve, and are listened to and
11 heard, um, whenever they may be raising a health
12 concern or another issue. Um, and that providers are
13 aware that one of the drivers of birth inequities is
14 not listening to patients when they bring, uh, a
15 health concern. So, the CDC's Hear Her campaign is
16 perhaps one example to share. I just, uh, shouldn't
17 really comment on the federal policy, uh, at this
18 time.
19 CHAIRPERSON NARCISSE: I understand. But you
20 almost, um, bring me back to the emotion that I
21 started when you talking about the lead paint in the
22 housing, the inequities in the housing. So, um, I'm
23 looking forward and listen to see what you offer to
24 that, because we know. The problem I have, during the
25 height of the pandemic, we all knew about all the

2 inequities we are talking about, but no one
3 addressing them. I don't want these inequities that
4 we're talking about pre-pandemic to continue. So,
5 please continue focus on maternal health is very
6 important. Thank you.
7 CHAIRPERSON SCHULMAN: So.
8 CHAIRPERSON NARCISSE: I'll pass it on to Chair
9 Schulman.
10 CHAIRPERSON SCHULMAN: Thank you. Um, obviously
11 this a big topic. We have a lot of questions. I'm
12 going to go out of turn and ask Majority Whip Selvena
13 Brooks-Powers, uh, to ask a few questions and then
14 come back to me. She has a hearing that she has to
15 attend. So, Council Member?
16 COUNCIL MEMBER BROOKS-POWERS: Bear with me. Thank
17 you so much, Chair, um, Schulman and Chair Narcisse
18 for convening today's, um, critically important
19 hearing. Um, black maternal healthcare is an issue
20 near and dear to me, as, uh, a black mother,
21 especially to my young daughter. Um, and the,
22 representing a community that's predominantly, um,
23 black as well, this issue is of utmost importance.
24 When we hear of these statistics that,
25 quote/unquote, "black women experience maternal

2 mortality two or three times higher than that of
3 white women, it is estimated that the black maternal
4 mortality rate is every 43rd out of 100,000 live
5 births that end up in death." And that's alarming and
6 clear that it's a national emergency. Repeatedly, we
7 hear of horror stories of black women not being
8 treated with the same respect and not being heard.
9 In April 2022, the CDC released a report working
10 to reduce black maternal mortality, highlighting the
11 underlying racial disparities, implicit bias, lack of
12 access to quality healthcare, and socioenvironmental
13 issues that attribute to these heartbreaking numbers.
14 Legislation like Introduction 472, to establish a
15 pilot program in the Department of Health and Mental
16 Hygiene to train doulas and provide doula services to
17 residents in all five Boroughs, provide lifesaving
18 resources and information for expectant mothers of
19 color. They also help with early detection of
20 potential issues. Pro-action is always better than
21 reaction, and that is the same with black
22 reproductive care.
23 Intro 478 that would require DOHMH to report on
24 polycystic ovary, um, syndrome, and endometriosis can
25 help black mothers plan appropriate steps to combat

2 potential healthcare issues and can offer a pathway
3 to motherhood.
4 I just to underscore that as someone who has
5 endured, um, procedures, um, as a result of, um,
6 cysts on my ovaries and fertility issues, um, I know
7 this firsthand in terms of how, um, we as women of
8 color are impacted, how it impacts our pursuit of,
9 um, being able to expand our family.
10 And so, we need to make sure that we're investing
11 resources so that, um, you know, our, our race, our
12 socioeconomic status does not preclude us from
13 expanding our families. And so, just going into, I
14 only have about two, three questions.
15 Um, so regarding Intro 472, how does DOHMH
16 evaluate the feasibility of a doula pilot program
17 including staff and funding? And how would the agency
18 identify neighborhoods and areas across the City to
19 introduce this program and ensure it's reaching New
20 Yorkers equitably.
21 CHIEF MEDICAL OFFICER MORSE: Thank you so much,
22 Council Member for, um, for that question. We are vey
23 aligned with you in wanting to address the upstream
24 social determinants of health. And we do, um, to your
25 point, see doulas as one of the ways, uh, to do that,

2 um, not just for the accompaniment they provide, but
3 also as, uh, as described, the connections to
4 resources that they can offer.
5 Um, one of the ways that we assess feasibility
6 is, you know, we're very honored to have been doing,
7 uh, doulas both services as well as training since
8 2010, um, before it was, uh, as widely recognized as
9 it is now as an intervention that advances birth
10 equity. And so, that experience over the past 12
11 years has been very helpful for our teams in, in
12 trying to figure out, again, how we continue to
13 expand doula services to all five Boroughs.
14 Um, and then for the second part of your question
15 about how do we figure out where to prioritize those
16 resources, what geographic communities, um, and what
17 is our place based approach to really ensure, um,
18 that the families and pregnant people that need it
19 the most really have access to doula services, uh, at
20 a way, in a way that, uh, that, that cost is not a
21 barrier.
22 The way that we have done that so far in the
23 City-wide doula initiative, um, which was just
24 launched this March, is to focus on the TRIE
25 neighborhoods, so that's the task force on racial

2 inclusion and equity. These are 33 priority
3 neighborhoods that we know experience, um, high
4 social vulnerability, um, and economic stress. And
5 unfortunately, many of those neighborhoods also had a
6 disproportional impact from COVID.
7 COUNCIL MEMBER BROOKS-POWERS: And then, how, um,
8 has DOHMH engaged with community-based organizations
9 to explore how doula services can be expanded and
10 supported?
11 CHIEF MEDICAL OFFICER MORSE: Yes, thank you for
12 that follow-up question. Um, and I'm honored to be
13 able to say that a big part of the work that we do in
14 the Center, the Center for Health Equity and
15 Community Wellness, um, is working with community-
16 based organizations. We have, um, several community-
17 based organizations that are co-located in our action
18 centers, and we partner very, very closely with them.
19 Um, specifically when it comes to doulas, um, you
20 are correct. That has been our strategy. Uh, in fact,
21 the City-wide doula initiative, a part of the way
22 that we expand that program from Brooklyn to all five
23 Boroughs, was to do a, a Request for Proposals, an
24 RFP, for community-based organizations that employ
25 doulas and many of them are led by doulas, um, to

2 respond to the RFP and be funded to be the, uh, what,
3 I guess you could call it the implementation arm,
4 the, the, the organizations that are actually working
5 with us to expand access to doula services. And so,
6 there are seven community-based organizations that
7 were funded through the City-wide doula initiative to
8 be able to expand doula services across all five
9 Boroughs.
10 COUNCIL MEMBER BROOKS-POWERS: Thank you so much
11 for that response. I just ask offline, if you can
12 share the list of those organizations with my office,
13 um, I would love to, um, know which ones they are.
14 And please use my office also as a resource cause I
15 do represent a hard to reach, um, community, when you
16 think about us being geographically isolated. And
17 it's something that is, again, a very critical issue
18 for the community I represent. Um, and I want to
19 thank the Chairs for the opportunity to ask my
20 questions. Thank you.
21 CHAIRPERSON SCHULMAN: Okay. Thank you. Thank you,
22 Council Member. I'm going to ask a few questions.
23 There's a lot more that we have, but I want to, two
24 things, I want to let my colleagues answer, we have
25 some panels who want to talk. We have to be out of

this room at 1:00, so, um, cause there's another hearing.

But I want to, okay. So, I want to focus on, um, the bill that I introduced, Introduction 509. Do you agree with the notion that pregnant people in New York City would benefit from a campaign about the risks of c-sections? That's, yeah, that's intro.

CHIEF MEDICAL OFFICER MORSE: Thank you, um, Chairperson for that question. Um, we, uh, are very much in agreement that there needs to be, uh, awareness raising campaigns and we also, um, agree with you, um, that it's very, very important for patients to have all the information they need to know the risks and benefits of any procedure.

Um, however, um, we know that some, uh, sometimes c-sections are necessary, and our concern would be, um, that we don't want to stigmatize cesarian sections, um, because some patients, uh, do need cesarian sections. Um, but what we, uh, agree with you for sure about is that we think it's very important to decrease the rate of unnecessary cesarian sections. Um, and many of the hospitals we work with are very much in line with that.

2 I do want to also underline again that doulas,
3 uh, as well as midwives have been shown to decrease
4 the rates of cesarian sections. And so, the work that
5 this Council is already doing to support doulas and
6 midwives is very, very important.

7 CHAIRPERSON SCHULMAN: I appreciate that. So, I'm
8 going to ask some questions about fertility. What is
9 the current amount that the City spends towards
10 fertility services like IVF for City employees?

11 CHIEF MEDICAL OFFICER MORSE: I'd like to pass
12 that one to my colleagues at ORL.

13 CHAIRPERSON SCHULMAN: Yeah, I'm, I'm looking
14 right at him.

15 FIRST DEPUTY COMMISSIONER POLLAK: Thank, thank
16 you for the question, uh, Chair Schulman. Uh, the
17 City currently spends, um, over $100 million on
18 fertility benefits for City employees.

19 CHAIRPERSON SCHULMAN: Okay. If none, if non-
20 heterosexual couples were included in IVF coverage,
21 how much would that amount increase?

22 FIRST DEPUTY COMMISSIONER POLLAK: Um, so, non-
23 heterosexual couples are included in the City's, um,
24 infertility benefits. Um, what is not included is
25 surrogacy. So, surrogates are, are, um, IVF involving

2 the surrogates is not currently covered. Um, we don't
3 have precise figures on the cost of that in surrogacy
4 benefits, but we do know that surrogacy costs are
5 very expensive.
6 CHAIRPERSON SCHULMAN: Okay. So, you don't have
7 any estimate or anything like that?
8 FIRST DEPUTY COMMISSIONER POLLAK: Not at this
9 time.
10 CHAIRPERSON SCHULMAN: Okay. Um, does the City do
11 outreach and education to City employees so that
12 they're aware of their coverage options?
13 FIRST DEPUTY COMMISSIONER POLLAK: Um, our
14 fertility benefits are set forth in the City's
15 summary plan description, um, which is available to
16 all City employees on OLR's website. Um, and lists
17 out the benefits, uh, all the health benefits under
18 our health plans.
19 CHAIRPERSON SCHULMAN: Does the City provide any
20 reimbursement toward out-of-pocket expenses relating
21 to fertility services?
22 FIRST DEPUTY COMMISSIONER POLLAK: Uh, so, it
23 depends on the service. Um, if you're talking about
24 an out of network provider, um, if someone's going to
25 an out of network provider for covered, uh,

2 infertility services, there could be reimbursement
3 through the primary health plan. Um, in addition some
4 welfare funds run by unions may provide some degree
5 of reimbursement for out-of-pocket costs, uh, for
6 example, the Management Benefits Fund, which is
7 available to, uh, non-represented employees as a
8 superimposed major medical plan which would provide
9 some additional reimbursement for out-of-pocket
10 costs.
11 CHAIRPERSON SCHULMAN: If the City's insurance
12 also covered fertility preservation like sperm or egg
13 freezing which is generally less expensive than IVF,
14 wouldn't that help same sex couples, and uncoupled
15 individuals conceive?
16 FIRST DEPUTY COMMISSIONER POLLAK: Um, I
17 apologize, this, uh, (INAUDIBLE) answer. Um, so, you
18 know, I think, we, uh, there are a number of services
19 we don't cover, obviously, and, um, you know, I think
20 there, uh, the question of what would assist some of
21 our employees in, uh, conceiving when they may not be
22 ready to conceive now, uh, that's certainly something
23 that would help them. And it's something that, um,
24 you know, is worth exploring. Um, you know, I, I
25 don't know the extent to which, what numbers of the

2 employees out there desire to use those benefits, but
3 I am sure they are out there.
4 CHAIRPERSON SCHULMAN: Well, cause, and so, my
5 next question is why isn't fertility preservation
6 like egg and sperm freezing included within the three
7 rounds of IVF that are covered?
8 FIRST DEPUTY COMMISSIONER POLLAK: So, it is
9 included where, um, egg freezing is included where
10 there's, someone's undergoing a procedure that could
11 impact the viability of the eggs. Um, so, you know,
12 I've, the premise of our benefits, which is based on,
13 you know, the state mandated benefits, is when
14 someone has, is not able to conceive, um, conceive
15 the traditional way. So, the, the service, those
16 services are covered where, uh, where someone has,
17 you know, been diagnosed with infertility or because
18 they're unable to conceive, um, by earlier attempts
19 to do so.
20 CHAIRMAN SCHULMAN: Understood, but that, the
21 implication of the, and then why we did the
22 legislation, is because that actually discriminates
23 against, um, LGBTQIA couples, those who are
24 uncoupled, and asexual. So, I just, I know there's a,
25 you know, there's some disagreement around that but I

just want to, I just want to point that out. I mean, I'm not going to debate it here.

FIRST DEPUTY COMMISSIONER POLLAK: I appreciate that, uh, Chair Schulman.

CHAIRMAN SCHULMAN: So, thank, thank you on that. And I just wanted to ask on, um, excuse me one second. So, implicit bias training, let's go back to that for, for one minute. Um, since 2018, bias training has occurred within relevant private and public healthcare facilities across the City. Can you provide an update on these, you did that? I'm sorry.

So, let me ask, let me ask this question. Uh, when you do the training, is that, does that also cover the affiliation agreements for the doctors that are affiliated with other hospitals that work at H and H?

CHIEF MEDICAL OFFICER MORSE: Um, I think for the H and H specific question, I'll pass to Dr. Allen.

CHAIRPERSON SCHULMAN: Dr. Allen.

CHIEF MEDICAL OFFICER ALLEN: Yeah, um, so thank you for that question. We have done system wide anti bias training, bias awareness training. We actually started with the Board of Directors and our senior leadership.

2 CHAIRPERSON SCHULMAN: Okay.

3 CHIEF MEDICAL OFFICER ALLEN: And we, in
4 conjunction with DOHMH, um, involved our front-line
5 staff at each of our facilities as well. And we're
6 doing through human resources, additional anti bias
7 training, diversity training, uh, so it's a full
8 (INAUDIBLE).

9 I can, uh, I had gone through this earlier. If I
10 put my glasses back on, I can tell you exactly what
11 we've done. If you could just give me a minute. Just
12 to go through some of the stuff that's offered
13 through human resources, we have an introduction, we
14 have eLearning modules, Introduction to Unconscious
15 Bias, Diversity Inclusion: A Business Imperative.
16 We've trained over 20,000 employees since January
17 2020.

18 Uh, the models, the modules on this topic are
19 also integrated into our new employee orientation and
20 annual in-service. We also have Employee Voices
21 sessions. These are anonymous conversations with the
22 employees on the topic of implicit bias and racism.
23 They're designed to give the employees a safe place
24 to share while learning concrete action steps to
25

2 mitigate bias. We've had six of these sessions within
3 the last three months.
4 We also host a variety of virtual workplace
5 inclusion workshops, year-round, that include the
6 following topics: diversity inclusion in the
7 healthcare setting, interreligious awareness for
8 patient centered care. It gives the employees skills
9 to meet patients' religious and spiritual needs and
10 to respectively interact with colleagues from
11 different faith backgrounds.
12 Having essential conversations, which provides
13 tools and techniques for having essential
14 conversations on the topic of racial equity. How to
15 be an inclusive colleague, which helps participants
16 gain the essentials of inclusive behaviors to support
17 a welcoming workplace environment. How to be an
18 upstander, which guides participants through proven
19 techniques to actively address and mitigate instances
20 of biased encounters.
21 Over 1,100 employees have participated in the
22 above virtual sessions since July 2020. And in our
23 simulation lab where we learn how to react to rare,
24 but serious instances like post-partum hemorrhage,
25 shoulder dystocia, we've actually just developed a

2 curriculum for recognizing bias in dealing with
3 patients. So, we're taking our. And, when you go
4 through the simulation lab, you don't go as an
5 individual. You go as part of a team, so you have
6 your nurses, your, your doctors, your residents, as
7 well as your administrator participating as a group.
8 So, we've just started that curriculum on anti-bias.
9 It's particularly important to us because in
10 recognizing the substance use disorder and impact on
11 the pregnant woman, the family, her fetus, her, the
12 siblings of the newborn child, the father, the
13 family, we recognize in assessing, doing substance
14 screenings, personal biases actually come in. So, if
15 you look a certain way, our response might not be the
16 same as if you looked a different way, including the
17 color of your skin, the texture of your hair, the
18 clothes you're wearing.
19 So, as we're developing the substance use
20 disorder identification and intervention from a
21 preventive perspective, it's very important to us
22 that our providers are sensitive to their own biases
23 as we begin these screenings and identifications.
24 CHAIRPERSON SCHULMAN: And just, uh, I want to
25 ask, are these, um, trainings mandatory?

2 CHIEF MEDICAL OFFICER ALLEN: Some of, so I can't
3 answer from the human resources, well, it's part of
4 the new, of new employee orientation so I don't think
5 you can opt out.
6 CHAIRPERSON SCHULMAN: Okay. Alright. Thank you
7 very much. What I'm going to do, um, in the interest
8 of time is ask, is go to my colleagues, and then we
9 can, if we have a chance, we'll circle back. Um, I'm
10 going to ask Council Member Gutiérrez, um, to ask
11 your questions. Thank you.
12 COUNCIL MEMBER GUTIÉRREZ: Thank you, Chair. Um, I
13 have a lot, but I will not ask all of them in, to
14 make sure that we're all getting our questions in.
15 Um, my first question is, how many hospitals have
16 midwives on staff? And how many midwives does DOHMH
17 employ?
18 CHIEF MEDICAL OFFICER MORSE: Thank you for that
19 question, Council Member. We are aligned with you in
20 really prioritizing midwifery, um, for the reasons
21 already mentioned, that it's shown that both doulas
22 and midwives decrease cesarian section rates, and
23 really again, are, uh, critical health workers to
24 advancing birth equity. Um, I don't believe we have,
25 um, that information about specifically how many

2 midwives there are per hospital across the whole
3 City, um, but I will pass to Dr. Tara Stein to share
4 more about our midwifery initiative in the health
5 Department.
6 COUNCIL MEMBER GUTIÉRREZ: Okay.
7 MEDICAL DIRECTOR STEIN: Thank you, Dr. Morse, and
8 thank you, Council Member, for the question. Um, we
9 are extremely excited at the Department of Health
10 about our new midwifery initiative, and we are in the
11 process right now of hiring a senior advisor on
12 midwifery initiatives who will be the first midwife
13 to be hired at the Agency. We have long known the
14 importance, um, of midwives and the role that they
15 play in improving health outcomes for parenting, um,
16 pregnant and parenting people. So, we are really
17 looking forward to this new position.
18 And much of the role of the midwifery initiative
19 and this new hire will be to assess the status of
20 midwifery care and to help, um, describe some of
21 those things that you're asking about.
22 COUNCIL MEMBER GUTIÉRREZ: Thank you. Um, I would
23 love to, to follow up. My understanding, um, often
24 times with midwifes, if they are not full time on
25 staff, I know that they will freelance or maybe it's

the doulas that I'm confusing it with. So, I think it'd be really helpful to have that, that data. Um, my next question is, um, we mentioned the, you mentioned, excuse me, the, in hospital level data kept and analyzed regarding rates of maternal mortality and morbidity by. Oh, uh, sorry. Is information about, uh, maternal mortality and morbidity, is it, do you all have it my demographic populations?

CHIEF MEDICAL OFFICER MORSE: Thanks again for that question. And it's very much in line with what we're required to do by the Board of Health resolution declaring racism a public health crisis. Um, but in fact, even before the resolution was passed last October, the Health Department did, uh, collect that information about race and ethnicity, um, and maternal mortality by race/ethnicity. Um, it is, uh, a part of the annual report that we publish, uh, online. And it's freely available for researchers, for others to look at that data, um, and to use it to continue to develop programs that might reduce racial inequities in maternal mortality.

COUNCIL MEMBER GUTIÉRREZ: Fantastic. Um, can I ask you, you had, um, talked earlier about the, um,

2 suicide being really high for, for new moms, new
3 parents in the first year. Um, can you talk a little
4 bit about how the, the midwife initiative will be
5 able to aid these moms in the, uh, in these
6 instances? And what are some of the, what are some of
7 the action plans that are in place now, uh, to really
8 prevent this from happening and really talking
9 through new time parents when we're talking about
10 suicide prevention?
11 COUNCIL MEMBER MORSE: Yes. Thank you, again, for
12 that. Um, I think for, um, for us who have been doing
13 this work for some time, it's not surprising to see
14 how much behavioral health is central, um, to health
15 outcomes for everyone that we take care of. Um, so,
16 thank you for raising more awareness again, around
17 behavioral health and suicide. Um, and overdose as
18 well, um, is a significant driver of, of, uh, deaths
19 in the year following, um, delivery.
20 Um, I would actually like to pass, uh, to my
21 colleague, um, Laura Louison, to speak a little bit
22 more about the new family home visit initiative and
23 how it might, uh, help to address what you're
24 describing.
25

2 ASSISTANT COMMISSIONER LOUISON: Thank you, Dr.
3 Morse, and thank you so much for this question. I'm a
4 clinical social worker by training, and so, maternal
5 mental health is a priority, a personal priority for
6 me, but it's also a priority for our work. Um, and as
7 you were pointing out, Council Member, suicide does
8 not happen in the hospital context. It happens post-
9 partum when many of the maternal deaths we know
10 occur.

11 Um, we are really excited about our new family
12 home visiting initiative and the expansion that was
13 announced, uh, in the past year because that
14 initiative will really allow us to support families
15 during that incredibly vulnerable period when you
16 bring home a new baby from the hospital.

17 So, if you've done that, you know, it's, it's a
18 really, can be a really hard time, particularly if
19 you're already struggling with other, uh, with other
20 concerns or other mental health concerns in your
21 life.

22 Our new family home visiting initiative expands a
23 wide range of evidence-based home visiting programs.
24 As Dr. Morse mentioned earlier, including
25 nurse/family partnership and newborn home visiting,

2 um, and the City-wide doula initiative. A critical
3 component of this expansion will be enhanced support
4 for mental health. That was a recommendation from our
5 Maternal Mortality Review Committee, that all
6 pregnant and post-partum people should be assessed
7 for mental health conditions, substance use,
8 interpersonal violence, that those who screen
9 positive, those who indicate a concern, should be
10 referred to supportive services. And so, our new
11 family home visiting initiative is currently working
12 on a strategy to support mental health for those new
13 families.
14 COUNCIL MEMBER GUTIÉRREZ: Thank you. Can I, just,
15 I know my time ended. Can I just have, make one more
16 comment and then? Oh, wait. Can I just make one more
17 comment before I. um, so I've talked about this
18 publicly many times about my experience at Woodhall.
19 I was really, really lucky to have, uh, a midwife and
20 a doula there present for me. I just want to shout
21 out, um, all the trailblazers coming out of, of all
22 of our public hospitals, specifically, um, Woodhall.
23 Um, I also just want to emphasize that when we're
24 talking about our public hospitals, wherever they
25 are, I think it's really important that we're talking

2 about how these midwifery programs are being
3 mitigated, are, um, and that they're equitable across
4 the board. What I don't want to see is that we're
5 seeing some thriving programs, um, in Coney Island,
6 but we're not seeing the same at, at Woodhall or at
7 Lincoln, for example. And so, um, I know that we have
8 a Mayor and an administration and certainly a Council
9 that wants to prioritize, um, all the things that
10 we're talking about today because I think we all know
11 how important is.
12 But how can we ensure that when we're talking
13 about this initiative, that when we're talking about
14 career pathways, that when we're talking about the
15 opportunities that every New Yorker has access to,
16 that we're doing it as equitably as possible, that
17 we're not letting programs, hospitals, midwifery
18 programs, fall through the cracks. Um, because I
19 really think although this a really important thing
20 to celebrate today what we're doing, um, I don't
21 think it would be in earnest if we're not doing it
22 equitably.
23 What I don't want to see, is that we're not
24 getting the same level of support in Coney Island or
25 Elmhurst, uh, that we're not getting somewhere else.

2 So, what can you all tell me about how you are
3 ensuring that this is done equitably every single
4 time, at every single public hospital to begin with?
5 CHIEF MEDICAL OFFICER MORSE: Thank you, Council
6 Member. We're aligned with your intent 1000% around
7 equity and how we operationalize it. Um, I'm going to
8 pass to Dr. Allen for the Health and Hospitals
9 specific question.
10 CHIEF MEDICAL OFFICER ALLEN: So, Health and
11 Hospitals is a system and what we implement, we
12 implement system-wide, so I'm not sure if you're
13 referring to suicide prevention or anything specific.
14 But, let me share with you that, when we look at
15 mental health services for our women, every single
16 woman, no matter hospital she presents to in labor,
17 and actually no matter what hospital or facility she
18 presents to her for her prenatal care, she gets
19 screened for depression.
20 COUNCIL MEMBER GUTIÉRREZ: Right.
21 CHIEF MEDICAL OFFICER ALLEN: A PHQ2 and a PH2Q9.
22 It's.
23 COUNCIL MEMBER GUTIÉRREZ: I was screened every
24 single visit. And so, that's really meaningful.
25

2 CHIEF MEDICAL OFFICER ALLEN: Okay. So, we do it
3 during the pregnancy and we also do it post-partum.
4 There's actually a specialty called reproductive
5 psychiatry and we work very closely with a couple of
6 reproductive psychiatrists who are supporting us in
7 our prenatal care as well, and we are building that.
8 But I can only that we are a system, when we are
9 talking about midwives, we are implementing that,
10 actually, I want to talk a little bit more time
11 talking about our midwifery services.
12 So, currently, we have midwives in eight of our
13 11 facilities, but we are expanding that. We actually
14 have funding from the New York Community Trust to do
15 a thorough evaluation of the midwifery care
16 throughout the system. We're actively hiring more
17 midwives. We've hired an additional 20 in the past
18 year. We have a Council of all the midwifery chiefs
19 throughout all of our systems. Once the evaluation
20 and analysis is complete, the midwives themselves
21 will have control over what's the best model of care
22 to deliver midwifery services in Health and
23 Hospitals. We have a very close collaborative,
24 collaboration with our midwives. We are committed to
25

2 building the service and strengthening the service
3 throughout all our facilities.
4 CHAIRPERSON SCHULMAN: Okay. Um, I'm going to ask
5 the Council Members, since we have, um, a time
6 constraint to please keep to their allotted time. I'm
7 going to ask, uh, Council Member Joseph to, uh, ask
8 question.
9 COUNCIL MEMBER JOSEPH: Thank you, Chairs, um,
10 Schulman and Narcisse for this very important
11 conversation. Um, my questions are a lot, but I'll
12 keep it short. Um, thank you for touching upon
13 curriculum. As the Chair of Education, that was very
14 important to me in terms of implicit bias. I don't
15 think it should start in the hospitals. I think it
16 should start in the nursing schools, at the, um,
17 medical schools. It shouldn't wait until we get into
18 the walls of the hospital to practice bias implicit
19 training. It should start there. But the fact that
20 you're doing it in the hospitals is very important.
21 Um, few questions on, um, language access for our
22 mom to bes. Is that being implemented? Do they
23 understand midwife, doulas in their native language
24 and also in culturally relevant settings? Um, is home
25 visit provided after care, which I think should be

2 very important to check up on the moms, especially,
3 um, the ones that don't have any supports? So, I
4 would like to know where H and H is, is on that. Um,
5 either, either one could answer.
6 We know that dismantling this racism, this racist
7 healthcare initiative should not only start behind
8 the walls of the hospitals, but I believe that it
9 should also start within the community and working in
10 partnership with CBOs. Um, let me know how that work
11 look like, explain to me what your partnerships are
12 on the grounds? And how are you supporting these
13 things? Thank you.
14 CHIEF MEDICAL OFFICER ALLEN: So, I, I think the
15 answer will be longer than the question. Um,
16 language, we have many different languages that are
17 represented in our facilities from Queens. Can you
18 hear me? Better?
19 So, we do have, and we appreciate the difference
20 between someone who has learned Spanish or another
21 language in school versus a native speaker, all the
22 difference in the world. And it actually was very
23 evident to me when we do the PH2Q9 screening for
24 depression, if you're talking to someone who's not a
25 native speaker, the idiomatic nuance of the language

2 really makes a big difference. So, we have access to
3 what we call a language line where we can call for an
4 interpreter to help us with our conversations.
5 In terms of, uh, we have a program called the
6 Maternal Home Program, which is of, in all of our
7 facilities. And even though we thought we would meet
8 the needs of 2,000 patients over five years, within
9 the first two years, we touched on 3,000 patients. In
10 the year of 2021, we saw 2,100 patients, which
11 represented 16 births, 16% of the births in H and H
12 and the majority of these were in Brooklyn, where 25%
13 of the, of the pregnant women were actually enrolled
14 in the Maternal Home. 75% of these patients were
15 either black or Hispanic. And 25% were referred to
16 community-based organizations.
17 And the support we got from the community-based
18 organizations from the medical side, 59% received
19 dental services, for pregnancy and parenting, 32%
20 received lactation support, 22% received doulas, uh,
21 13% were referred to the DOHMH Nurse Family
22 Partnership. Um, so our involvement with community-
23 based organizations is very strong. We depend upon
24 them. 14% were referred for community care, 20%
25 collaborative care, 18% for nutrition, 35% were

2 referred to WIC, 15% were referred to food pantries,
3 12% to, to, uh, SNAP, 8% for legal services, 5% for,
4 uh, financial counseling, 11% for mental health
5 services. So, the community support is very important
6 to us. We couldn't do our work without, without the
7 community-based organizations.
8 So, we provide language access. I can't tell you
9 the number, and I'm happy to give you the number of
10 languages that we have access to. I think on any
11 given day, we have over 20 or 30 different languages
12 in, in our facilities. Um, any other questions that I
13 didn't answer, Council Woman Joseph?
14 COUNCIL MEMBER JOSEPH: Um, no. It was about the
15 home visit. You touched on that. And, um,
16 breastfeeding, um, I know that's not promoted among
17 women of color and Latina women. I would like to see,
18 um, is there a campaign in place, is there something?
19 CHIEF MEDICAL OFFICER ALLEN: So, we're all, um,
20 we're all, uh, friend, baby friendly, all of our
21 sties are baby friendly sites which is a designation
22 by the World Health Organization. I just wanted to
23 say in terms of community-based organization support,
24 32% of our patients were, were referred for lactation
25 support. So, that is encouraged to have the WHO baby

2 friendly designation is, I think, a very good one and
3 it allows for our patients. And we are aware of the
4 deficit that we've had with formula in this country,
5 so, we don't really depend on formula within our H
6 and H facilities because we are such a strong
7 proponent of lactation and breastfeeding.
8 CHAIRPERSON SCHULMAN: Okay. Thank you very much.
9 Um, I'd like to, before I go to the next, uh, Council
10 Member, I want to acknowledge that we've been joined
11 by Council Member Yeger. Uh, so the next person up is
12 Council Member Julie Menin.
13 COUNCIL MEMBER MENIN: Thank you so much, Chair.
14 Uh, so, uh, first of all, I was pleased to hear in
15 the testimony that you believe that my bill 490 would
16 codify the Bureau of Maternal, Infant, and
17 Reproductive Health. So, I have a number of questions
18 on that. First of all, how many referrals is that
19 Bureau currently making to women in terms of
20 providing safe and affordable, uh, abortion services.
21 CHIEF MEDICAL OFFICER MORSE: Thank you so much,
22 Council Member, for, uh, the question and for your
23 support, um, around sexual and reproductive health.
24 Um, we do have a Bureau of Maternal, infant, and
25 Reproductive, uh, Health that handles this work, so

2 I'm going to pass to, um, Assistant Commissioner
3 Louison to share more.
4 ASSISTANT COMMISSIONER LOUISON: Thank you, Dr.
5 Morse. And, um, thank you for the opportunity,
6 Council Person, to talk about our part of the Health
7 Department.
8 So, our office, the Bureau of Maternal, Infant,
9 and Reproductive Health handles this work for the
10 Department. We work closely with our colleagues who,
11 from the Bureau of, uh, Hepatitis, HIV, and Sexually
12 Transmitted Infections as well as the sexual health
13 clinics to ensure that we are providing services to
14 New Yorkers really through a, what I would describe
15 as a, a sexual and reproductive justice lens so that
16 all New Yorkers have the ability to make decisions
17 about how, when, and if they choose to parent, and
18 are supported with the appropriate resources, whether
19 those are resources for, I think you mentioned
20 testing, or, um, uh, contraception.
21 Within our, uh, sexual and reproductive health
22 unit that exists within our Bureau, we have some
23 amazing work happening. I want to highlight the work
24 of our program, the New York City Teens Connection,
25 which is a program that works, is currently expanding

2 across all five Boroughs to support adolescents in
3 linking them directly to services through clinics
4 that are teen-friendly and providing them education
5 and resources in the spaces where they are in schools
6 and other youth serving organizations.

7 We are actively working, as I mentioned earlier,
8 um, in close collaboration with our national and
9 local partners to respond to the recent overturn of
10 Roe versus Wade and will begin to be, uh, developing
11 implementation strategies for providing even more
12 information about abortion access. I don't have, uh,
13 numbers for you currently about how many folks we're
14 referring to abortion services. But I'm happy to
15 follow up with you on that specifically after the
16 hearing.

17 COUNCIL MEMBER MENIN: Sure. That, that would be
18 very helpful. And then, as a corollary to that, how
19 many staff are in that Bureau? And what are the
20 Bureau's plans to ramp up in terms of the expected
21 influx of women who are going to come to New York to
22 seek safe and affordable abortions?

23 ASSISTANT COMMISSIONER LOUISON: Thank you for
24 your question. Our Bureau has, I believe, over 200
25 people in it, and that includes a really wide range

2 of professionals. In addition to the sexual and
3 reproductive health unit, our Bureau is also
4 responsible for a significant portion of home
5 visiting services within the City, including Nurse
6 Family partnership, and the newborn home visiting
7 program that were mentioned earlier. Um, and so, our
8 plan is to work closely, um, with our colleagues to
9 determine what are our needs for staffing, for
10 infrastructure, in order to be able to really meet
11 the increased demand that we anticipate.
12 COUNCIL MEMBER MENIN: Okay. And then my last
13 question is what are the Bureau's plans in terms of
14 the fact that some states have threatened to restrict
15 travel to women, what are the Bureau's plans to
16 address that and to help relieve some of these
17 burdens?
18 ASSISTANT COMMISSIONER LOUISON: Absolutely. And I
19 will say that we share you concern that we are seeing
20 throughout the country, efforts to really prevent
21 people from accessing care by limiting their ability
22 to travel or seek appropriate medical services that
23 they choose. Um, we are in close, uh, contact and
24 really close collaboration with our colleagues to
25 better understand, um, what opportunities exist to

support those folks who may be prevented from travel or for whom seeking abortion is a criminalized act. Um, and we are working with our colleagues at the New York State Department of Health as well on this.

COUNCIL MEMBER MENIN: Okay, great. Thank you very much.

CHAIRPERSON SCHULMAN: Thank you, Council Member. Now, I'm going to ask Council Member Velázquez, um, to ask her questions.

COUNCIL MEMBER VELÁZQUEZ: Okay. So, I have a series of questions, I'll read them out so, be as I know as we're short on time. Um, first of all, thank you, thank you for coming.

Today is very important to me, um, as I am currently doing IVF, I have several questions for you because it wasn't easy. It hasn't been easy, the communication, uh, the, the way that the accessibility we have wasn't there. So, I advise you to go back into the program, um, please let the providers know that. additionally, there is, um, a lot of out of network that is involved, and I know that the WINFertility, um, has been mentioned. However, when we were researching, me and my husband, it wasn't available to us. We did not know about

2 WINFertility and it wasn't communicated effectively
3 to us.
4 FIRST DEPUTY COMMISSIONER POLLAK: Thank you,
5 Council Member, um, for those comments and thoughts.
6 Um, you know, we will certainly go back and take a
7 look at those issues. Um, you know, WINFertility, um,
8 my colleague Claire Levitt can speak more to when it
9 was established. So, I'm not sure if your experience
10 was prior to that, but we will certainly go back and
11 ensure that the benefits that we provide are
12 communicated, um, effectively to our employees, um,
13 and that, uh, employees going through this, you know,
14 what I know can be a difficult process, um, have aid,
15 have access, have assistance and can be directed on
16 where to go and have somewhere to turn when they have
17 questions.
18 DEPUTY COMMISSIONER LEVITT: We're certainly very
19 concerned to hear that you have had difficulties. Um,
20 is there, uh, if there's something that we can do to
21 help assist you through the process right now, we
22 certainly want to do that and I can be in touch with
23 you to make sure that we can make the proper
24 connections for you.
25

2 COUNCIL MEMBER VELÁZQUEZ: As you know, so, me and
3 my husband have, you know, full time jobs, keeping
4 me, you know, up to date, and making sure that we
5 have accessibility, right, and if this is something
6 I'm personally going through, what about the other
7 City employees that are also affected by this? That's
8 my problem with it, right.
9 We have an opportunity here to say, "You know
10 what, let's reconfigure this so it can be
11 accessible." Right, because accessibility is part of
12 the ability to manage this, um, situation and this
13 healthcare, uh, procedure. Right, it's a choice,
14 right, what we're talking about today, it's like a
15 choice, and we're not really providing our members
16 with real, um, accurate information, uh, on time
17 information, and the outreach has been poor.
18 We had to literally call through so many numbers
19 to make sure that we were doing this. We had spent
20 over an hour on hold with our insurance provider just
21 to see what was covered. So, that has not been
22 effectively communicated to us. So, I really want to
23 like harp on this that we need to do better.
24 Um, with that being said, I did mention choice.
25 We are going to get an influx of people coming for

2 services for abortion services. And I know that that
3 is going to draw a lot of attention at the same time
4 we are dealing with the pregnancy service centers or
5 the crisis prevention centers which we all know are
6 just fraudulent abortion clinics. I said what I said.
7 They are just, uh, their deceptive practices hurt our
8 communities, specifically black and brown communities
9 like mine.
10 And so, what are we doing, what is the
11 administration doing in looking forward to, um, not
12 only limiting them but exposing this dangerous
13 practice that they have? And also, once again, going
14 back to our communities, making sure that we're
15 outreaching, right, performing the proper awareness
16 outreach to our communities, but more importantly,
17 communication, communication in different languages,
18 um, as well, and who do you think would be the best
19 partners, have you worked with? Um, which CBO's have
20 you worked with? And how do we go through that? So, I
21 know that was a lot, but this is something I'm really
22 passionate about because, uh, we should not defraud,
23 um, folks who are seeking care.
24 CHIEF MEDICAL OFFICER MORSE: Thank you so much
25 for that, Council Member. And again, we are so

2 thankful that in New York, abortion is legal. Um, and
3 your point about, uh, communication campaigns, in
4 particular, we are very aligned with you on that. We
5 see that as a critical strategy and agree that it has
6 to be in multiple languages. Um, and we also
7 acknowledge that there will be a hearing about this
8 on Friday, where we can go in even more depth. Um,
9 but I'm going to pass to my colleague, Laura Louison
10 to share more about what we're doing on crisis
11 prevention centers.
12 ASSISTANT COMMISSIONER LOUISON: Thank you, Dr.
13 Morse. And Council Member, I share your anger. These
14 are really better called fake clinics because they
15 intentionally imitate health clinics by using names
16 and banners and signs that look similar to real
17 clinics. And they often offer low-cost resources like
18 baby clothes and diapers, but they do not provide
19 abortions, and they intentionally mislead people who
20 can be seeking abortion care.
21 We look forward to working with DCWP in
22 collaboration on your bill, and I also want to note
23 that we have recently done a lot of work updating our
24 website to make sure that New Yorkers have access to
25 accurate information about abortion. That website

2 includes information about how to determine whether a
3 clinic is a fake clinic and how to report someone who
4 may be misleading a patient.

5 COUNCIL MEMBER VELÁZQUEZ: That is huge, and I
6 appreciate that. And I look forward to making sure
7 that we really do provide all aspects of information
8 and care. The last follow up, and I'm, Chairs, if
9 you'll allow me to ask this, security for the
10 abortion clinics, how are going about that, and, um,
11 what are we looking forward to that?

12 ASSISTANT COMMISSIONER LOUISON: Thank you, and I
13 really appreciate you raising this issue because we
14 know that abortion is legal in New York City and it
15 is safe, and that we have seen increased protestor,
16 uh, presence at the healthcare facilities that
17 provide abortions throughout the five Boroughs. Um,
18 and that patients, in order to uphold our commitment
19 to safe and legal abortion, we need to ensure that
20 patients are not harassed or intimidated when they
21 are entering a clinic. And that is also true for
22 providers. Provider and patient safety is critical.
23 Um, we know that the State Department of Health has
24 also increased funding for security at clinics, and
25

2 that's going to be a critical aspect of our strategy
3 to ensure safety.
4 We also look forward to working with NYPD to
5 ensure that those who intimidate or harass or attempt
6 to prevent people from accessing abortion services
7 are removed and prosecuted.
8 CHAIRPERSON SCHULMAN: Okay. Thank you. Um, I just
9 have a couple more questions. Um, and then I'll turn
10 to, um, Chair Narcisse to see if she has more, and
11 then we'll open it up to, um, to the public. So, I
12 want to know, what resources does a pregnant person
13 have if they don't feel they know how to navigate the
14 medical system or experience complications and don't
15 feel they're being heard? Because I've seen it
16 happen, personally, and experienced it and, um, in,
17 in our public hospital system. So, I just, that's the
18 question I want to get answered.
19 CHIEF MEDICAL OFFICER MORSE: Thank you,
20 Chairperson, for, um, for that question. And we are
21 aligned with you very much about the need to make
22 sure that patients, um, and pregnant people in
23 particular have the support they need to navigate our
24 complex health system. Um, in fact, that is, uh, one
25 of the key challenges here because, um, most of our

2 hospital systems are not actually formally connected,
3 it can be even more challenging, um, for, uh,
4 pregnant people to, to navigate them.
5 Um, at the same time, we do think that our New
6 Family Home Visit Initiative actually is one of the
7 ways that can help, uh, patients and pregnant people
8 navigate the health system. Um, and our doula
9 services similarly, um, are really intended to
10 support and accompany pregnant people, um, through
11 what is, unfortunately, a fragmented and complex
12 system, and one in which cost is also often not
13 transparent as well. Um, I do want to, uh, give the
14 opportunity, if, um, Laura, um, Laura Louison or Dr.
15 Allen want to add to that.
16 CHIEF MEDICAL OFFICER ALLEN: So, so your question
17 is resources for patients who find themselves lost in
18 the system.
19 CHAIRPERSON SCHULMAN: Also, patients that feel
20 they're not being heard when they're in the hospital.
21 CHIEF MEDICAL OFFICER ALLEN: So, what we do have
22 posted throughout all of our facilities are the
23 patients' bill of rights. We've been walking with,
24 working with DOHMH in a collaboration around
25 respectful care, publicizing with pamphlets just what

2 the patient should expect, what they're due. Um,
3 respectful care is a human right.
4 We also have patient advocates within the
5 hospitals which are available to the patients where
6 the patients can go and express their disappointment
7 or complaints as well. And on our website, we've been
8 working on our website, so that there is information
9 there to hopefully help a patient navigate, if they
10 want to find a specific doctor, or if they want to
11 find a specific service. That is a work in progress,
12 which we're building currently.
13 CHAIRPERSON SCHULMAN: Thank you. Now, I'm going
14 to ask, um, just one set of questions and then, um,
15 I'll be complete. So, I want to know, and this is a
16 little controversial, um, does the City collect
17 hospital level maternal health data, um, for each, at
18 each hospital? And is this something that can be
19 shared with the Council. We understand there may be
20 HIPAA concerns, but that's my question.
21 CHIEF MEDICAL OFFICER MORSE: Thank you for the
22 question. We are really aligned in the intent of
23 making sure that data is used to drive decisions and
24 programs and certainly also our health equity work,
25 in particular. Um, we, as you described, um, because

2 of confidentiality, um, for patients, in particular,
3 and because of the small number of maternal deaths
4 every year, we aren't, uh, able to share information
5 at a more, kind of, precise, uh, level, um, because
6 of concerns about confidentiality.
7 CHAIRPERSON SCHULMAN: So, even if the data is not
8 public, um, what is being done if there's a trend of
9 deaths or morbidity at a particular hospital? What is
10 it that you do to make sure that there's
11 accountability, and, um, measures put in place for
12 that not to happen again?
13 CHIEF MEDICAL OFFICER MORSE: Thank you again for
14 that question, and, and we are aligned with you
15 around accountability. Um, one of the programs that
16 really does help to advance that, um, is the Maternal
17 Hospital Quality Improvement Network. Um, and that
18 Network really uses quality improvement methodology
19 and strategies to work with hospitals, um, to make
20 more immediate improvements and to prevent, um,
21 severe maternal morbidity and mortality.
22 Um, and it is also, um, very exciting that we
23 are, over the coming months, going to be able to
24 expand the Maternal Hospital Quality Improvement
25 Network. Um, the original cohort was 14 hospitals,

2 and we're going to be offering membership into the
3 cohort, into the Maternal Hospital Quality
4 Improvement Network to all 38 hospitals that do
5 deliveries over the coming months to years. So, we're
6 excited about that expansion as well. And I'm going
7 to pass to Dr. Allen.
8 CHIEF MEDICAL OFFICER ALLEN: In terms of quality
9 and looking internally at our quality, we do report
10 our morbidity and mortality to the state through
11 their regional perinatal center. We've also, um,
12 engaged ACOG, the American College of Obstetrics and
13 Gynecology. They have a voluntary quality review
14 committee, and they have started actually coming in
15 to each of our labor and delivery suites to do an
16 objective evaluation of the quality of our services.
17 CHAIRPERSON SCHULMAN: Okay. Thank you very much.
18 Um, I'm, we, uh, Council Member, um, Rivera, uh, has
19 some questions. She just, uh, joined us again. Thank
20 you.
21 COUNCIL MEMBER RIVERA: Thank you so much.
22 CHAIRPERSON SCHULMAN: Oh, and, um, we're going to
23 try, we're, we're asking all the Council Members to
24 please keep to the time. Thank you.
25

2 COUNCIL MEMBER RIVERA: Absolutely. Thank you for,
3 uh, conflicting hearings here. So, thank you so much
4 for your testimony. Thank you for being here. I
5 really do appreciate you answering all of our
6 questions. Uh, some related to my bills in the
7 package, one of them calls for the Council to support
8 state legislation mandating that all maternity
9 patients receive culturally competent notices of the
10 risks associated with c-sections.

11 I know you covered a little bit of that today.
12 But how does H and H currently communicate the risks
13 of c-sections to pregnant people in New York City?
14 What are the current rates? Do you have this data
15 available by demographic? How many do you estimate
16 are emergency c-sections? And how do you, well,
17 we'll, we'll stop there, actually.

18 CHIEF MEDICAL OFFICER MORSE: Thank you, Council
19 Member Rivera, for that phenomenal question. We, um,
20 are, one thing I do want to share before I pass it to
21 Dr. Allen, um, to share more about the rates and the
22 work, um, that Health and Hospitals is doing in this
23 realm. Um, we do have a coalition to end racism in
24 clinical algorithms that the Health Department
25 launched last fall and one of the algorithms that

2 we've been looking at is specifically how race is
3 used in determining risk for vaginal birth after
4 cesarian section. Um, and we're honored to partner
5 with Health and Hospitals. Health and Hospitals is a
6 member of that coalition, and Health and Hospitals
7 has been looking very closely, um, at how that
8 algorithm, uh, could, uh, be de-implemented, um,
9 which we do see as one of the ways to address, um,
10 unnecessary cesarian section rates. I'm going to pass
11 to Dr. Allen to speak more about Health and
12 Hospital's work.
13 CHIEF MEDICAL OFFICE ALLEN: So, your specific
14 question is, demo, outcomes by race and ethnicity. I
15 don't have that for you. I do have our rates for
16 cesarian sections and how they compare to the city
17 and the state. We do educate each patient on an
18 individual basis. If someone needs a cesarian
19 section, it's an individual conversation of the risk
20 and benefits and, of course, with informed consent.
21 Currently, our overall cesarian section rate is
22 20%. This is the primary cesarian section rate for,
23 of a woman at term with a singleton who has her first
24 cesarian section, and it's well below the healthy
25 people 2030 target of 23.6%. The total cesarian

2 delivery rate for New York City Health and Hospitals
3 is 33%, which is consistent with the City and state
4 rates across the board.
5 Um, we work very hard to avoid unnecessary
6 cesarian sections. We do not do cesarian sections
7 that are not indicated clinically. Um, and for the
8 (INAUDIBLE) patient population, as I said, our
9 overall cesarian section rate of 33% is about normal.
10 Our primary cesarian section rate is lower than the
11 City and state numbers.
12 COUNCIL MEMBER RIVERA: How do you collect and
13 evaluate key maternal safety data for hypertension,
14 hemorrhage, infections, and c-section rates? And
15 every hospital should have a systematic approach to
16 reviewing maternal health complications, acting on
17 the data as appropriate, and, and implementing
18 improvement strategies. So, how does the data inform
19 patient communication regarding the c-sections?
20 CHIEF MEDICAL OFFICER ALLEN: So, we do collect
21 the data, as I said, and report it to the state
22 through our regional perinatal center.
23 COUNCIL MEMBER RIVERA: And on some of things I
24 specifically mentioned, right, hypertension?
25 CHIEF MEDICAL OFFICER ALLEN: Hypertension.

2 COUNCIL MEMBER RIVERA: Hemorrhages, infections?

3 CHIEF MEDICAL OFFICER ALLEN: Yeah, the medical
4 complications. And it's part of, you know, the CDC
5 has started this SS, SMM, severe maternal morbidity,
6 which is collecting data on your rates of
7 hypertension and how diabetes and other medical
8 conditions. So, we are collecting that data. We don't
9 have a systematic process of sharing our dashboards
10 with our patients, but we do, as I said, have the
11 individual conversations with every woman who has a
12 cesarian section, these are the risks in general.
13 These are your personal risks based on your medical
14 condition that you're presenting now.

15 COUNCIL MEMBER RIVERA: And my last question is,
16 so, I have a, a, another piece of legislation to take
17 action so the doulas community is explicitly and
18 thoughtfully included in navigating, making doula
19 services more accessible to individuals with Medicaid
20 and those without health insurance. I know we, we
21 don't want to repeat the 2018 pilot program that
22 failed to adequately compensate doulas for their
23 expertise and time.

24 Uh, I think you've seen the survey regarding
25 doula care in New York City. 72% of women reported

2 that their doula helped them communicate their
3 preference and needs. But 80% of this cohort reported
4 that cost was prohibitive when opting to work with a
5 doula. So, does the administration support the urgent
6 need for state legislation to, uh, work in
7 collaboration with doulas? And how does Health and
8 Hospitals collaborate with birth workers to improve
9 patient experiences and outcomes? Thank you.
10 CHIEF MEDICAL OFFICER MORSE: Thank you, Council
11 Member. Um, and just before we answer that question,
12 I did want to highlight, uh, and Dr. Stein was just
13 reminding us of the, um, the data. We do actually
14 publish annual data on cesarian section rates as
15 well, on our Health Department website. Um, and so,
16 just wanted to mention that resource.
17 Um, in terms of doulas, um, we are aligned with
18 you. We would never want cost to be a barrier to a
19 pregnant person who is interested in receiving the
20 support and services of a doula. Um, in fact, our
21 City-wide doula initiative, um, allows for, uh, I
22 should say, provides access to doula services for
23 free. Um, and we're excited to continue to enroll
24 more and more families in that program. Um, we're
25 happy to share with Council the specific information

2 for people across New York City who are interested in
3 access to that program, and we actually do prioritize
4 the communities that have the highest rates of
5 poverty for enrollment in, uh, the City-wide doula
6 initiative. And I'll pass it to Dr. Allen to answer
7 the Health and Hospitals specific question.
8 CHIEF MEDICAL OFFICER ALLEN: So, we do not hire
9 doulas ourselves. And I think if the New York state
10 legislation, with your support, comes to a conclusion
11 of how to compensate doulas for their work, it would
12 be a tremendous advantage to us. What we do do is
13 work with the community-based organizations and the
14 community doula services and we actively refer our
15 patients to those organizations like Ancient Song and
16 By My Side and Caribbean's Women Service.
17 But totally aligned with you that this is an
18 important service, needs to compensated properly, the
19 commercial carriers as well as Medicaid should
20 participate in that compensation so we can more
21 actively engage the doulas appropriately.
22 CHAIRPERSON SCHULMAN: Thank you very much. I'm
23 going to ask, um, Chair Narcisse if she has any, um,
24 remaining questions.
25

2 CHAIRPERSON NARCISSE: Um, I'm going to yield to
3 the advocates because I want to hear from them. But
4 before I leave, I want to talk about advocacy group
5 that working so hard about, um, language access and
6 cultural competency is very important. Just keep that
7 in mind. And you don't have to answer that, but I
8 know you have it in mind, but I just want to know
9 that, uh, I say it, so don't forget that part.
10 Because a lot of folks who come to the hospital
11 because of language, they cannot get the care they
12 deserve. So, I want to say thank you for your time.
13 And I appreciate you being here. So, I'm looking
14 forward to listen to the advocate I guess. Thank you.
15 CHAIRPERSON SCHULMAN: Thank you very much to the
16 administration for being here today. We really
17 appreciate it. And if you have somebody that can stay
18 to hear the, um, advocates, that would be great.
19 Thank you.
20 COMMITTEE COUSEL AHUJA: Thank you, Chair, and
21 thank you to the administration for their testimony.
22 At this time, we have concluded administration
23 testimony. We'll be moving on to public testimony.
24 Um, we'll be calling on individuals who are here in
25 person, and at, um, and on Zoom, um, on the Zoom

2 webinar as well. Um, our first panel will be Lorraine
3 Ryan from the Greater New York Health Association.
4 You may begin, uh, your testimony as soon as you're
5 ready.
6 SENIOR VICE PRESIDENT RYAN: Okay. Sorry about
7 that. I just had a little trouble getting off mute.
8 Um, good afternoon, at this point, um, and thank you
9 for, um, allowing Greater New York to participate in
10 this hearing today. I do realize that time is short,
11 so I'm going to really abbreviate my remarks and
12 hopefully address some of the issues there were
13 already, um, raised, um, this morning, and very well
14 raised, asked, and answered. Uh, I just want to thank
15 Chairs Schulman and Narcisse and Members of Committee
16 for allowing me to participate.
17 I'm the Senior Vice President of the Greater New
18 York Hospital Association working in the clinical
19 regulatory, and quality improvement, um, division and
20 I'm also a registered nurse. Um, I don't need to
21 repeat all that we know about the studies and that
22 black and brown people suffer, um, disparities in,
23 with regard to outcomes of care in, um, with regard
24 to pregnancy, um, and actually, pre-pregnancy health
25 as well as post-partum care.

2 Um, in recognizing, um, those disparities both
3 the New York State Department of Health, um, the
4 American College of, um, of, um, Obstetricians and
5 Gynecologists, District two New York, Greater New
6 York and others have been actively engaged for many
7 years in different types of supportive programming
8 and improvement efforts. Um, and despite those
9 efforts, um, these disparities persist. We have seen,
10 um, somewhat of a drop in, um, mortality in black
11 and, black and brown populations more recently,
12 however, um, it's really, um, not where we need to
13 be, and we have a lot more work to do.
14 I want to point out a few of the challenges that
15 our hospitals do face, knowing that, um, hospitals
16 are the biggest providers of perinatal, um, prenatal,
17 and post-partum care as well as delivery services, as
18 you know. And this particularly true for Medicaid
19 beneficiaries and the uninsured. And hospitals face,
20 um, significant challenges with this with regard to
21 the inadequacy of the Medicaid rate and the ability
22 to, um, properly, um, expand these services, um, as
23 needed, um, across their systems.
24 Um, we have, uh, 30 hospitals across the state,
25 um, on the watchlist for closure, primarily, um, in

2 high need New York City areas. And, at any one time,
3 seven to 10 of those are in the New York City areas.
4 Um, this is very concerning and yet, um, it persists.
5 We have been able to, with, um, 1199, successfully,
6 um, achieve a 1% Medicaid rate increase in this
7 year's state budget. Um, this will help but this is
8 clearly not enough.
9 Um, there are lots of insurance gaps. I won't get
10 into that, um, with you today, but it is in my, um,
11 prepared testimony, written testimony that you have.
12 I do want to, uh, point out to our gratitude to the
13 legislature for passing the post-partum, um, coverage
14 up to one year, uh, for pregnant people. Uh, we think
15 this goes a long way of ensuring that that one post,
16 um, delivery visit, um, happens. Right now, only 40%
17 of birthing people, many of them Medicaid
18 beneficiaries or uninsured do attend a post-partum
19 checkup. And I know that was raised earlier today.
20 Um, we believe that expanding post-partum coverage
21 will improve the long-term health and wellbeing of
22 not only the patient but the family.
23 There was commentary earlier today about pre-
24 pregnancy wellness. We believe that is essential. And
25 we have worked with primary care providers to

2 identify for them the things that they should be
3 looking at and looking for in their patients once
4 they, um, become, uh, you know, able to become
5 pregnant and to conceive, and ensure that that
6 patient, um, if they have underlying medical
7 conditions, um, are, are already that, they are under
8 control.
9 Um, there's a lot that has been said on the
10 social determinants of health and we know that, um,
11 in hospital care, uh, pre-pregnancy, prenatal aid,
12 post-partum, is not enough. It's what we do for
13 patients in the community with regard to housing,
14 education, transportation, and employment, and, um,
15 just, you know, the four walls of the hospital
16 setting alone cannot guarantee the best outcomes.
17 Um, and just like lastly on insurance, medical
18 liability reform is essential in New York state.
19 Right now, it is driving obstetricians from our
20 state, and again, our safety net hospitals are those
21 who are the most impacted, who cannot adequately
22 recruit, um, and retain, um, these essential
23 providers.
24 There are a number of improvement initiatives
25 that have been going on, um. Greater New York has

2 been a part of many if not all of the ones I'm going
3 to mention. Or, I should say, they have been a part
4 of all the ones I'm going to mention. Um, but
5 clearly, um, we still need to do more. We have had
6 clinical improvement projects focus on, um,
7 hemorrhage, preparation and response to hemorrhage,
8 um, identifying the risk of hemorrhage in different
9 populations, um, venous thromboembolism, which is a
10 leading cause of death, um, in patients post-partum,
11 and ensuring that, uh, patients know what to look for
12 on discharge from the hospital, um, and, and many
13 others.
14 We participated in helped implement a maternal
15 depression screening collaborative in the New York
16 City region, uh, with the, the assistance of the New
17 York State Department, I'm sorry. The City Department
18 of Health and Mental Hygiene. That was very
19 successful and we're seeing, seeing the screening
20 continue and to be very effective in identifying
21 either early on in the pregnancy or in the post-
22 partum phase, um, signs and symptoms of mental, um,
23 the lack of mental wellbeing and referral.
24 Significantly, however, the rate, the referring is
25 not easy. It's always a challenge in finding

providers to, you know, assist with that ongoing care, um, is something that we need to focus on.

I do want to mention, um, the birth equity improvement program. We've talked a lot. I've heard a lot about implicit bias training and that is excellent. And, um, in the 2018 state budget there was a certain amount of money put forward for a number of initiatives including this implicit bias training. However, the Department of Health, um, is using that funding in what, we all think is a much, in a very meaningful way.

SERGEANT AT ARMS: Time is expired.

SENIOR VICE PRESIDENT RYAN: Which is this birth equity improvement program which gets at disparities and the measures include the patient's reported experience of care. It gets the voice of the patient, how they see themselves in the eye of the medical providers, but isn't happening for those patients, uh, and we think that this is a really improvement, uh, a really important program that should be sustained beyond, uh, even beyond the state's, um, support. We believe this is something that hospitals can do.

2 Very importantly, they are collecting race,
3 ethnicity, and language data. They are reviewing, uh,
4 those prenatal data stratified by race and ethnicity
5 and language. There are anti racism components. The
6 measures included are patient reported experience
7 measure, how they experience that institution and
8 those providers as well as a goal of reducing c-
9 section rates among black patients by 5%. And this
10 would be in the lowest risk populations, um, for any
11 risks to having a c-section.
12 Um, there are other initiatives that are ongoing,
13 um, as well as, um, hopefully you've all seen the
14 first, um, New York State Department of Health
15 maternal mortality, uh, report that was issued in
16 April, which outlines in great detail, the findings,
17 um, in those reports in terms of what was pregnancy
18 associated versus pregnancy related, the leading
19 causes of death, um, in that report, um, which are,
20 uh, embolism, uh, hemorrhage and mental health
21 issues, and also, um, defines a set of approaches to
22 improvement which have not yet been put into place,
23 but hopefully with the right support and funding,
24 will be in the future so that we find ourselves in a
25

much better, um, state, in New York, um, than we are today with regard to outcomes of care.

Um, I had to rush through that, and I apologize, um, for stumbling a bit. But I thank you for the opportunity to participate today on this critically important issue. Our members are committed to working with the City, the state and federal government, which is also very well focused on this initiative in this current administration, and other providers, um, across the state, uh, to improve.

If I could, there was a lot mentioned around doula, and I do want you to know that during the pandemic, we were very, um, helpful in getting, ensuring that doulas had, um, their access to their patients in hospitals. And the question came up earlier, did the doula, you know, supplant if you will, or replace the patient partner, and the doula did not. The state, um, rules around this during the pandemic were to allow both a partner and a doula access because of the importance of doulas to those patients and we very much believe in, uh, how doulas and midwives can be very, very instrumental in improving outcomes going forward.

2 And we're currently working with the, um, City
3 Department of Health and Mental Hygiene, Maternal and
4 Infant, Reproductive Health Group on looking at doula
5 compensation. We know that the pilot failed downstate
6 because of an inadequate rate for doulas to have a
7 living wage, if you will. And we have been working
8 with the State's Office of Health Insurance Programs
9 looking at how that can be addressed. Uh, and also
10 that the, the, the pipeline of doulas, um, is
11 available to all the New York City Boroughs and those
12 Boroughs that we know are most in need.
13 Thank you very much. I have a lot more to say,
14 but, um, with limited time, I will hold that for now
15 and you do have my written testimony. Thank you.
16 COMMITTEE COUNSEL AHUJA: Thank you so much for
17 your testimony. We'll now be moving on to our next
18 public panel, um, which is Brooklyn Borough President
19 Reynosso, followed by Janet Peguero from the, uh,
20 Deputy, the Deputy Bronx Borough President. Um,
21 Borough President Reynosso, you may begin as soon as
22 you are ready.
23 SERGEANT AT ARMS: Time starts now.
24 BROOKLYN BOROUGH PRESIDENT REYNOSSO: Thank you so
25 much. Oh, thank you so much, uh, I want to say hi to

2 this amazing panel, um, of amazing women, uh, and,
3 uh, from all of the Boroughs, especially from the
4 ones from Brooklyn, um, but, uh, just want to say
5 thank you all for having this important, important
6 hearing.
7 Um, as you know, and I have made it my mission
8 this year to focus on maternal health, um, and, uh,
9 have invested significant amounts of, uh, resources
10 to our public hospital systems in Brooklyn to ensure
11 that we lower the, the mortality rate for black
12 women. Uh, what we've been able to accomplish is, um,
13 about $15 million per hospital in Brooklyn, uh,
14 Woodhall Hospital, Kings County Hospital, and Coney
15 Island Hospital, in efforts around infrastructure
16 that speaks to the type of standard of care that we
17 want, uh, black and brown women to receive in our
18 Borough.
19 We're hoping to make Brooklyn the safest place
20 for all women to have babies, uh, within four years,
21 uh, and, uh, hopefully within eight, Brooklyn the
22 safest place in all of the country for women to have
23 babies. Um, and it's not an easy task because the
24 infrastructure is one part of a bigger problem that
25 we have when it comes to maternal mortality. Um, and

2 I will work the best I can on those type of
3 resources.
4 But I want to just talk to this Committee about
5 two issues that I think are extremely important. Uh,
6 one is, is the midwifery programs within the Health
7 and Hospital system. Many hospitals within H and H
8 have midwives, um, uh, in their program, but the work
9 is not centered around midwives. Um, doctors and
10 surgeons still run the show, and midwives are looked
11 at as secondary or B-level players within the
12 birthing experience for black women.
13 So, I want to change that, um, and make sure that
14 the executives in these hospitals and that H and H at
15 the top levels, um, ensures that midwives run the
16 show. They are actually the people that are making,
17 uh, the decisions for these women. Um, should we do
18 that, um, I think that we will see a significant drop
19 in the cesarian rates and in the maternal mortality,
20 um, in our, in our City.
21 Um, I also want to talk about wait times. Um,
22 many, uh, of the poor population here in the City of
23 New York go to public hospitals because of its, uh,
24 affordability and accessibility which is a great
25 thing. Um, but we're hearing about two, three, four,

2 and in some cases more than four hours of wait time
3 to see, uh, doctors, which means people have to take
4 off an entire day, um, of work, uh, or have to commit
5 to a, to a whole day of, um, to be able to see, um, a
6 midwife or a doctor, or any, um, uh, anyone that's
7 providing care. Um, it's extremely concerning because
8 in a private hospital, um, these things can happen in
9 30 to, 30 minutes to an hour. Um, and just that wait
10 time alone, um, I think discourages people from
11 continuing to go back or from having to continue to
12 take time off from work. Um, so I just wanted to make
13 sure that we brought both of those issues up.
14 So, again, I'll be focused on working on the
15 infrastructure work and the marketing to educate and
16 inform, uh, uh, birthing people of the risks and how
17 they can better prepare themselves to have babies.
18 Um, but when it comes to the work that needs to be
19 done at the leadership level within these hospitals,
20 um, I, I want to task and, and hope that my, uh, my
21 colleagues within the City Council can really hold to
22 the Health and Hospitals to task.
23 I want to thank you all for, uh, taking on this
24 very incredibly important issue, um, and, uh, see me
25 as an ally. Just very quickly, a little bit of the

2 background as to why this is so important to me. My
3 wife had two babies in a public hospital. I didn't, I
4 wasn't aware or aware enough of the dangers that, um,
5 this birth or these births were posing on my wife. I
6 felt helpless as a Council Member, a person that has
7 some influence and power, uh, to affect any change,
8 to put my wife in a position to not be 9.4 times more
9 likely to die than her white counterpart. And I
10 couldn't do anything about it.
11 Now, as the Borough President, I really feel that
12 I can affect change, and it's why I'm investing all
13 of my resources in the capital side this year on this
14 type of work. So, again, thank you to everyone
15 working on this, uh. Please see me, um, as an ally,
16 and, uh, just want to make sure everyone spreads
17 love. It's the Brooklyn way. Thank you so much.
18 COMMITTEE COUNSEL AHUJA: Thank you so much for
19 your testimony. Um, I'd like to now turn it to Janet
20 Peguero, uh, Deputy Bronx Borough President.
21 DEPUTY BRONX BOROUGH PRESIDENT PEGUERO: Good
22 afternoon, and thank you, Chairperson Schulman,
23 Chairperson Narcisse, and Members of the New York
24 City Council Committee on Health and Hospitals for
25 the opportunity to speak on today's package of bills

2 relating to combating the high rates of maternal
3 mortality and morbidity in our City and providing
4 access to reproductive care.
5 My name is Janet Peguero and I'm the Deputy Bronx
6 Borough President and I am here to provide testimony
7 on behalf of our Bronx Borough President, Vanessa L.
8 Gibson. Thank you all as a collective for being
9 intentional when drafting each and every Introduction
10 and Resolution. At a time in which we are seeing an
11 unprecedented attack on our reproductive freedom, it
12 is imperative that our legislators on the City and
13 state levels take immediate action to protect women
14 and birthing individuals.
15 The Borough President was proud to introduce
16 Intro 0086 alongside public advocate Jumaane Williams
17 to improve outreach and education regarding the
18 standards for respectable care at birth and other
19 information that will improve the birthing experience
20 for women in our City.
21 It is clear that this healthcare crisis is rooted
22 solely on the color of the birthing person's skin.
23 And there is a direct target on the lives of black
24 and brown women in the City of New York.
25 Additionally, the Borough President is in support of

2 these bills as they will strengthen and expand and
3 provide the necessary resources, we need to save
4 lives in our Borough and across the City of New York.
5 The administration today addressed the current
6 doula services. However, the current City services
7 are burdensome to our doulas and birthing workers who
8 are already severely underpaid via public
9 reimbursement. The Mayor announced a plan to expand
10 doula access, and though it is a start, it is not
11 nearly enough. Training 50 doulas to help 500
12 families in three months is not feasible. And
13 although we are grateful for the service providers,
14 none of them are based in the Bronx, which is why
15 many of our on the ground, grassroot organizations
16 and advocates are delivering direct services, uh, to
17 birthing persons on the ground, uniquely, in unique
18 and creative ways, and still without the support or
19 funding from the City of New York.
20 The onus is not on our doulas to make up for the
21 work that the City has neglected. It is up to us, the
22 legislators. That is why the Borough President is in
23 support of this, these bills.
24 Despite our Borough being one of the epicenters
25 of maternal mortality in the, in the state of New

2 York, we have limited resources to address these
3 issues and are in dire need of a birthing center in
4 our Borough. This is why we initially created the
5 Bronx Maternal Health Consortium which emerged from
6 the Black Maternal Mortality Task Force with the
7 purpose to affect change through public policy and
8 Borough-wide community activism. This is very much
9 aligned with what we are discussing here today.
10 As you all know, according to the 2020 CDC data,
11 black women in the City of New York were three times
12 likelier to die from maternal causes as white or
13 Hispanic women, and each year the death count rises.
14 The striking disparity persists and highlights the
15 need of Intro 0409, a local law that will increase
16 access to data in maternal mortality and morbidity.
17 Again, the administration refused to share data while
18 asked by the Chairperson this morning.
19 Again, the state of New York lags behind other
20 states when it comes to funding doula services
21 through Medicaid. As of December 2021, 17 states were
22 offering or are on the path of providing state-wide
23 doula coverage through Medicaid. The BP strongly
24 supports Resolution 0205 calling on the state
25 legislator to make doulas more accessible to

2 individuals with Medicaid as well as those without
3 health insurance. New York should extend doula
4 coverage state-wide on a permanent basis and increase
5 the reimbursement rate to match our peer states like
6 New Jersey, Virginia, and California.
7 New York is at a historic moment with a female
8 leadership team at Bronx Borough Hall, the New York
9 City Council, and on the state level. Now, more than
10 ever, with the ruling of Roe v Wade, we need stronger
11 legislation on the local level to support women and
12 lead this progressive national effort to ensure that
13 the standards of respectable care at birth become
14 universal.
15 As a collective, these bills will help tackle the
16 racial disparities in adverse maternal outcomes. The
17 more we wait, the more women and birthing persons we
18 will lose. You all have been valuable partners in
19 combating maternal mortality and severe morbidity.
20 The Bronx Borough President strongly commends you all
21 for the shared commitment and strongly endorses each
22 and every bill. She strongly wants to thank each and
23 every advocate. Your leadership has saved lives and
24 has grown our communities in the Borough of the
25 Bronx. Thank you.

2 COMMITTEE COUNSEL AHUJA: Thank you so much for
3 your testimony. Um, we'll now be moving on to our
4 next public panel. In order, I'll be calling on Paige
5 Bellenbaum, followed by Patricia Loftman, followed by
6 Teresa Ginger. Um, in the meantime, if you are here
7 for the Women and Gender Equity hearing on childcare,
8 that's taking place next door in the committee. Uh,
9 this the Health and Hospitals hearing on maternal
10 health, mortality, and morbidity. Thank you. Okay,
11 you can get started.
12 FOUNDING DIRECTOR BELLENBAUM: Members of the
13 Health Committee and committee of Hospitals, thank
14 you for the opportunity to testify here with you
15 today. My name is Paige Bellenbaum and I am the
16 founding director of a maternal mental health clinic
17 called the Motherhood Center. Opened in 2017 by
18 reproductive psychiatrist and founder of the Payne
19 Whitney Women's Clinic at Weill Cornell, Dr.
20 Catherine Birndorf, and myself, the Motherhood Center
21 provides support and psychiatric clinical treatment
22 to new and expecting mothers and birthing parents
23 experiencing perinatal mood and anxiety disorders,
24 PMADs, otherwise known as postpartum depression.
25

2 We have since become a leading maternal mental
3 health facility in New York City and nationwide, and
4 New York state’s only article 31 perinatal partial
5 hospitalization program. We also provide PMAD
6 education and training to the medical community and
7 outpatient therapy and medication management. Over
8 the past five years, we’ve treated thousands of
9 perinatal women in New York City struggling with
10 PMADs. As a result, we have also saved thousands of
11 lives.
12 Perinatal mood and anxiety disorders including
13 perinatal, during pregnancy, and post-partum
14 depression, anxiety, obsessive compulsive disorder,
15 post-traumatic stress disorder, bipolar disorder, and
16 in rare but life-threatening instances, post-partum
17 psychosis. One in five new and expecting mothers
18 experience a PMAD, but those of us that do this work,
19 know it’s more like one in three. Since the pandemic,
20 global studies have found PMAD rates to be as high as
21 72%. Tragically, overturning Roe v Wade will increase
22 maternal mental illness even further.
23 Though hormonal changes during pregnancy and the
24 post-partum period can cause mood and anxiety
25 disorders to surface, PMADs are not exclusively

2 driven by neurochemical causes, other key factors
3 including racism and low socioeconomic status can
4 increase the risk and severity. These external
5 stressors can have significant effects on pregnancy,
6 maternal health, and child's development.
7 Black, indigenous, and other people of color and
8 those with low incomes experiencing post-partum
9 depression at significantly higher rates. Studies
10 show more than half of infants in low-income
11 households live with a mother experiencing
12 depression. New mothers of color have rates of post-
13 partum depression close to 38%, almost twice the rate
14 of white new mothers. Nearly 60% of black and Latinx
15 mothers receive no treatment or support services for
16 prenatal and post-partum mental health. Reasons
17 include lack of available perinatally focused
18 treatment, insurance coverage, social and cultural
19 stigma related to mental health needs, logistical
20 barriers to services, and lack of culturally
21 appropriate care.
22 Sadly, 80% of all PMAD cases go undiagnosed and
23 untreated due to the enormous shame and stigma that
24 surrounds maternal mental health. For many new
25 mothers, their greatest fear is that their child will

2 be taken away if they tell anyone how they really
3 feel, and that they will be deemed an unfit mother.
4 This is why screening along is not sufficient.
5 PMADs are the number one complication associated
6 with childbirth in this country, far surpassing the
7 rates of hypertension and gestational diabetes. PMADs
8 are also one of the leading causes of maternal
9 mortality in the US, yet despite these startling
10 statistics, PMADs receive little to no mention in
11 conversations and policies pertaining to maternal
12 health outcomes. And PMADs are totally treatable.
13 Today, you have a set of essential bills in front
14 of you that will improve birth outcomes and increase
15 accessibility to reproductive supports and workplace
16 protections. Yet rarely, if at all, is there mention
17 of maternal mental health. I am here today in support
18 of these bills, but I would remiss if I did not say,
19 shame on us as a city for neglecting the mental
20 health needs of new and expecting mothers and
21 birthing parents.
22 I would venture to believe that every single
23 person in this room either knows someone who has
24 suffered from post-partum depression or experienced
25 it themselves. Perhaps you or someone close to you

2 struggled with feelings of hopelessness,
3 helplessness, dread, shame, guilt, overwhelm, scary,
4 intrusive thoughts of harm coming to the baby, a
5 sense of regret, loneliness, isolation, rage, feeling
6 as though having a baby was a huge mistake, longing
7 for life before becoming a mother, feeling trapped
8 and exhausted and unable to sleep or eat, perhaps
9 even thinking, "I don't want to live anymore. This is
10 too much. My family would be better off without me."
11 And because the shame and stigma that surrounds
12 maternal mental health are so great because we live
13 in a society that glamorizes and romanticizes
14 motherhood, presents it as the most blissful and
15 amazing thing that will ever happen to a woman, the
16 new or expecting mother can feel like a failure if
17 she experiences anything but, and she becomes one of
18 the 80% who suffer silently.
19 I was one of those mothers. 16 years ago, I gave
20 birth to a beautiful healthy baby boy. A few weeks
21 after he was born, I began feeling severely depressed
22 and anxious. I couldn't take care of myself or my
23 son. I couldn't sleep, eat, or function. I was
24 miserable and I didn't want to be alive anymore. I
25 felt alone and ashamed and I hated myself for being

2 such a failure at the one thing I was supposed to
3 know how to do.
4 I kept all of this to myself for nine months
5 until one day I decided I couldn't carry on and that
6 my family would be better off without me. I am
7 fortunate to be sitting here in front of you today,
8 but according to data released by the New York City
9 DOHMH Maternal Mortality and Morbidity Review
10 Committee, of which I am proudly a member, mental
11 health conditions caused 18% of pregnancy-associated
12 deaths in 2016 to 2017. This is 16 of the 91 deaths
13 that year. And all but one were deemed potentially
14 preventable, most with some chance of altering the
15 outcome. These women were not as lucky as I was.
16 A review of 14 state maternal mortality review
17 committees from 2008 to '17, among 421 pregnant-
18 related deaths, 11% were due to mental health
19 conditions. Pregnancy-related health deaths were more
20 likely than deaths form other causes to be determined
21 as preventable, 100% versus 64%.
22 According to a recent Surgeon General's report,
23 maternal mental health disorders contribute to the
24 US's high maternal mortality rate and impact
25 mother/infant bonding and infant development. The

2 report states, each year more than 20% of US women
3 experience a mental, behavioral, or emotional
4 disorder such as depression or anxiety. Mental health
5 conditions are also common complications during
6 repgancy and post partum and contricubte to pporr
7 maternal health outcomes.
8 Mental health conditions are underlying factors
9 in injury or death due to overdose or suicide. Mental
10 health conditions in the post-partum period such as
11 post-partum depression are associate with poor
12 maternal and infant bonding, decreased breastfeeding,
13 initiation, and delayed infant development.
14 And let's talk more about the impacts of
15 untreated PMADs in mothers and babies. Rigorous,
16 systemic reviews have found that untreated PMADs
17 cause a whole host of adverse impacts on both mother
18 and baby. According to one meta-analysis, women
19 experiencing depression or anxiety during pregnancy
20 are 40% more likely to have hypertension than those
21 who do not. Women with untreated bipolar disorder are
22 more likely to experience adverse pregnancy outcomes
23 such as gestational hypertension and hemorrhaging and
24 are nearly twice as likely to have a preterm birth
25 compared to women without mental health challenges.

Pregnant women with untreated anxiety have higher risk of preterm birth and lower birth weight, and their infants have higher risk of being small for gestational age. And children, as they grow older, of women with untreated post-partum depression, can experience long term impacts on their health, mental health, motor development, cognitive and emotional health.

Undiagnosed and untreated psychiatric disorders such as depression are risk factor for suicide in new mothers, a leading cause of maternal mortality in the United States.

New York City can and must do a better job in addressing mental health needs of new and expecting mothers and birthing parents. The Motherhood Center is thankful to have joined forces with DOHMH and the Bureau of Maternal, Infant, and Reproductive Health on efforts to educate and train the MHQIN network on PMADs. We collaborate with Nurse Family Partnerships by offering maternal mental health client consultation and provide support groups for NFP clients struggling with PMADs.

But still there is so much more that needs to be done. We can look to other states and localities that

2 have embarked on government-led initiative that have
3 significantly impacted PMAD rates. Some of these
4 initiative for New York City could include
5 establishing a maternal mental health task force
6 responsible for identifying the scope of PMADs
7 locally and devising policy and practice
8 recommendations, initiating a City-wide PMAD public
9 awareness campaign aimed at defeating the stigma
10 surrounding maternal mental health, normalize the
11 challenges parts of becoming a mother, communicating
12 basic PMAD symptoms and providing support and
13 treatment resources, initiating a City-wide PMAD
14 education and screening initiative, training
15 hospitals, behavioral health clinics, OBBYNs, and
16 pediatric office across the City on what PMADs are
17 how to routinely screen with appropriate instruments
18 and dialogue. An attempt was made at this effort five
19 years ago as a part of Thrive NYC but it somehow
20 evaporated.
21 Most importantly, offering enhanced specialized
22 PMAD treatment, investing in effective and affordable
23 maternal mental health treatment programs
24 specifically for low-income women, and training
25 behavioral health clinicians and other municipal

2 mental health providers on PMAD best clinical
3 practices.
4 We can and must do better, including maternal
5 mental health in conversations and policies that
6 strive to improve maternal health outcomes will save
7 lives. Thank you again for the opportunity to testify
8 today.
9 CHAIRPERSON SCHULMAN: I want to thank you for
10 that testimony, and we will, um, keep PMAD in mind
11 for, as we move forward.
12 FOUNDING DIRECTOR BELLENBAUM: Thank you.
13 BILPOC MIDWIFE LOFTMAN: Good afternoon, Chair,
14 Chairperson Schulman and Chairperson Narcisse. Thank
15 you for this opportunity to provide testimony. My
16 name is Patricia Loftman, I'm a certified nurse
17 midwife and I am providing testimony on behalf of and
18 represent New York midwives and the black,
19 indigenous, people of color representative.
20 New York Midwives is the professional
21 organization that represents certified nurse
22 midwives, and certified midwives. I am currently a
23 member of the New York City Department of Health and
24 Mental Hygiene Maternal Mortality, and Morbidity
25 Review Committee and I am a member of Health Equity

2 Work Group of the Advisory Committee on Infant and
3 Maternal Morbidity and Mortality which makes
4 recommendations to the Secretary of Health and Human
5 Service.
6 Um, in the service of time, I'm going to
7 abbreviate my comments since you do have my written
8 testimony in front of you. So I'll, what I will do is
9 highlight what I think are the most important parts
10 of my testimony.
11 I respect that these legislations are the work
12 of, work product of individuals who have the best
13 intentions and whose goal is to improve the health
14 status and decrease the maternal morbidity and
15 mortality of black women and reproductive age
16 persons. However, I think it's really important that
17 we evaluate what the impact of these legislations
18 will be.
19 The medical and public health community have
20 accepted the thesis that institutional racism
21 generate racial and health, reacial and ethnic health
22 disparitiyes. Racism has the power to control the
23 distribution of necessary resources guaranteeing
24 equal access to the systems that affect all, all
25

2 phases of one’s life, political, economic, social,
3 and health.
4 In an ideal world, racism would not exist. In an
5 ideal world, everyone would have impartial and
6 unimpeded access to effective political
7 representation, decent housing in safe neighborhoods,
8 quality education with access to gifted and telented
9 education and specialized high school, employment
10 opportunity with a living wage, merit-based
11 compensation, and quality healthcare. Health
12 disparities in racial and ethnic communities would
13 disappear if racism did not exist.
14 Today, words such as institutional and structural
15 racism, health equity, diversity and inclusion, birth
16 equity, reproductive justice, and social justice have
17 become such an integral part of our daily language
18 that they no longer elicit the sting and bite that
19 they once had. Legislators and policy makers are
20 quick to lament that we can’t undo racism, but racism
21 must be dismantled. Legislation in healthcare alone
22 cannot alleviate or mitigate the dire consequences
23 that racism was and remains imbedded in the
24 foundation systems that continues to affect the daily
25 lives of black, brown, and indigenous communities.

2 So, what I did was I looked at all the, all the
3 proposed legislations and I grouped them based on
4 similar or identical language. And what I noticed was
5 that many of the proposed legislations either already
6 exist somewhere or they're very, very similar in
7 other languages. So, what I did was, I grouped them
8 together based on similarities.

9 And the first group have to do with, um, the
10 education about City standards for respectful care at
11 birth, health proxy forms, and patients' rights.
12 There currently exists a pamphlet titled New York
13 Standards for Respectful Birth and Care. This
14 pamphlet discusses education, informed consent,
15 decision making, quality of care, support persons,
16 and dignity and non-discrimination. While it does not
17 address workplace accommodations for breastfeeding,
18 disability insurance, or paid sick leave, the
19 pamphlet can be corrected and updated to include
20 these topics.

21 Nurses are among the largest group of educators,
22 yet they are missing from the list of providers and
23 should be added to the list of persons providing
24 education. Additionally, while doulas provide a
25 valuable service to black women and reproductive age

2 persons, they are not clinical providers which might
3 be confusing to the public. So, this information
4 should also be corrected. Additionally, it would be
5 helpful to explicitly state the scope of practice of
6 all care providers listed. And additional problem,
7 however, is that while this document exists, there
8 does not appear to be monitoring, oversight, or
9 enforcement within the institutions.
10 The next one has to do with increasing access to
11 maternal mortality and morbidity data. So, as was
12 previously described, the, uh, maternal morbidity and
13 mortality review committee was formed in 2018, and of
14 course the purpose is to reduce preventable, uh,
15 preventable maternal mortality in New York City and
16 to eliminate inequities. The report, the, the most
17 recent report is, uh, was published in October of
18 2021, so it’s up to date and it’s available. So, if
19 the goal is to decrease maternal morbidity and
20 mortality, the public deserves to know the identity
21 of the hospitals where maternal deaths occur. And
22 this information should be reported yearly.
23 Additionally, currently exists a pamphlet
24 entitled Maternity Information, Childbirth Services
25 which provides information about childbirth practices

2 and procedures in all hospitals in New York state
3 including cesarian birth rates, vaginal birth rates
4 after cesarian, episiotomy rates, and other
5 statistics birthing people should rightfully have
6 access to. Hospitals are required to forward the data
7 to the New York State Department of Health. The New
8 York State Department of Health then compiles the
9 data which is then published and becomes the
10 maternity information childbirth services pamphlet.
11 The new York State Department of Health
12 distributes the pamphlet to the hospitals. The
13 hospitals are supposed to, then distribute the
14 pamphlet to women and reproductive age persons
15 seeking care. The value of obtaining this pamphlet is
16 that receiving this information empowers black women
17 and reproductive age persons with the inforatom that
18 they need to make an informed choice about the site
19 where they choose to receive services. The problem is
20 that few legislators, policy makers, hospitals, or
21 even the public is aware that this document exists.
22 There is no accountability or enforcement placed on
23 hospitals to forward this legally required data to
24 New York State Department of Health. Choice increases
25

2 birth equity and birth equity decreases maternal
3 morbidity and mortality.
4 Consequently, the New York City Department of
5 Health and Mental Hygiene, as a recommendation,
6 should be mandated to protect black women and
7 reproductive age persons by generating the New York
8 City maternity information childbirth services with
9 an enforcement process, rather than relying on a
10 state process that apparently does not currently
11 appear to be working.
12 Another, uh, legislation talks about training
13 doulas to provide doula services in all five
14 Boroughs. There currently exists a very detailed
15 report, uh, that was created in 2021, just a year
16 ago, and can be accessed. I, uh, have provided the
17 citation. The report outlines in detail, the
18 challenges in providing women and birthing people
19 with doula care in New York City. The report also
20 identifies doula programs that have completed their
21 initiatives, are ongoing, at risk, or off track.
22 Another proposed legislation talks about the
23 benefits of services, um, provided by doulas and
24 midwives. The public is currently unaware that
25 midwives are available and accessible in many

2 hospitals throughout New York City. And so, as a
3 recommendation, I think it would be very, very
4 helpful if a public service campaign, um, by,
5 through, either through the New York City Department
6 of health or DOHMH, about the fact that midwives are
7 available and accessible in hospitals throughout New
8 York City.
9 You know, I was on the train this morning, and in
10 one of the cars, the entire car was plastered with
11 information about cannabis. But, so, my, I, uh, a
12 recommendation would be that such a public service
13 campaign be conducted, uh, in terms of providing
14 information to the public about midwives, doulas, and
15 the benefits that they serve.
16 There was another proposed legislation about, uh,
17 an outreach campaign on the risks of cesarian
18 sections. New York State Assembly Member Amy Paulin
19 has introduced two bills to address cesarian birth.
20 The first, uh, talks about informing, uh, women about
21 the risks associate with cesarian birth and the
22 second establishes a cesarian birth review board to
23 improve cesarian birth rates and outcomes. I think
24 the overarching theme is that a lot of what these
25 legislations, the proposed legislations, are designed

2 to do, either already exist in some form, however,
3 lack enforcement, monitoring, and accountability, or
4 exist at another level, at the state, and may be the
5 resources of both City and state should be blended.
6 So, I think, um, what I'd then like to then talk
7 about is some recommendations. And I've broken them
8 down into two. One is policy, and the other is
9 service delivery. I think we need to rethink how data
10 is captured. Currently, data is obtained from
11 institutions via monthly report. Data is also
12 extracted from the maternal morbidity and mortality
13 report. However, missing are the voices of the women
14 and reproductive age persons who utilize the services
15 and who are most effected by the care that they
16 receive. They have the answers. Create health
17 delivery systems based on what the women want, not
18 what policy makers think they should receive.
19 What is the perception of women and reproductive
20 age persons? What is their perception of the quality
21 of the primary and reproductive care that they have
22 received? Women and reproductive age persons want
23 respectful care based on a relationship. Black,
24 brown, and indigenous women reported that the
25 perinatal care system currently available to them

does not provide them access to care by the provider of their choice. They report that the ideal system would have more access to care by midwives, a midwife or doctor who shares their heritage, race, ethnic, or cultural background, a provider with whom they can develop a trusting relationship, a doctor or provider who is a good match for what they value and want for pregnancy and birth care, continuity of care throughout pregnancy and birth, shared decision making, a pregnancy and birth free of mistreatment, a pregnancy and birth characterized by respect, privacy, and dignity, a pregnancy free of pressure to accept interventions and, and procedures.

Also missing are the voices of the leadership at the local level who women and reproductive age persons identify as their advocates. For example, um, bodies such as the New York City Maternal Morbidity and, and Mortality Review Committee, how are the voices of the women represented? What is the racial and ethnic composition of the committee? Are there midwives, doulas, community health workers present who represent the geographic corners of the City? Or is the Committee composed of individuals who black

2 women and reproductive age persons report have failed
3 to render respectful care?
4 Unpacking the issue around Committee composition
5 is critical because Committee composition dictates
6 the discussion, direction, and the recommendations
7 that are put forth. Entities or organization that
8 have historically opposed policies that support
9 birthing people choices or are not supportive of a
10 shared decision-making model of care should be
11 precluded from participation on the, on the Maternal
12 Morbidity and Review Committee.
13 Black and reproductive age persons want access to
14 midwives. One recommendation from the review, from
15 the Maternal Mortality and Review committee is that
16 midwives must be integrated into obstetrical
17 departments throughout New York City. This
18 recommendation is consistent with research findings
19 that poor coordination of care across providers and
20 birth settings has been associated with, with adverse
21 maternal/newborn outcomes. The integration of
22 midwives into regional health systems is a key
23 determinant of optimal maternal newborn outcomes. And
24 I thank you very much for this opportunity to
25 `present my testimony.

2 CHAIRPERSON SCHULMAN: Thank you very much. Um,
3 what I'm going to do, in the interest of time, we're
4 going to ask every other panelist that's coming on,
5 there's a three-minute limit, um, please summarize
6 your testimony. You can submit written testimony
7 either today or within what, 70, 72 hours, 72 hours,
8 and the staff goes through it completely. So, thank
9 you very much.
10 PRESIDENT DAVIS: Thank you very much to Council
11 Person Schulman and Council Person Narcisse and the
12 Health Committee. My name is Ginger Davis. I am the
13 President of the Sickle Cell Thalassemia Patient's
14 Network. I am also an adult living with sickle cell
15 disease.
16 Listening to all the testimony today is, it's,
17 it's been a lot. Um, happy that the City and state is
18 making an effort to gain more health coordinators,
19 uh, to help women during their pregnancies and after
20 their pregnancies. And as, Ms. Ryan says, you know,
21 the availability of, of registered nurses who are
22 midwives is a resource that's underutilized. And
23 usually, women who are on Medicaid and Medicaid-
24 managed care, do not have the opportunity to get
25

2 these services. They also don't have the opportunity
3 to get fertility services.
4 Um, right now, for the first time in more than a
5 hundred years, there is a tremendous amount of study
6 and development for disease modifying medications,
7 cell and gene therapies for sickle cell disease, beta
8 thalassemia, and other inherited blood disorders. And
9 some of them that are requiring particularly the
10 disease modifying treatments that are cell and gene-
11 based therapies that require chemotherapy, uh, women
12 with sickle cell disease, Von Willebrand, and
13 hemophilia, and, uh, thalassemia, aren't given the
14 option for fertility services to preserve, um, ovum,
15 uh, before they go through a procedure. And that is
16 something that we have been advocating for for a long
17 time for those to chance and have the same parity of
18 women with cancer when they're undergoing treatment
19 to preserve their reproductive, um, choices.
20 Also, I want to speak briefly on people with
21 sickle cell trait. The problem of sickle cell disease
22 is not really the disease itself, but the fact that
23 the public does not know about sickle cell trait.
24 They don't know that they carry. They don't know that
25 there's more than one trait. They don't know how it

2 impacts. And there also is very little information
3 about people carrying a trait, a hemoglobin trait who
4 are impacted, and being told that it's everything
5 else, but sickle cell.
6 We, we'd like to see that the same metabolic and
7 genetic panel that happens in newborn screening here
8 in the state, also happens for people of childbearing
9 age, starting with teenagers, who, unfortunately, you
10 know, there is a lot of, of teenage pregnancies, and
11 starting from a young age right through, um, to now,
12 women are having babies in their fifties, they should
13 be able to have access to these metabolic and genetic
14 screenings so they know before their child is born
15 and the newborn screening panel comes back that they
16 were carriers for a genetic trait that will impact
17 their child. Thank you for allowing this opportunity
18 to testify.
19 COMMITTEE COUNSEL AHUJA: Thank you so much for
20 your testimony. We'll be moving on to our next public
21 panel. Uh, in order, I'll be calling on Charlene
22 Magee, followed by Deidra Sully, followed by Nila
23 Natarajan. Um, Charlene McGee, you may begin your
24 testimony as soon as you're ready.
25 SERGEANT AT ARMS: Time starts now.

2 FOUNDER MAGEE: Hello, um, good afternoon,
3 everyone. My name is Charlene Magee. Um, I am the
4 founder of Niecy's Purple Heart Foundation and I'm
5 going to tell you how Niecy's Purple Heart Foundation
6 was founded. Last year, August 28th, my niece, Denise
7 Williams went to Queens Hospital seeking help for
8 post-partum depression. She went into the hospital on
9 the 28th of August. She died on August the 30th. As a
10 result, my family's life has changed forever. Um,
11 Denise left behind two children, Adalee (SP?) and
12 Aviana (SP?), who I care for everyday. And, um, my
13 niece Belinda, she's their caretaker.
14 Um, I became a maternal health advocate like I
15 said, since last year. I have had the opportunity to
16 work with many doulas, um, within, um, New York City,
17 um, quite a few midwives, and one of the things that
18 I've learned, um, which the young lady was speaking
19 about, uh, was PMADs, was something which, uh, that's
20 what my niece, um, was suffering from, and she
21 shouldn't have, she shouldn't be dead, period.
22 Um, so what I want to say, uh, and I'm getting a
23 little bit choked up because this is, uh, very
24 important for, for me to speak about this. Because I
25 have a daughter who's pregnant right now and doulas

2 are very important in our communities. My niece did
3 not have, um, a, a, she had health insurance, but it
4 wasn't the health insurance, um, I'm guessing you
5 want to call it the, the good health insurance, um,
6 so she was just subjected to go to a, a community,
7 uh, hospital.
8 But I'm here today just to basically, um, say,
9 and its' really, really important for you all to
10 really take a look at the bills that they are
11 presenting today, because like I said, doulas and
12 midwives are, um, what is needed in the maternal
13 health field. Um, I really do have much more to say,
14 but, um, I know we only have three minutes. So, I'm
15 going to say thank you again, for giving, um, me the
16 opportunity to share just a little tidbit about my
17 niece's story and if anyone wants to find out any
18 more information about Niecy's Purple Heart, um,
19 Foundation, we are on social media, um, uh. We will
20 be real welcoming, um, you know, to work with people
21 and, um, really just, um, here to advocate for all of
22 women who do not have voices on their own. Thank you
23 again.
24 CHAIRPERSON SCHULMAN: Thank you very much for
25 your testimony. We really appreciate it.

2 COMMITTEE COUNSEL AHUJA: Thank you so much for
3 your testimony. We'll now move on to Deidre Sully.
4 You may begin as soon as you are ready.
5 SERGEANT AT ARMS: Time starts now.
6 DIRECTOR SULLY: Good afternoon to the City
7 Council Committee on Health, and the Committee on
8 Hospitals, and respective Chairs Schulman and
9 Narcisse. Thank you for your time today and your
10 commitment to learning about and addressing maternal
11 health access and equity. We have heard a lot today
12 about maternal health access and equity, so I'll keep
13 it brief.
14 Structural racism is the root cause of
15 disparities in perinatal health and cannot be
16 overlooked. It is known that patients respond better
17 to providers that represent a shared, lived
18 experience. Many black and African American women are
19 denied optimal care because providers fail to impart
20 and engage them with respect and dignity.
21 Furthermore, 75% of pregnancy-related deaths of
22 black mothers are deemed to be preventable. Building
23 capacity and opportunities to train black and
24 indigenous persons of color as healthcare providers
25 within the community is one step to decreasing the

2 implicit bias that results in racial discriminations,
3 strengthening maternal/child health systems of care
4 and individual family health and wellbeing are
5 powerful drivers of equity.
6 At Public Health Solutions, we are creating
7 partnership and a technology driven network between
8 clinical care providers, managed care payers, and
9 community-based organizations, providing
10 maternal/child health services to strengthen the
11 system of care and unify access to proven programs
12 that enhance maternal and child health.
13 Research is very clear that increasing access
14 across perinatal continuums with sexual reproductive
15 health programs, home visiting, and family support
16 services, improves health, stability, and outcomes
17 related to the social determinants of health. Because
18 health services are often fragmented and
19 uncoordinated, PHS is working to implement a strong
20 community resource network that connects New Yorkers
21 to home visiting, doula care, breastfeeding support,
22 father support, education on the NYC standards for
23 safe and respectful care at birth, and resources
24 related to the social determinants of health.
25

2 Where you live and where you give birth should
3 not dictate whether you live or die. Efforts to
4 advance quality clinical care and anti-bias and
5 discrimination in the hospital setting must be paired
6 with comprehensive community support systems and
7 infrastructure development for us to collectively
8 move the needle on maternal morbidity and mortality.
9 Thank you.
10 COMMITTEE COUNSEL AHUJA: Thank you so much for
11 your testimony. We'll now hear from Nila Natarajan.
12 You may begin your testimony as soon as you are
13 ready.
14 SERGEANT AT ARMS: Your time starts now.
15 SUPERVISING ATTORNEY NATARAJAN: Good afternoon.
16 My name is Nila Natarajan and I'm a supervising
17 attorney and policy counsel in the Family Defense
18 Practice of Brooklyn Defender Services. In this role,
19 I also serve on the City's Maternal Mortality and
20 Morbidity Review committee as mentioned earlier
21 today. I thank the Committees on Health and
22 Hospitals, and Chairs Schulman and Narcisse for the
23 opportunity to address the Council.
24 Given Brooklyn Service's experience working with
25 thousands of parents and families prosecuted by the

2 City in neglect and abuse proceedings in family
3 court, we are keenly aware of the ways in which
4 inequities in the City's provision of maternal and
5 perinatal healthcare render black and Latina parents
6 and families vulnerable to the discriminatory and
7 disproportionate surveillance and punishment of the
8 family regulation system, which you may also know as,
9 also known as the Child Welfare System.
10 Critical for your consideration today is that a
11 primary way that pregnant people, new parents, and
12 newborns come to the attentions of family regulation
13 authorities is through prenatal and post-partum care
14 providers. These professionals entrusted with the
15 care and treatment of our City's birthing people and
16 newborns are routinely drug testing patients
17 particularly black and Latina people and their
18 newborns, without notice, and without consent.
19 In our practice, we have rarely, if ever, seen an
20 explanation recorded for why a drug test was deemed
21 medical, medically necessary, and despite the absence
22 of any indicators of harm to a newborn and the
23 additional cost associated with drug testing,
24 hospitals conduct these tests on poor patients and
25 routinely report results to the authorities. This

unconsented to practice, often called test and report, much like the practice of stop and frisk, leaves pregnant patients, especially those using public insurance vulnerable to intrusive government investigations and traumatic family separation, and does nothing to guarantee that patient with the care and support we have discussed in detail today.

When pregnant people are tested and reported to authorities, or live in fear of the surveillance, their relationships with medical providers are damaged or severed, and future engagement with vital healthcare drops.

This Council has the ability to repair some of this harm. Introduction number 1426 was previously introduced by now Borough President Reynosso and requires that medical providers get the informed and voluntary consent of patients before conducting a drug test, just like is required for any other medical procedure.

In order to truly address the inequities in maternal wellbeing that our Committees are aiming to eliminate today, this Council must enact both solutions such as 1426 that ensures healthcare that

2 is non-discriminatory, dignified, and patient-
3 informed. Thank you very much.
4 COMMITTEE COUNSEL AHUJA: Thank you so much for
5 your testimony. Um, I'd like to now just, um, read
6 out the names of some folks who have registered to
7 testify just to ensure that we didn't miss anyone. We
8 have Gregory Brender (SP?), Emily Frankle (SP?),
9 Nagosi (SP?) Moses, Megan Racline (SP?), Eva Cornecca
10 (SP?), and Jessica Tang. If anyone is present, you
11 can use the Zoom raise hand function. Okay. That
12 concludes, um, public testimony, so I'll turn it to
13 the Chairs.
14 CHAIRPERSON SCHULMAN: Okay. I want to thank
15 everyone for the testimony today, and, um, again for
16 the administration. And we have, obviously, we have a
17 lot of work to do. This is an extremely important
18 topic, uh, and we will continue to work on it. And I
19 want to thank everyone, and I will now hand it over
20 to Chair Narcisse.
21 CHAIRPERSON NARCISSE: I, I just wanted to say
22 thank you to everyone, all the advocate that came to
23 testify. We appreciate that, and, um, I have to say
24 again thank you to Committee Counsel Harbani Ahuja,
25 Policy Analyst Em Balkan, as well as my amazing team

that always supported me. This is Saye Joseph, Frank Shea, Kim, Irene, Bonnie, um, Evens, and Stephanie. So, thank you for, um, doing the work that you do for the people of New York City. Thank you.

CHAIRPERSON SCHULMAN: This, this Committee hearing is now adjourned.

[GAVEL]

CHAIRPERSON NARCISSE: Thank you.

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date August 17, 2022