CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

OF THE

COMMITTEE ON HOSPITALS, JOINTLY WITH
COMMITTEE ON WOMEN AND GENDER EQUITY
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Thursday, October 23, 2025
Start: 1:22 P.M.
Recess: 4:03 P.M.

HELD AT: 250 Broadway - 8th Floor - Hearing Room 1

B E F O R E: Hon. Mercedes Narcisse, Chair and
Hon. Farah Louis, Chair

COUNCIL MEMBERS:

Committee on Hospitals:

Gale A. Brewer
Selvena N. Brooks-Powers
Jennifer Gutiérrez
Kristy Marmorato
Francisco P. Moya
Vickie Paladino

Committee on Women and Gender Equity:

Tiffany Cabán
Jennifer Gutiérrez
Kevin C. Riley
Inna Vernikov

OTHER COUNCIL MEMBERS ATTENDING: Speaker Adams, Schulman

COMMITTEE ON HOSPITALS, JOINTLY WITH
COMMITTEE ON WOMEN AND GENDER EQUITY

A P P E A R A N C E S

Wendy Wilcox, MD, MPH, MBA, FACOG
Chief Women's Health Officer, Chief of OB/GYN
NYC Health + Hospitals

Patricia Loftman,
Nurse Midwife; Former Director of Midwifery Service at Harlem Hospital in New York City; Founding Member of the New York City Maternal Mortality Review Committee (MMRC); Council on Maternal Health Steering Committee

Bruce McIntyre,
SaveARose Foundation

Lacey Tauber,
Representing the Office of the Brooklyn Borough President

Judith Cutchin, DNP, RN,
First Vice President of the New York State Nurses Association Board of Directors (NYSNA)

Elizabeth Grellier,
Government Affairs Operations Specialist at VNS Health

Beth McGovern,
Associate Vice President, Quality and Clinical Initiatives at Greater New York Hospital Association (GNYH)

Mia Wagner,
Director of Health Policy at the Community Service Society of New York (CSS)

Sarah March,
Program Director of the Young Mothers Program (YMP) at Samaritan Daytop Village.

COMMITTEE ON HOSPITALS, JOINTLY WITH
COMMITTEE ON WOMEN AND GENDER EQUITY
A P P E A R A N C E S (CONTINUED)

Tori Newman Campbell,
Legislative Coordinator at 1199SEIU United Healthcare Workers East

Eman Rimawi-Doster,
Executive Director of Diversity Includes Disability

SERGEANT PAYTUVI: This is a microphone check for the Committee on Hospitals, joint with the Committee on Women and Gender Equity, located in Hearing Room 1, recorded on October 23, 2025, by Nazly Paytuvi.

SERGEANT AT ARMS: Settle down, please, we are beginning. Thank you. Good afternoon, and welcome to today's New York City Council Hearing for the Committee on Hospitals and the Committee on Women and Gender Equity. If you would like to testify, you must fill out a speaker card with one of the Sergeant at Arms in the back of the room. You may submit written testimony at testimony@council.nyc.gov.

At this time, please silence all electronic devices, please silence all electronic devices. No one may approach the dais at any time during this hearing.

Chairs, we are ready to begin.

CHAIRPERSON NARCISSE: [GAVEL] Good afternoon. I'm Council Member Mercedes Narcisse, Chair of the Committee on Hospitals. Thank you for joining us today for this Oversight Hearing on *Improving Maternal Health in New York City*. I'm going to pass it on to Speaker Adams. As a matter of fact,

I thought she was not here. I love my Speaker to speak before me. So, opening the hearing, I would like to hear from my Speaker first.

SPEAKER ADAMS: Thank you so much, Chair. I'm sorry, I just kind of tiptoed in. Sorry.

Good afternoon, everyone. It's good to see you all here today. And I want to thank especially Council Member Mercedes Narcisse, Chair of the Committee on Hospitals, and Council Member Farah Louis, Chair of the Committee on Women and Gender Equity, for convening today's very important Oversight Hearing on *Improving Maternal Health in New York City.*

Our city continues to face this major public health emergency of maternal mortality. In New York City, between 50 and 70 people who can become pregnant lose their lives during pregnancy or up to one year postpartum. Black New Yorkers are six times more likely to die of pregnancy-related causes, with Black women and others who can become pregnant accounting for 28 of the 66 deaths in 2022.

These disparities are a product of medical and structural racism that leave Black patients, communities of color, immigrants, and low-

income New Yorkers without access to adequate health care and medical treatment while experiencing stressors that exacerbate severe disparities in health outcomes.

Maternal health and mortality are issues that are deeply personal to me, and I've publicly shared my own mother's struggles with her birthing process. As is the case for so many Black women and patients of color, her pain and symptoms were dismissed by medical professionals, endangering both her life and mine. This unacceptable pattern of having severe pain ignored, being sent home despite concerning symptoms, and being dismissed until the condition progresses to an emergency are the same circumstances surrounding the deaths of Bevorlin Garcia Barrios at Woodhull Hospital last year. Miss Barrios was the third person to die during childbirth at the hospital since 2020, and among the dozens of New Yorkers who have died during childbirth in the last five years. My heart goes out to her loved ones and to all of the women who have tragically passed due to complications resulting from their pregnancies.

These tragedies, which occur at a time when families should be celebrating a joyful addition to their lives, must be answered with action. These injustices are why my office and this Council have prioritized the improvement of maternal health during pregnancy, convening a steering committee to collaborate with diverse stakeholders on means to end these preventable deaths. Working with the Steering Committee has given us the opportunity to learn and build upon the existing work of advocates, midwives, doulas, clinicians, directly impacted families, and community leaders, and better understand meaningful, lasting solutions to this crisis.

Ensuring dignified medical care for Black women and all people who can become pregnant requires giving them health care that is culturally appropriate, compassionate, and responsive to each person's unique needs. It requires that we improve the social determinants of health, from poverty to stable housing and education. This means elevating the quality and accessibility of mental health support for pregnant and postpartum patients across all five boroughs, no matter their insurance coverage.

We know the solutions to the maternal mortality crisis. We must continue to harness our shared political will to fix the patchwork of challenges that allow so many to fall through the cracks.

Today, I look forward to hearing from the Administration about what City agencies are doing to understand this public health emergency and how they are advancing progress and change to this dire crisis.

Finally, I want to sincerely thank all of the advocates who have worked tirelessly in honor of their friends and families they have lost, and women like my mom, everywhere. We carry their light forward with us in the fight to improve maternal health and end maternal mortality. Thank you all very much. And I turn it back over to Chair Narcisse.

CHAIRPERSON NARCISSE: Thank you once again. I'm so happy to be here in the presence of my speaker, who has been fighting for maternal health from her own life experience.

I'm Council Member Mercedes Narcisse, Chair of the Committee on Hospitals. Thank you for joining us today, as I'm seeing there are some

advocates I've been seeing in the field with me, and I love it when I see a male dedicated... I have to keep saying I'm sorry for what took place. And I am so delighted to have you in the room as a male fighting for maternal health.

As the Speaker just articulated, maternal mortality and morbidity in the city are part of a pressing, ongoing crisis. We are grateful to all of the affected individuals, advocates, and healthcare professionals who are here today to share their experiences and their expertise. We look forward to hearing your suggestions, your recommendations on how this Council can help improve maternal health outcomes for parents in this city—the capital of the world, as I would say.

As a registered nurse, I know first hand the importance of preventive care and routine medical examinations. Regular checkups and screenings allow for early detection of potential health issues and can flag problems early enough to avoid emergencies. This is particularly true for pregnant patients, for whom we must identify any complications or chronic conditions that may impact the health of the birthing person or the baby.

Access to high-quality healthcare is the paramount key to improving maternal health outcomes. However, the need to conduct regular medical examinations does not end once the pregnancy ends. In New York City, most maternal deaths occurred during the postpartum period. In 2020, 19 pregnancy-associated deaths occurred during pregnancy or at birth. At the same time, 32 such deaths occurred within a year after the end of pregnancy. Moreover, of the 51 pregnancy-associated deaths that were recorded in the city in 2020, 34 were found to be preventable—That means we could have prevented that from happening. Many of these tragic deaths were attributed to challenges with mental health or to infections or complications directly resulting from giving birth. We must use this data to focus our strategies moving forward by ensuring postpartum and pregnant individuals have increased access to mental health screenings and high-quality checkups throughout their pregnancy journey.

I look forward to hearing from our witnesses and exploring solutions that will help us continue to improve the maternal healthcare system

and support those who are on the front lines of patient care, like Dr. Wilcox.

Before we begin, I'd like to thank committee staff, Senior Legislative Counsel Rie Ogasawara, and policy analyst Joshua Newman, as well as Women and Gender Equity committee staff, Julia Goldsmith-Pinkham, and Katie Salina, for their hard work in preparing for this hearing.

I also like to thank my staff, Frank Shea, Stephanie Laine, and Irena Khlevner, for their hard work as we strive to serve our constituents and the City as a whole. But I want to say now I have a newcomer in my district, Juasheena Gilot, who is over here, who is going to take care of the budget, and she has her degree in administration, and we're talking about Health Administration. So thank you for being here, and of course, my Fellow, my new one who loves to work on education and, of course, maternal health as well, Kourtney Li.

I would like to recognize my colleagues, of course, Chair of Health, Council Member Lynn Schulman, and, of course, my colleagues here, who you're gonna hear from, Chair Farah Louis. And who else is here with me? Oh, Jen, the mother of all, Jen

Gutiérrez, and of course, I love men who recognize and acknowledge and support us all. Council Member Kevin Riley, a dad who loves his children, I love to see that.

So thank you, and I will now turn it over to Chair Louis for her opening remarks.

CHAIRPERSON LOUIS: Thank you, Chair Narcisse.

Good afternoon, I am Council Member Farah Louis, Chair of the Committee on Women and Gender Equity, and I'm pleased to join the Committee on Hospitals and Chair Mercedes Narcisse for today's Oversight Hearing on Improving Maternal Health in New York City.

The maternal health crisis is a public health emergency that demands attention. While often seen as a medical issue, maternal health outcomes are deeply connected with inequities in our society. Black and Hispanic birthing people in New York City face starkly worse outcomes. According to the City's own data, Black birthing people are four to five times more likely to die from pregnancy-related complications than white birthing people. This represents a devastating and preventable loss of life

for too many families, where the moment of bringing a new life into the world is shattered and shadowed by fear.

This crisis is a direct result of deep systemic failures that come from structural racism and chronic underinvestment in communities of color. A person's health is determined by more than just medical care. Factors like unstable housing, food insecurity, and economic hardship add up to the threat to maternal well-being.

We need sustained and comprehensive action. As someone who represents central Brooklyn, a community that has long borne the weight of systemic inequities in healthcare, this issue is profoundly personal to me. My mother gave birth on the floor of a New York City hospital to my little sister. I've also heard from mothers, fathers, and families who face these challenges firsthand. Too many women in our neighborhoods struggle to access consistent, compassionate care before, during, and after childbirth.

Addressing maternal health affirms dignity, strengthens families, and ensures that our city invests in the well-being of every resident.

This work is at the heart of what drives me as chair of this committee, confronting disparities, uplifting equity, and ensuring that no woman is left behind because of her race, income, or zip code.

We have the tools and the knowledge to make a difference. Programs that this Council has fought for, including the Citywide Doula Initiative, are making progress, but our work is not done. So today we'll hear from New York City Health + Hospitals, clinicians, advocates, and families to ensure that every birthing person in New York City feels respected in every healthcare setting and that the right to a safe pregnancy should not be dictated by a person's race, income, or a zip code.

Thank you to the members of the Committee on Hospitals and Women and Gender Equity who have joined us today. I would also like to thank committee staff Julia Goldsmith-Pinkham, Senior Legislative Counsel, Katie Salina, and Allie Stofer, as well as my own staff, Daniel and Shubhra, for their work on today's hearing. I will yield back to our chair.

CHAIRPERSON NARCISSE: Thank you. I acknowledge that Council Member Chair Selvena Brooks-Powers has joined us.

And, now I would like to turn it over to the Chair of the Committee on Health, my friend, Lynn Schulman.

COUNCIL MEMBER SCHULMAN: Thank you very much, Chairs.

Good afternoon. First, I want to thank the Speaker and the Chairs of the Committee on Hospitals and on Women and Gender Equity for convening this important hearing. I'm going off book for a minute——The Speaker has been so involved in this issue. And I want to thank her for her leadership on this. This is something that's very important. There was also an op-ed in the Daily News today by Grace Bonilla from United Way, and a member of the state senate, on this important issue. So I'm hoping that we can-- I have a resolution that I'm going to be talking about-- that we can really move forward on this and make some inroads.

As the Chair of the Committee on Health, maternal health has been a major focus of mine. My colleagues at the Council and I have worked tirelessly to improve the health outcomes for pregnant New Yorkers, and we will continue to work until this crisis is behind us. In line with this, I

have introduced Resolution 1087, which is being heard today—— The New York Patient Occurrence Reporting and Tracking System, or NYPORTS, serves as the statewide entity for reporting and tracking adverse events in healthcare facilities like hospitals, including adverse maternal health events. However, a 2009 audit conducted by the New York State Comptroller's Office found that 84% of the deaths and more serious occurrences that should be reported within 24 hours to NYPORTS were reported late. The same audit also found that errors relating to the administration of medication were under reported in New York City hospitals.

My resolution calls on the State's Department of Health to more thoroughly review the data collected by NYPORTS, and where found, require hospitals to fill in any missing data.

The last audit was conducted in 2009, and we have no way of being sure that the issues it found have been resolved. We need much more transparency, and we need better data. It is crucial to the issue we are dealing with today, maternal health, and many other healthcare issues we face in the city.

I look forward to advancing this resolution to enhance the healthcare of all pregnant New Yorkers. I want to thank the Chairs again for hearing this resolution as part of today's hearing. Thank you.

CHAIRPERSON NARCISSE: Thank you, Chair. We'll be hearing testimony from representatives from the Administration. I'll now turn to the Committee Counsel to administer their oath for this panel of administration officials. Thank you.

COMMITTEE COUNSEL: Good afternoon. Do you affirm to tell the truth, the whole truth, and nothing but the truth, before this committee, and to respond honestly to Council Member questions?

DR. WILCOX: Yes.

COMMITTEE COUNSEL: Thank you. You may begin.

DR. WILCOX: Thank you.

Good afternoon, Chairwoman Narcisse, Chairwoman Louis, and members of the Committee on Hospitals and Women and Gender Equity. My name is Dr. Wendy Wilcox, Chief Women’s Health Officer of NYC Health + Hospitals, and, as of February of this year, Chief of OB/GYN Service at NYC Health +

Hospitals/Woodhull. In addition to these roles, I have been with our health system for over 15 years, working at acute-care centers, which include Jacobi, North Central Bronx, and Kings County, in a clinical role. Maternal and women's health has been the foundation of my career. In addition to my clinical work, I serve as Co-Chair of the New York State Maternal Mortality Review Board and the Brooklyn Borough Maternal Health Task Force, and I am a member of several statewide and national bodies dedicated to improving maternal outcomes and advancing birth equity.

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

World Report as "2025 Best Hospitals for Maternity Care".

Addressing the maternal health crisis requires a multi-pronged approach: from focusing on preventative health care to addressing social detriments of health, there are various pathways to ensuring that maternal mortality and morbidity are addressed efficiently. Over the past two decades, NYC Health + Hospitals has made significant strides in improving maternal health outcomes, with a focus on reducing maternal mortality and addressing health inequities. In collaboration with the American College of Obstetricians and Gynecologists, all 11 hospitals in our health system have participated in the Safe Motherhood Initiative, which developed safety protocols targeting the leading causes of maternal mortality in New York. This initiative has helped standardize best practices across our system, ensuring better care and fewer complications during childbirth. In addition, in 2018, NYC Health + Hospitals launched six state-of-the-art simulation labs in trauma centers to allow obstetrical staff, including OB and anesthesia physicians, nurses, midwives, and physician assistants, to practice

handling critical obstetric emergencies. While the simulation labs initially focused on the three top causes of maternal mortality, its success invited expansion over the recent years into covering topics including cardiac resuscitation during pregnancy, obstetric hemorrhage, and shoulder dystocia, sepsis, and other simulation courses, which are all crucial in reducing maternal mortality rates and preventing avoidable, potentially fatal complications.

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

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

- Two onesies
- Footie pajama
- Cap
- Burp cloth
- Swaddle blanket
- Bath towel

- Newborn diapers
- Newborn clippers
- Baby wipes
- Two types of diaper rash cream
- Baby shampoo
- Nipple cream
- Nursing Pads
- Postpartum pads
- Breastmilk bags
- Resource guides
- Thermometer

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

Health + Hospitals always strives to bring preventative care to patients, and this past August, our acute care site at Kings launched a Cardio-Obstetric program, which aims to reduce maternal mortality and morbidity among women of color by focusing on heart disease during and after pregnancy. This program additionally focuses on targeting risk factors, which include hypertension, obesity, and diabetes during the prenatal period as well as through one year postpartum. We have also partnered with community-based organizations to promote health education and refer individuals to this program. As part of NYC Health + Hospitals' Behavioral Health Blueprint, we highlight the System's commitment to providing comprehensive substance use care for New Yorkers, including pregnant individuals. The RISE Center, which stands for Recovery, Integrated Support, and Empowerment, is expected to open in 2026 at NYC Health + Hospitals/Lincoln. It will focus on early intervention to support healthy pregnancies and break the intergenerational cycle of substance use and dependency. Partnering with additional programs on site, our aim is for the RISE Center to serve

pregnant and parenting people affected by substance use disorder and their children. Utilizing a family-centered model, we aim to provide a deeply welcoming and supportive services in one location. With wrap-around services on site, families will have access to childcare, food pantries, parenting education, referrals to treatment, and screenings.

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

Moreover, all 11 hospitals have achieved Baby Friendly status, a certification that highlights their leadership in promoting and supporting breastfeeding, a key factor in improving maternal and infant health. Our system’s cesarean delivery rate also remains consistently below the state average, underscoring our success in reducing unnecessary interventions.

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

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

CHAIRPERSON NARCISSE: And I want to say, thank you, and now I will pass it on to Speaker Adrienne Adams. Speaker?

SPEAKER ADAMS: Thank you so much, Chair Narcisse.

Dr. Wilcox, welcome. It's great to see you.

DR. WILCOX: Thank you.

SPEAKER ADAMS: Thank you for your work. Thank you for effectively beginning the process of turning Woodhull into the wonderful health establishment that we know the community deserves. Thank you for your work.

DR. WILCOX: Thank you.

SPEAKER ADAMS: Just a few questions for you, Dr. Wilcox. How is Health + Hospitals guaranteeing respectful and dignified care and maternal healthcare settings across the System?

DR. WILCOX: Speaker Adams, thank you very much for asking that question. All New York City Health + Hospitals employees, including staff who work in maternal child health, must take courses offered by the Office of Diversity and Inclusion. These are: Introduction to Unconscious Bias and Diversity and Inclusion of Business Imperative. Modules on this topic are also integrated into new employee orientation and our annual in-service. In addition, the simulation-based programs that I mentioned earlier, the ones that train doctors, nurses, and others on the delivery team to respond to the highest risk emergency situations, uh, those courses have evolved to also include bias-- implicit bias training and debriefing into the course of the simulation framework.

An additional way in which we work against bias is that we educate staff on the Health + Hospitals toxicology testing policy for mothers and

babies. Substance use disorder is treated like a medical condition, and it is the goal to get patients into treatment. Written informed consent is required in order to test a pregnant person for substances. And in fact, what we found is that while referrals remain up for referring patients to substances, we do not test.

SPEAKER ADAMS: Do emergency rooms at Health + Hospitals locations have a separate section that's dedicated specifically to patients who are pregnant or recently pregnant?

DR. WILCOX: All of our labor and birthing units have something called OB triage, and those OB triage areas are for pregnant people and assess people for emergency conditions that may come up while pregnant.

SPEAKER ADAMS: And they're in separate sections?

DR. WILCOX: Those are part of the labor and birthing suites. They're generally aligned with those suites.

SPEAKER ADAMS: Got it. Okay. Are there dedicated clinicians in the ER, including nurses, who

would address labor and delivery needs? I'm assuming that's, I hope that's a yes.

DR. WILCOX: Yes.

SPEAKER ADAMS: Midwives and doulas continue to face significant barriers to practice. How are you supporting their integration into the maternal health care system?

DR. WILCOX: New York City Health + Hospitals is the largest employer of midwives in New York City. All of our Health + Hospitals facilities share information regarding midwifery services with patients seeking prenatal care. Across all of our facilities, midwives care for prenatal patients, perform births in the labor and birthing suites, perform postpartum rounds on patients who have delivered, and provide women's healthcare in our ambulatory care practices, a midwife's scope of practice is typically for low-risk patients without complicated prenatal conditions, but in our system, midwives also practice in an integrated way with physicians, so they can work with physicians to care for patients who have medical conditions or other complications of pregnancies.

I believe you also asked about doulas.

SPEAKER ADAMS: Mm-hmm.

DR. WILCOX: New York City Health + Hospitals does not hire doulas. However, we are the largest referral base to doula services in New York City, mainly through our maternal homes and our social workers, and many of our maternal home team members have taken doula training, so that they also, while being part of the maternal home, they also have a doula certification.

SPEAKER ADAMS: Do you know what it would take to have the System hire doulas?

DR. WILCOX: So you have to come back to you... (CROSS-TALK)

SPEAKER ADAMS: (INAUDIBLE)

DR. WILCOX: I would have to come back to you with that information.

SPEAKER ADAMS: Okay. I'm really curious about that. And, thank you for letting us know. I did not realize that.

How many Health + Hospitals offer birth and labor care?

DR. WILCOX: All maternity... (CROSS-TALK)

SPEAKER ADAMS: All of them?

DR. WILCOX: hospitals. Yes.

SPEAKER ADAMS: Okay. How many of these hospitals have midwives on staff? Do all 11 have midwives on staff as well?

DR. WILCOX: All 11 do not. Three of our facilities do not have midwives.

SPEAKER ADAMS: Which ones do not?

DR. WILCOX: I can answer that, give me one second—Harlem, Lincoln, and Queens.

SPEAKER ADAMS: Okay. And do the midwives work independently or under the supervision of an OBGYN?

DR. WILCOX: Midwives operate independently.

SPEAKER ADAMS: Okay, do midwives attend low-risk births independently?

DR. WILCOX: I'll say in most cases, yes. I can't attest to what happens on an individual floor of a facility, but in our midwifery scope of practice for Health + Hospitals, they are given the ability to do so.

SPEAKER ADAMS: Okay. I'm going to go back to the doula question. You said that H&H doesn't hire doulas, but doulas are allowed by state law to be in

the delivery room unless there is an emergency...(CROSS-TALK)

DR. WILCOX: That is correct.

SPEAKER ADAMS: What are the policies for determining when the birth is an emergency and a doula should be excluded?

DR. WILCOX: In our system-wide doula policy, the emergency is when a patient is taken for an emergency cesarean birth, and based on-- It actually is not just for doulas, but when someone has many, many emergent-- there aren't many emergencies thankfully, but in the ones that have, I would say, general anesthesia, those generally do not have anyone from the outside in. Because the main purpose of having a support person is to really be able to speak to the patient, and normally, they are awake during a cesarean birth.

SPEAKER ADAMS: Okay. And are there partnerships? Do you know if there are partnerships that are being built between specific Health + Hospitals, hospitals, and community midwifery or doula services?

DR. WILCOX: Yes, there are many partnerships. It would depend on the facility in

terms of the partnerships they have. But most of our sites do have partnerships with community-based doula services to which they refer patients.

SPEAKER ADAMS: How does a clinician at a Health + Hospitals hospital decide whether to screen a patient for depression, anxiety, intimate partner violence, domestic violence, or another issue?

DR. WILCOX: All patients are screened for those.

SPEAKER ADAMS: Everyone?

DR. WILCOX: Everyone.

SPEAKER ADAMS: That’s good. Okay. Are these screenings integrated into a physical checkup or other visit?

DR. WILCOX: I'm not sure I understand the question, but they're in our EMR, and so when a patient presents as part of the intake process, they're asked the screening questions.

SPEAKER ADAMS: Okay, that’s what I mean.

And how are they conducted, the screenings? Is it a survey? Is it a piece of-- how are the screenings conducted?

DR. WILCOX: They are validated survey tools. Those are either given to the patient to

answer themselves in their own language and/or administered-- the same tools administered by either a nurse or PCA.

SPEAKER ADAMS: And how long are the screenings provided? Is there a time period every month? Every two months?

DR. WILCOX: So the depression screenings probably happen more often, but they definitely happen at the initial prenatal visit. They are repeated again in the inpatient realm or during the birthing process, and then again for the postpartum visit. Those are the minimum number of screenings. Most patients have more.

SPEAKER ADAMS: Okay. And what resources does Health + Hospitals provide when certain issues are present?

DR. WILCOX: So this is where I put it in a plug for Woodhull. Woodhull actually has integrated mental health services in our Women's Health practice. We are the envy of many of our facilities. However, it generally works through a referral service. If someone has a positive screen, they may see a social worker, and then we have behavioral

health services on site, and we would get the patient to those behavioral health services.

SPEAKER ADAMS: Okay. And Congrats.

Let's talk a little bit about cesarean deliveries. What, if any, uniform policies does H&H have to help clinicians determine whether to recommend that an emergency C-section be performed on a patient?

DR. WILCOX: So those are based on clinical indications. We follow a standards set by our professional organization, which is the American College of Obstetricians and Gynecologists, as well as other nursing standards such as A1. A common reason why someone may have an indication for cesarean birth might be a deterioration of the fetal heart rate tracing. Last year, we trained over 90-- I would say 98% of our staff, in the A1 fetal heart rate training module. And we keep up with those trainings to ensure that certainly patients who need a C-section will get one, and to try to prevent those who don't need one from getting one. Other indications might be a severe hemorrhage or something else going on with the mother.

SPEAKER ADAMS: That's actually during labor. What about pre-existing medical conditions?

DR. WILCOX: So clinically, there would probably be...(CROSS-TALK)

SPEAKER ADAMS: (INAUDIBLE) assessments, yeah...

DR. WILCOX: Yeah, there aren't many of those, thankfully. I would think if someone had a cardiac issue, we would send them to a specialist to make that assessment. But there are very few-- other than the indication of prior cesarean, where we have an informed consent discussion with the patient of whether or not they would like to try for a trial of labor after cesarean, and as long as there are no other contraindications to that, there are some contraindications, but as long as there aren't any, a patient, if they desire, would be allowed to have a trial of labor after cesarean.

SPEAKER ADAMS: Are STIs (sexually transmitted infections) considered pre-existing medical conditions?

DR. WILCOX: Not necessarily unless someone has an active herpetic lesion, and generally we test for that as per guidance from our

professional organization and would offer someone treatment in the last trimester to avoid that.

SPEAKER ADAMS: Okay. This is interesting. Okay. How does H&H evaluate the rates of cesarean and vaginal births at each facility?

DR. WILCOX: We track our outcomes, and that data is sent to our regional perinatal center, which is Bellevue.

SPEAKER ADAMS: Okay. And how regularly does H&H evaluate that data?

DR. WILCOX: That data is sent monthly to our regional perinatal centers.

SPEAKER ADAMS: Who's responsible for reviewing and evaluating the data?

DR. WILCOX: Interestingly enough, uh, the Regional Perinatal Center has a quarterly meeting of the H&H QUAPI Committee (Quality Assurance/Performance Improvement) just like all of the facilities do.

SPEAKER ADAMS: Okay. And in addition to clinical indicators, does H&H review this data by patient race, ethnicity, age, primary language, insurance type, immigration status, and birthing history?

DR. WILCOX: Through our Office of Population Health, we are starting to get down to that level of data. Right now, it's not at the point where we're regularly able to pull it up from a dashboard, but in some cases, we're able to do that.

SPEAKER ADAMS: Would you say most of these indicators are one or two... Or?

DR. WILCOX: So, we have in the past, in the most recent years, been entering data for the US News and World Report, and we are able to get down to racial and ethnic data.

To my knowledge, we're not at the level of language yet. However, right now, we really have to involve our full data team in order to do that deep dive. We are looking forward to a day when we can pull it up on a dashboard, but we're not there yet.

SPEAKER ADAMS: Any idea when that day will be here?

DR. WILCOX: I will have to get back to you with that.

SPEAKER ADAMS: Okay, fair enough. If disparities are identified in the data, what is the

formal process, if any, for investigation, corrective action, and follow-up to ensure improvement?

DR. WILCOX: I'm not aware that we've seen any disparities in the data. I would have to get back to you with that information.

SPEAKER ADAMS: Okay, interesting.

Some clinicians may have higher rates of performing cesareans than others because they see patients with higher risk factors. Still, they may also perform cesareans when it is not medically necessary. How does H&H review clinician records on this issue?

DR. WILCOX: Physicians have something called an Ongoing Professional Peer Evaluation or OPPE, and the department chair reviews this data. I'm trying to think of the-- I'd have to get back to you at the interval, but it's reviewed by the department chair.

SPEAKER ADAMS: Okay. If a clinician has statistically different rates of cesareans than their colleagues, what is the evaluation process to ensure there is evidence of the need for those procedures?

DR. WILCOX: That would be at the level of the department chair and then the medical director for the facility.

SPEAKER ADAMS: Okay. What methods does H&H use to evaluate differences in cesarean rates across clinicians and facilities? More broadly, what is the System's process for reviewing outlier patterns and determining whether higher rates reflect clinical need, patient characteristics, or potentially avoidable procedures?

DR. WILCOX: We are using a system called Mdstat, which pulls information from Epic to give provider-level information.

SPEAKER ADAMS: And what's the process if there is an internal concern that a clinician performs too many, too many, possibly unnecessary cesareans?

DR. WILCOX: Again, that would be at the level of the department chair reviewing the results of the providers in the department, and if there is a concern, it would be taken up to the chief medical officer of the facility.

SPEAKER ADAMS: Okay, if a patient arrives at an H&H location and doesn't have their medical

records available on Epic MyChart, what do clinicians do to access medical records for that particular patient?

DR. WILCOX: I have actually seen clinicians do some pretty amazing, uh, calisthenics to get patients' records. They will call around, and they will ask the patient where they received care. They've even, in cases, made international calls to try to get that data. Very often, patients will have a copy with them, even if it's a paper copy. And I've even personally seen, like MyChart records from other countries...

SPEAKER ADAMS: Wow.

DR. WILCOX: It's kind of interesting, yeah. Patients are pretty good at-- pregnant people are good about their records.

SPEAKER ADAMS: Resourceful. Are there any privacy laws that would complicate the process at all?

DR. WILCOX: We would leave it up to the patient to provide that information, and if we're requesting a chart from another facility, there is a process to follow whereby the patient would sign a release of records, and then we could obtain it.

SPEAKER ADAMS: Okay. When examining past data on maternal deaths that have occurred at H&H facilities, such as those of Ms. Fields or Miss Garcia Barrios, what common challenges stand out to you, and what corrective action can you take?

DR. WILCOX: I'm very sorry, Speaker Adams, I'm not able to speak on individual patient outcomes at Health + Hospitals.

SPEAKER ADAMS: Do you know of any corrective actions that could be taken, just given the knowledge of anybody reading the news or media, uh, not even necessarily investigative, do you know of any corrective actions that can be taken that could reduce the likelihood of adverse maternal outcomes occurring in the future?

DR. WILCOX: I will just say that in general terms, if there are any adverse events that happened, the hospital and department will go through a very robust root cause analysis of the event to see whether or not there were any gaps in care and whether or not there are any opportunities for improvement. From that information, corrective actions will be made, and the corrective actions will be made in the hospital if that's necessary. If there

are any system-wide gaps identified, those would also be spread across the System.

SPEAKER ADAMS: Thank you. I just have one more, just a couple of questions, turning a different way and speaking about this current administration. We know that the impact, the detrimental impact that this administration is having across the board in a lot of different ways, following the passage of Public Law 119-21. Also referred to by the President, and not by anybody on this panel, I'm sure, as the "One Big Beautiful Bill".

The New York State Hospital System is projected to lose $8 billion. These cuts compound the cuts to Medicaid disproportionate share hospital payments, which also amount to $8 billion. At the Committee on Hospitals Executive Budget Hearing for Fiscal Year 2026, Dr. Katz suggested that, in order to stay afloat, public hospitals in the City would likely trim specialty care options. Could this affect maternal care at H&H hospitals? And how are obstetric units across the hospital system preparing to face possible budget cuts like this?

DR. WILCOX: At New York City Health + Hospitals, we care for patients regardless of their

insurance status or ability to pay. Our mission will not change due to these cuts, and we will not back away from serving New York City. We are committed to maintaining stability and safety for our system, patients, and staff. This includes a commitment to maximizing efficiencies within our system while maintaining the high quality of care that our communities deserve.

Our system has proven that we can meet challenges head-on, over and over again. We are confident we will do so again. In coordination with our system leadership, we are working on financial and strategic plans to support our problem-solving. As we receive more information about H.R.1 and other federal actions, we will continue to adapt to best serve our patients and communities safely.

SPEAKER ADAMS: That's a good statement.

It's just one final question...

ALL: (LAUGHTER)

SPEAKER ADAMS: Just one final question-- You did that? Kudos. It's a good statement. I hope the Administration is listening.

Let's talk-- my last question has to do with staffing challenges, which we know is an issue as well.

Are there any staffing challenges that maternal care units are facing, and how will these budget cuts affect staffing for maternal care professionals?

DR. WILCOX: At present, we do not have any staffing challenges, and we do not anticipate having.

SPEAKER ADAMS: Well, that was my last question. That took away—like, kind of deflated my balloon here.

ALL: (LAUGHTER)

SPEAKER ADAMS: Dr. Wilcox, thank you so much for answering my questions. Thank you for being part of this panel today. And once again, thank you for your leadership at Woodhull.

DR. WILCOX: Thank you, Speaker Adams.

SPEAKER ADAMS: We really need you. Thanks for being here. I yield back to the chairs.

CHAIRPERSON NARCISSE: Thank you, Madam Speaker. You were going deep. So many questions, I was listening, it’s a life experience, exposing to

know how difficult it is, especially when you come to Black and brown communities in New York City.

Now, is H&H guaranteeing respectful and dignified care in maternal health care settings across the city?

DR. WILCOX: We are providing all of our staff with those-- Sorry. Thank you...

So, as I stated a little bit earlier, all of our staff, all of our employees who work in maternal child health must take the courses offered by the Office of Diversity Inclusion and these are Introduction to Unconscious Bias and Diversity Inclusion of Business Imperative. There are also new modules-- There are also additional modules that one can do. And every new employee has to take this because it's in their orientation and our annual in-service, so we must do it annually.

I also mentioned our simulation training before, and our Implicit Bias and Equity are embedded in each one of those simulation exercises.

Interestingly, when we started the simulation exercises, we were looking for-- we use high fidelity mannequins that look like patients in order to try to run the simulations, and we realized

that there weren't any that actually looked like our patients. There were no Black birthing mannequins. So we asked the company, and the company actually listened and started creating mannequins for this purpose. So not only do we have Black birthing mannequins, but they started offering different ethnicities in the mannequins so that when you're doing the simulation, you could actually feel like you're actually caring for a real patient.

CHAIRPERSON NARCISSE: The reason for that question is just a lot of, I would say, some, I don’t want to say all, but some medical folks, cultural competency is a problem for us, because they also think that Black people need a different guideline, and white people want a different guideline, and separated, in the meanwhile, you have to understand it fully. It’s not the separation, it’s the understanding of the person. And many Black women will tell you that when they say they are in pain, or they have a little difficulty, nobody takes them seriously. But, I don’t expect, let’s say, H+H to do that. But I just have to ask the question to make sure that we are on the same page.

So, now I have to acknowledge my colleague, who has just joined us: Inna Vernikov.

Does H&H conduct regular, *regular* Cultural Humility trainings? I (INAUDIBLE) hearing some to ensure that clinicians are taught how to provide care in a respectful way. If so, how often is this training session required? Are they required of all levels of clinicians—meaning all the way from nurses, residents, attendants, or everyone? What is taught during this training session? Do you believe that they make an impact on a majority of the clinicians, or could the training be reformed to be more impactful?

DR. WILCOX: Thank you, Chairwoman Narcisse. That is a very--Thank you.

(LAUGHS) That's a very loaded question, so I'll answer the first question first, which is that all employees must take these courses. It's not certain segments or types of employees. We're all required to take the-- and not just in maternal health, everyone is required to take these courses on an annual basis. There's also a voice system. Voice is an anonymous reporting system that allows

employees to report on any topic of harm or potential harm, or any adverse event in a facility to report.

So everyone is encouraged to report. And the reporting has actually gone up exponentially since the Voice system was started. And certainly if any one of these voice reports involved someone with bias, then the supervisors would receive that report. And they would go through the normal processes for dealing with that.

There are a variety of virtual workplace inclusion workshops year-round. These include the following topics: Diversity and Inclusion in a Healthcare Setting, Interreligious Awareness for Patient-Centered Care, Having Essential Conversations, How to Be an Inclusive Colleague, and How to Be an Upstander, which guides participants through proven techniques to actively address and mitigate instances of biased encounters.

CHAIRPERSON NARCISSE: Thank you. But do you believe that they make an impact on the majority of the clinicians? Or could the training be reformed to be impactful

DR. WILCOX: Respectfully, Chair Narcisse, I am not able to comment on the effectiveness of the training.

CHAIRPERSON NARCISSE: All right, fair enough.

DR. WILCOX: Thank you.

CHAIRPERSON NARCISSE: Are there ways for patients or colleagues to report concerns about a clinician displaying micro-aggressive, culturally insensitive, or otherwise disparaging behavior?

DR. WILCOX: There are ways, and I mentioned the Voice system, which is an anonymous reporting platform. But also, our staff at H&H is not shy, and people would send an email or talk to their supervisor if they encountered any other behavior.

But certainly through the Voice system, they're able to do so anonymously. And then it would have to go through an investigation.

CHAIRPERSON NARCISSE: Could you, I mean, share with us any of those actions that have been taking place where you have people making reports on each other? Like we call it back in the day, snitch, but it's not snitch. It's about people's health. People's lives.

DR. WILCOX: We would need to get back to you with that.

CHAIRPERSON NARCISSE: Mm-hmm. All right.

What type of policies does H&H enforce that are aimed toward reducing the rate of incidents where patients' symptoms or pain are being ignored until their condition escalates to an emergency?

How are these policies balanced with the need for the hospitals, I mean, for the needs of hospitals, often with limited staff to give—because we know you have limited staff—to give attention to all patients who come to the hospital?

DR. WILCOX: I'm not sure I understand that question. We have... (CROSS-TALK)

CHAIRPERSON NARCISSE: I will repeat it in full.

DR. WILCOX: Okay.

CHAIRPERSON NARCISSE: What type of policies does H&H enforce that are aimed toward reducing the rate of incidents where patient symptoms are often ignored until their condition escalates to an emergency? And how are these policies balanced with the need for hospitals, often with limited

staff, which you have sometimes, to give attention to all patients who come to the hospital?

DR. WILCOX: Mm-hmm. So any adverse outcome can have a root cause analysis. I'll talk about that process first. So those are probably the worst of the worst, and we don't want cases to end up in a root cause analysis.

So, there are two other initiatives that I will talk about. One is the early warning system, which is in our EMR, which will alert clinicians, nurses, and providers about abnormal vital signs, so that they will have to take notice of that.

We are actually excited to be implementing a system called PeriGen, which is a new fetal heart rate monitoring system, PeriGen [PeriWatch] Vigilance, as well as automating our early warning system so that it really does give visual cues to our clinical teams when someone may have a deteriorating status.

That is not implemented yet. We are starting the implementation and should be finished by the end of this year.

CHAIRPERSON NARCISSE: End of this year?

DR. WILCOX: We want to give our entire clinical staff all the tools that they will need to care for patients in a safe manner... (CROSS-TALK)

CHAIRPERSON NARCISSE: Mm-hmm. Yeah. We know it's going to be very difficult with all the cuts coming up. And Dr. Wilcox, I appreciate you, but the questions have to be asked, because we want to know where we are in terms of our healthcare delivery, especially with maternal health being a problem in our city.

Language Access—State law mandates that H&H develop a language assistance program to ensure meaningful access to the hospital services and reasonable accommodation for all patients who require language assistance. How does H&H interpret meaningful access? And how does it implement the language assistance program? How are you ensuring that all birthing people have meaningful language access?

DR. WILCOX: Language access services are available at all of our facilities 24 hours a day, seven days a week, to any patient who needs them. There are over 300 languages available. And

providers-- clinicians across the board have access to on-demand phone and video interpretation.

CHAIRPERSON NARCISSE: Are the interpreters at language lines specifically trained to provide interpretation services in specific medical fields such as obstetrics or gynecology?

DR. WILCOX: Yes, they are trained medical translators.

CHAIRPERSON NARCISSE: In what cases can a clinician use a family member or a friend for translation purposes? Does H&H advise clinicians to do this or to use Language Line or a comparable service?

DR. WILCOX: Health + Hospitals encourages all providers and clinicians to use certified translators, which are available through Language Line. We are encouraged not to use family members. However, a patient may refuse the interpretive services and say that they only want to use their family member, in which case, we will try to encourage them to use the language line. But if that is what the patient wants, then, you know...

CHAIRPERSON NARCISSE: You try to accommodate them.

DR. WILCOX: Yes.

CHAIRPERSON NARCISSE: One other thing, knowing that I speak about three languages or more, I'm trying. My fault. It's difficult in some cultures, when you speak or you're on the line, because I have witnessed, as a nurse, in the emergency room, when things are collapsing around you, right? Patients have difficulties getting on the line to get the communication going smoothly.

I don't know from your experience if you have experienced that, but I know that you can tell them one thing, and they can take it as the total opposite, when they are on the line, because they were waiting for a gesture. Because a lot of languages, like mine, the one that I speak, they're waiting for the gesture to get it.

DR. WILCOX: Especially in the hospital and in our ambulatory care centers, Propio Video, the video monitors, can be used and are encouraged so that the patient can actually see the interpreter when they're speaking. And the interpreter can see both the patient and the provider. So it's almost like FaceTime.

CHAIRPERSON NARCISSE: Okay. Oh, that is nice! I'd rather see that than being on the phone, because I have seen that where people do not get it when you're on the line, because they're not hearing you.

DR. WILCOX: Right.

CHAIRPERSON NARCISSE: And I'm concerned about the hearing deficit as well, while the person is hearing, so they can take it to the next level.

So last time Dr. Katz was here, I was telling him about my culture, especially the Haitian folks, older ones, they like to hear things. They have to see you in front of them.

I have my colleague, Chair Selvena Brooks-Powers. Before she left, she left some questions. I'm gonna ask her questions for you before I forget.

Could you provide data on which neighborhoods or boroughs of New York City experience the highest rates of maternal mortality? And how have those trends shifted over the past five years?

DR. WILCOX: We would need to get back to you with that answer.

CHAIRPERSON NARCISSE: Okay.

How is the City addressing maternal health challenges through a multi-pronged approach that considers environmental, economic, and social determinants of health in addition to clinical care?

DR. WILCOX: I will say that I serve on a number of committees, as you heard, and so when able, I will take the information that I gleaned from being on those committees and bring it back to Health + Hospitals.

If you'd like a more comprehensive answer, we can get back to you with that answer, but I'll say in general, that's how we function.

CHAIRPERSON NARCISSE: In light of the tragic death of Tanisha Evans in Far Rockaway, what immediate steps are being taken to improve follow-up care for mothers after childbirth? And how can City agencies ensure that families in high-risk communities receive timely support and answers after maternal health complications?

DR. WILCOX: Thank you for asking that question. I believe you're asking about postpartum care?

CHAIRPERSON NARCISSE: Mm-hmm.

DR. WILCOX: We make sure that patients will receive a postpartum visit appointment before they leave the hospital. We give patients the option for either telehealth or in-person postpartum care services. Patients are also able to call our telehealth number if they're having concerns.

Prior to being discharged, all patients are given postpartum education. It is tailored to the individual patient's needs. So all patients will receive general information about how to care for themselves and what signs and symptoms to look out for in the postpartum period. However, if someone has additional clinical concerns, it will also include those.

As I said before, patients who leave the hospital will leave with a postpartum appointment. And many of our sites have implemented televisits, which patients actually prefer because then they don't have to leave with their baby, you know, especially in the wintertime, or you know, if the weather is inclement. So patients have actually shown that they like the telehealth visit follow-up. And our clinicians will conduct, you know, a postpartum visit via that way. If it's necessary for the patient

to come in, then we will absolutely also bring them into the practice.

CHAIRPERSON NARCISSE: I think I had some follow-up myself.

As part of your maternal health care model, how many follow-up visits do mothers routinely receive after giving birth? And is there flexibility to address that number based on medical or mental health needs?

DR. WILCOX: Absolutely. The postpartum, as you're aware, uh, visit and coverage expansion covers now up to a year postpartum after the birth of the baby.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. WILCOX: So, based on clinical needs, patients will be followed up. Someone, for example, who may have hypertension during pregnancy may require more visits than someone who does not have that complication. But we will tailor it to the patient and provide the number of visits that each patient will need.

CHAIRPERSON NARCISSE: So, for the standard—no complication, no mental health, how many visits?

DR. WILCOX: Usually, it's one postpartum visit, within a month postpartum.

CHAIRPERSON NARCISSE: Okay. I'd like to know whether electronic health records are fully connected. I know they should be, but I just want to know—across all H&H hospitals and Gotham clinics, are there still gaps in that system, and what is being done to close them?

DR. WILCOX: They're not gaps. Our Epic system is... (CROSS-TALK)

CHAIRPERSON NARCISSE: So they're all connected?

DR. WILCOX: They're all connected. And if a patient opts in, we can even see records from other places where the patient is gone that are not H&H, only if the patient opts in.

CHAIRPERSON NARCISSE: All right.

I know there's a different medical record being used, right? So, (INAUDIBLE) the doctor who goes to the private doctors, and they are in the hospital, are you mostly connected to all physicians now working? Do you have to use the same medical record system?

DR. WILCOX: So any patient who comes to us who is not coming from a Health + Hospitals facility and is coming from a practice that does not use the Epic system, we would not be able to see their records unless they had MyChart, you know, or unless they brought us their records. And many patients do.

CHAIRPERSON NARCISSE: Mm-hmm, Mm-hmm. Do all Health + Hospitals and Gotham Health Centers offer the same type of care for pregnant patients? Or are there certain locations that offer more advanced care to pregnant or postpartum patients, particularly if the pregnant patient is experiencing other medical complications?

DR. WILCOX: All of our maternity hospitals offer prenatal and postpartum services as well as intrapartum care. Not all of our ambulatory care sites that are not affiliated with hospitals offer it; however, when a patient calls for an appointment or when they go, if it's not one that will provide prenatal care, they will be referred to one of our sites that does.

CHAIRPERSON NARCISSE: Thank you.

When a pregnant patient arrives at an H&H location for their regular visit as they get closer to giving birth, do they consult the same clinicians every time they arrive at the H&H facility, or is there no guarantee that a doctor will always be available for a given patient? Basically, do you see the same doctors, or do you see some... (CROSS-TALK)

DR. WILCOX: I will say that most of our sites operate on a group practice model, as do most groups, at least in New York, and probably around the country. Most obstetrical care has moved to a group practice model where you may not see the same provider over and over again, but they will have access to your records and know your history.

CHAIRPERSON NARCISSE: Okay, thank you.

Can a patient request to see the same clinician if they actually repeatedly ask for that? Is that possible?

DR. WILCOX: I believe it's possible; however, I'm not able to attest to that at each site.

CHAIRPERSON NARCISSE: Okay. What is the Health + Hospitals individual hospital policy for internal reviews after a death occurs? Is it different for maternal deaths?

DR. WILCOX: All of our adverse events will go through the same process, which is a root cause analysis, which really is a process that is standardized, that digs deep into all of the factors that were involved in evaluating when this event occurred. And any gaps that are identified are analyzed. And if it's facility-specific, that will be taken care of at the facility. And if it is something that is a system-wide problem, then that will be at the level of the system, and we will strive to address it there.

CHAIRPERSON NARCISSE: Dr. Wilcox?

DR. WILCOX: Yes, ma'am.

CHAIRPERSON NARCISSE: I appreciate (INAUDIBLE) McIntyre's questions. I will be coming back after I pass it over to my colleagues, Chair of Women and Equity. And I have to say (INAUDIBLE), thank you for being here again. So, I will pass it on my colleague, Farah Louis.

CHAIRPERSON LOUIS: Thank you, Madam Co-Chair. Bruce, very happy to see you. Thank you for always standing up for Amber and your son, and for all of those impacted by maternal mortality in New York City.

I'm very happy to see you, Dr. Wilcox. I'm gonna be super quick. I have like five questions.

So the first question is around data transparency and accountability. I wanted to know how frequently does H&H internally reviews maternal health outcomes disaggregated by race, ethnicity, borough, and hospital site. And how are those findings shared with the public?

DR. WILCOX: As I stated earlier-- thank you for that question.

Every facility will submit data to our regional perinatal center on a monthly basis. The regional perinatal center compiles it for the New York City Health + Hospitals system. That is shared with our OBGYN Council, which is the council of all of the OBGYN departments across our system. As well as with the Health + Hospitals QAPI, which is the Quality Assurance in and PI Committee on a quarterly basis.

CHAIRPERSON LOUIS: Thank you. And does H&H collaborate with DOHMH's Maternal Mortality and Morbidity Review Committee to implement specific recommendations at the hospital level? And what

accountability structures ensure those recommendations are enacted upon?

DR. WILCOX: Would you please repeat the question? Sorry.

CHAIRPERSON LOUIS: Does H&H collaborate with DOH's MMRC to implement specific recommendations at the hospital level, and what accountability structures ensure that those recommendations are enacted upon?

DR. WILCOX: I am aware that there are certain staff members—I myself was a member of the New York City Department of Health's Maternal Mortality Review Committee...

CHAIRPERSON LOUIS: Mm-hmm.

DR. WILCOX: I'm no longer on that committee.

CHAIRPERSON LOUIS: Okay.

DR. WILCOX: Certain other individuals are, and I'm not aware of the rest of the question; we would have to get back to you with that answer.

CHAIRPERSON LOUIS: Okay, thank you for that.

DR. WILCOX: You're welcome.

CHAIRPERSON LOUIS: This one is a quick, sorry... Let me go to another question.

Does H&H evaluate patient satisfaction or trust levels in maternity wards? And if so, how are those evaluations informing improvements in patient care or communications?

DR. WILCOX: There are two ways by which that would occur. One is Press Gainey, which is a national system for evaluating patient satisfaction that is not specific to labor and delivery or maternity. Those are on a hospital level. However, those results are shared with the unit level leadership and then shared back to the units and the people who work there.

Another system is the New York State Quality-- I'm blanking on the name, but there is a...

CHAIRPERSON LOUIS: (INAUDIBLE)

DR. WILCOX: I'm sorry?

CHAIRPERSON LOUIS: There are so many, right? So many different...

DR. WILCOX: I know. There is a statewide maternity hospital quality initiative that also gives the PREM survey. So it's the patient reporting...

CHAIRPERSON LOUIS: Okay.

DR. WILCOX: Yeah, surveys to patients, and the hospitals receive reports back on the percentage of patients who've answered it. And there are monthly meetings conducted by the state DOH and the quality committee to review results and work on methods of improving response rates.

CHAIRPERSON LOUIS: Okay. And I have a quick question on cultural competency. Beyond cultural humility training or within implicit bias training, has H&H implemented or embedded any structural accountability mechanisms, such as patient feedback loops, evaluation metrics, or supervisor review processes to monitor how staff apply culturally responsive care in real time?

DR. WILCOX: Other than the patient reporting mechanisms through Press Ganey and the (INAUDIBLE) surveys that I've just, you know, reported on, I'm not aware of any others.

CHAIRPERSON LOUIS: Okay. This one is about midwives and doulas, and I know you can't answer all of them, but some of them...

DR. WILCOX: (LAUGHS) I'll try.

CHAIRPERSON LOUIS: I'll ask it a different way. Has Health + Hospitals considered the

integration or expansion of midwives within hospital-based maternity units since the launch of the New York City Midwifery Initiative? Because you stated earlier that midwives are not-- they're independent, but I wanted to know if Health + Hospitals considered the integration or expansion of the program?

DR. WILCOX: Health + Hospitals has considered expansion of midwifery services. And the leadership of those departments and those hospitals would need to carry that further.

CHAIRPERSON LOUIS: Okay. And which of the programs you mentioned in your testimony earlier ensure continuity of care for low-income birthing people before, during, and after hospital delivery?

DR. WILCOX: I would have to get back to you with the answer for that one.

CHAIRPERSON LOUIS: Okay. Last two questions—— What strategies are Health + Hospitals implementing to retain and recruit experienced labor and delivery nurses, midwives, and OBGYNs, especially in high-need hospitals?

DR. WILCOX: Thank you for that question. I would definitely need to get back to you with that response.

CHAIRPERSON LOUIS: That would be helpful.

Are there mentorship or pipeline programs that specifically recruit residents or medical students from underrepresented backgrounds to specialize in maternal health within H+H hospitals?

DR. WILCOX: We have the MOSAIC program (Medical Opportunities for Students and Aspiring Inclusive Clinicians), which is not specific to maternal-child health, but really seeks to improve the diversity of our workforce and reaches out to historically underrepresented minorities to do rotations in our New York City Health + Hospitals. And we could probably get you data... (CROSS-TALK)

CHAIRPERSON LOUIS: But so far, the MOSAIC program is like one avenue?

DR. WILCOX: That's the one I'm thinking of now, but we could get you a more comprehensive answer.

CHAIRPERSON LOUIS: Okay. Lastly, you were talking about the NYC Baby Boxes program, and I wanted to know who identified the placements of the H&H sites for the NYC Baby Box program?

DR. WILCOX: That is the loaded question. Thank you. (LAUGHS) A team between Health + Hospitals

and City Hall really worked the entire project from soup to nuts. And when we were looking at the hospitals that had the largest birthing populations, those are the four where we were able to, I would say, get the biggest bang for our buck. So, to offer the baby box to every birthing person and reach about half of our birthing population, those four hospitals do half of the births in New York City Health + Hospitals.

CHAIRPERSON LOUIS: Thank you for that.

I do have one last question. I promise this is the last one. I saw Bruce earlier, and I was like, I have to ask this one.

You mentioned earlier-- and if you can elaborate on how social workers or care coordinators in every H&H maternity unit help pregnant patients connect to City resources before and after discharge, as well as supporting partners before and after discharge.

DR. WILCOX: So our social workers do that. Also, I was talking about the Maternal Home, which is in all of our 11 maternity hospitals. They really aim to provide wrap-around services and screen patients in a standardized way and identify patients

who might be at higher risk for undesired pregnancy outcomes, whether it's for needs for social determinants of health, behavioral health, or those who have complex clinical needs where they'll need that.

So, patients are referred to a Maternal Home team member, they undergo a standardized screening, and the Maternal Home team member will assign a risk tier to the patient that determines the number of times they need to be seen. Sometimes it's, you know, every time they come in, sometimes it's, it's one time, and they really aim to get the patient to the resources that they need.

Community-based resources, hospital resources, City resources, you name it. The Maternal Home is the largest referral base to doula services. They're the largest referral base for other needs that patients may need, and they really aim to be a one-stop shop to help patients in this regard. They're also available in the postpartum period. Certainly, if they've met the patient prenatally, that helps, but even if someone didn't see them prenatally and it's determined that they have these

needs postpartum, they can see them as well, as well as our in-hospital social workers.

CHAIRPERSON LOUIS: Thank you, Doctor. I am going to hand it back to my co-chair.

CHAIRPERSON NARCISSE: Thank you, Chair.

What policies does H&H have in place to notify the families and loved ones when a pregnant patient passes away?

DR. WILCOX: Thank you for that question. I will need to come back to you with an answer for that one.

CHAIRPERSON NARCISSE: Is there uniform guidance that H+H clinicians provide to new parents about what type of symptoms post-partum patients can expect to experience after giving birth? If so, does such guidance outline specific symptoms that require immediate medical attention? Can a postpartum patient call H&H, where they delivered their baby, to ask about postpartum symptoms?

DR. WILCOX: They can. All patients receive discharge instructions on what to look out for in the normal postpartum-- signs and symptoms of things that may happen, such as preeclampsia.

They also tailor the discharge instructions based on whether or not a patient may have additional risk factors. So all patients will receive the general training, and then patients who are either anemic or have high blood pressure, diabetes, or whatever other clinical condition will receive additional training.

Patients may call H+H telehealth services. They are also given instructions on when they should absolutely call 911 and come in, and, uh, how ever else to, you know, reach the practice.

CHAIRPERSON NARCISSE: So now that leaves me with a preeclampsia-- Do they get a sphygmomanometer when they're going home?

DR. WILCOX: Most patients do, we have them available to give to patients... (CROSS-TALK)

CHAIRPERSON NARCISSE: They get it... They give it to them before they discharge?

DR. WILCOX: Mm-hmm.

CHAIRPERSON NARCISSE: Okay. That was blood pressure (INAUDIBLE)... (CROSS-TALK)

DR. WILCOX: We try to get it to them in the prenatal period.

CHAIRPERSON NARCISSE: Hmm?

DR. WILCOX: We try to get it to them in the prenatal period, actually.

CHAIRPERSON NARCISSE: Okay, got it.

DR. WILCOX: But yes, they need it postpartum; we will get it to them as well.

CHAIRPERSON NARCISSE: Okay.

How does H&H support a postpartum patient who needs to be evaluated for postpartum symptoms? Do facilities provide lactation pumps and allow children to visit during treatment?

So I'm gonna make a joke at my colleague, because she has to run outside to do that. (LAUGHS)

UNIDENTIFIED: Yes, now the whole world knows.

CHAIRPERSON NARCISSE: The whole world knows. (LAUGHS) So that's an open conversation because we're not gonna hide anymore from talking about it. Because now I love it. Women now come out in the clinic. They do what they have to do. So we're women.

DR. WILCOX: So all of our sites have facilities, have lactation rooms. All of our sites are baby-friendly, which means that they've gone through a national certification for breastfeeding

support. So, all patients in New York are covered by Medicaid. They can get a pump; they're able to get a lactation pump.

If there is difficulty, our Maternal Home or our social workers will try extra hard to get that for them. We've tried very hard to enable people to breastfeed.

CHAIRPERSON NARCISSE: So now when you said...

DR. WILCOX: (INAUDIBLE)

CHAIRPERSON NARCISSE: When you talked about the insurance, Medicare, you know, I go like (LAUGHS) because we're about to lose about 165,000 people. That is a problem for us in New York City.

So I'm not gonna get to (INAUDIBLE)... (CROSS-TALK)

DR. WILCOX: We will have to find another way to get breast pumps to people... (CROSS-TALK)

CHAIRPERSON NARCISSE: We have to find a way. Yes, we are very resourceful for folks, and I do trust and believe our medical groups that provide services. We're going to fight until we die for each other.

DR. WILCOX: Right now, it's very easy, though. It's literally just signing a script, and the patient can get one. And they can even have one sent to them.

CHAIRPERSON NARCISSE: Very difficult. I'm going to pass it to my colleague whom I just made a joke at.

COUNCIL MEMBER GUTIÉRREZ: Thank you, Chairs, and thank you, Dr. Wilcox.

So I apologize if someone did ask these questions because I was out for a few. So good to see you.

DR. WILCOX: Thank you.

COUNCIL MEMBER GUTIÉRREZ: I always love being in the presence of Woodhull folks. Shout out to Ms. Grant and Ms. Pat, who are here. Ms. Grant was one of my midwives when I delivered my first baby. So obviously, this is something that's very dear to my heart.

Dr. Wilcox, I'm going to ask a couple of questions, so if we can keep the answers short. Can you just repeat for me the H&H hospitals where there is a midwifery unit or midwifery personnel? I think

you said it was one of the first questions that the speaker asked.

DR. WILCOX: All of them have midwives-- midwifery services except for Harlem, Lincoln, and Queens.

COUNCIL MEMBER GUTIÉRREZ: Harlem, Lincoln, and Queens? And Kings County has a midwifery personnel? They do? Okay. I was told otherwise.

For Harlem, I know that they had midwives there up until at least May of last year, because I was a patient there. So, can you tell us what happened there or what has happened there?

DR. WILCOX: I'm not able to comment on that.

COUNCIL MEMBER GUTIÉRREZ: You're not able to comment on that? Okay.

Is there a pathway for reinstating a midwifery unit in Harlem?

DR. WILCOX: We would have to get back to you with the answer on that one.

COUNCIL MEMBER GUTIÉRREZ: Okay. And then of the other two facilities? Is there a pathway for midwifery personnel or units at those two hospitals as well?

DR. WILCOX: I know there's a desire to implement a new service. A new service does take some planning... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: They did not have midwifery before those two? The remaining two Queens, and I'm sorry I forgot the other one.

DR. WILCOX: Lincoln.

COUNCIL MEMBER GUTIÉRREZ: And, Lincoln, they did not have-- No, okay, so sorry. So you were saying... (CROSS-TALK)

DR. WILCOX: (INAUDIBLE) starting de nova. So, in order to start a new service, it requires a business plan, and they would have to, you know, probably hire a director, and then...

COUNCIL MEMBER GUTIÉRREZ: Okay.

DR. WILCOX: Start hiring, and then... You know what I'm saying?

COUNCIL MEMBER GUTIÉRREZ: Sure.

DR. WILCOX: It's a process. So...

COUNCIL MEMBER GUTIÉRREZ: But, is it a process that's supported by H&H in some capacity or.. (CROSS-TALK)

DR. WILCOX: It could be supported.

COUNCIL MEMBER GUTIÉRREZ: (INAUDIBLE) or it's the individual hospital that...

DR. WILCOX: The hospital would have to initiate it. It would be supported.

COUNCIL MEMBER GUTIÉRREZ: Okay. Okay.

Now just jumping on some questions about data. I don't know if you have it. Can you share the general rates of C-sections performed at H&H hospitals that have midwives versus those that do not?

DR. WILCOX: I'm not able to give you specific data on that. I can tell you that the overall C-section rate for Health + Hospitals is lower than the New York State average.

COUNCIL MEMBER GUTIÉRREZ: But in that rate that you're referring to, this is from data from what year?

DR. WILCOX: 2024.

COUNCIL MEMBER GUTIÉRREZ: 2024? So you don't-- You can't share the rate, but you can tell me it's less than the rest of New York City?

DR. WILCOX: I can't share the rate. Can you please give me one second? It’s 32%.

COUNCIL MEMBER BREWER: It's 32% as of 2024?

DR. WILCOX: Yeah.

COUNCIL MEMBER GUTIÉRREZ: Okay. That's the H&H rate. And then the citywide rate?

DR. WILCOX: (PAUSE) Okay, sorry about that. I just need to get to the right page.

COUNCIL MEMBER GUTIÉRREZ: That's all right.

DR. WILCOX: C-section deliveries for the Health + Hospitals system were 32%, which is on par with the national level. The C-section rate for New York State is 33.9%.

COUNCIL MEMBER GUTIÉRREZ: Okay. And do you know if you can get back to me, apologize, and have these rates increased or decreased since the pandemic or increased or decreased since the City's Citywide Doula Initiative?

DR. WILCOX: I would need to get back to you with that.

COUNCIL MEMBER GUTIÉRREZ: Okay. Specifically, I'm interested in the impact of the Citywide Doula Initiative. If you can share-- the

program started in 2022-2023. So, if there's any comparative... (CROSS-TALK)

DR. WILCOX: Yeah, I'm aware of... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: data.

DR. WILCOX: an article that we could send you that shows that the initiative did not have any effect on C-section rates. That was (INAUDIBLE)... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: (INAUDIBLE)

DR. WILCOX: from that article, which we can share with you.

COUNCIL MEMBER GUTIÉRREZ: Mm-hmm?

DR. WILCOX: I'm not sure of any updated information.

COUNCIL MEMBER GUTIÉRREZ: Okay.

And then, I have 30 seconds, but can you share if midwives specifically, if there is a process for them to report concerns about staff in their interpersonal relationships or instances with patients?

DR. WILCOX: All employees, that is, all employees in New York City Health + Hospitals, can anonymously report any interaction that they feel is

adverse or incorrect through the anonymous voice reporting system. (TIMER)

COUNCIL MEMBER GUTIÉRREZ: Mm-hmm?

DR. WILCOX: It actually... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: Can I have one more minute?

DR. WILCOX: Can go through on a unit level. There's a way that it tracks to the correct supervisor, but it is anonymous, and it will be investigated. And reports through that system have been encouraged, and there is a lot of reporting through that system, and it's handled, I think, through our Risk Management and Quality Management Department... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: Okay. And then that system, and the Chair is going to give me a few more seconds, so thank you-- That process is the same process for a staff member reporting treatment of a patient or treatment towards themselves? (INAUDIBLE)... (CROSS-TALK)

DR. WILCOX: It is, but it’s tracked differently. It's actually a very smart system. So, depending on whether it's like a patient occurrence, a staff occurrence, or even like an environmental

issue, it will track it to the correct place to be addressed.

COUNCIL MEMBER GUTIÉRREZ: What is the accountability piece? What is that timeline? I am curious. I know that-- I think the Speaker had asked before, I don't know if you were able to respond. But, you know, here at the Council, if a complaint is lodged about whoever, it is very quickly investigated. There is some portion of it that, you know, there's a transparency piece to it. I am just curious—what can you share about what that process is like...

DR. WILCOX: So...

COUNCIL MEMBER GUTIÉRREZ: Like, the accountability piece.

DR. WILCOX: As a manager, which I am, I get reports from Voice all the time. I get it daily if one is lodged. If it's something that would involve HR, I imagine that it would have to go through an HR process, which I'm not privy to, and we could probably... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: And is there always a response, even if the responses were

investigating it? (sic) Is there always a response to each of those anonymous complaints that are reported

DR. WILCOX: That's a good question. I know it goes to the managers. I guess the manager would then have to follow up with-- it's anonymous, right? If the report mentions names, I imagine that the manager would then have to go through somewhat of an HR process and investigate that if it did not involve a patient. If it involves the patient, the medical record number is there, and then we can look and see who was attending to the patient, and you know the manager would investigate what's going on... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: But if it was lodged by a staff member, you're not sure if there is a response of recognition (INAUDIBLE)... (CROSS-TALK)

DR. WILCOX: We can find out and get back to you. I'm not sure... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: Okay.

DR. WILCOX: of the ones that don't involve-- I'm mostly clinical, so...

COUNCIL MEMBER GUTIÉRREZ: (INAUDIBLE)

DR. WILCOX: The clinical ones definitely come to me. I'm not aware of the ones that are not... (CROSS-TALK)

COUNCIL MEMBER GUTIÉRREZ: Okay, all right, thank you. I have more questions, but I'll pass it back.

CHAIRPERSON NARCISSE: (INAUDIBLE)

COUNCIL MEMBER GUTIÉRREZ: What trainings are-- I know that-- I think you had mentioned this while I was out, I was streaming it, my apologies. I guess what are the specific steps that you all take to ensure a positive work culture for the staff?

I mean, I've been, obviously, a patient at Woodhull, and I have, you know, just had gold star reviews for my experience. And of course, I want that to be the experience for every person and every family. I know that some things have changed at this specific facility. The reason I raised Harlem is again, because I was a patient there also. And again, I want that experience to be the standard for everybody.

So what can you, what can you share? And I know that you're specific to one facility. But what

can you share about what you all do for work culture, specifically for integrating?

Because I think it's tough, and I know it's tough to integrate the midwifery practice into these units. You know, I think Woodhull is a specific example of when it works, it works super well, and in my experience working with midwives throughout the city, sometimes that is not, or oftentimes, almost no time is that the experience of midwives across the other H&H hospitals.

So what can you share? What specific examples can you share of what actions or steps are taken to replicate that to ensure a positive work culture, just ensure that there is a positive work experience and integration, so that the patient, ultimately, that pregnant person, is benefiting...

DR. WILCOX: Mm-hmm.

COUNCIL MEMBER GUTIÉRREZ: from this comprehensive care?

DR. WILCOX: Thank you for asking that question. I hear a lot of different questions in your question. I will say that, as a system, we recently launched an ICARE Initiative, both a pledge and a training. And the ICARE initiative is really centered

not just on maternal child units or labor and birthing units, it's really hospital-wide to instill empathy and caring for all who work at New York City Health + Hospitals.

ICARE stands for integrity, compassion, accountability, respect, and excellence, and every employee is expected to go through this training and also sign a pledge that they will identify the ICARE values.

COUNCIL MEMBER GUTIÉRREZ: And this is a new initiative, you said?

DR. WILCOX: It’s fairly new.

COUNCIL MEMBER GUTIÉRREZ: Okay. And it’s been implemented in every H+H?

DR. WILCOX: Yes.

COUNCIL MEMBER GUTIÉRREZ: Okay. And how often do they have to do this?

DR. WILCOX: Annually.

COUNCIL MEMBER GUTIÉRREZ: Okay. Mm-hmm. Okay, I’ll pass it back to the chairs. Thank you so much.

DR. WILCOX: Thank you.

COUNCIL MEMBER GUTIÉRREZ: Thank you, Chairs.

CHAIRPERSON NARCISSE: Thank you. Now we are going to go a little bit again on mental health.

If a pregnant patient presents with existing mental health challenges, before or during their pregnancy, what steps do clinicians take to provide additional supports to the patient during the course of their pregnancy and postpartum period?

Do you have suggestions for other methods to improve the delivery of mental health care services to such patients? You know, the second part is yours.

DR. WILCOX: Thank you for asking that. I know you see me nodding so. Patients with pre-existing mental health services hopefully, are receiving care. As a clinician, we would ensure that they are receiving that care, whether it's inside our Health + Hospitals walls or externally, and that they're still following up with their care provider.

What we have found to work well and what we would like to-- So through our Maternal Home, which you've heard me talk about several times today, we have made over 1,300 referrals to behavioral health services. So if patients do not have a

regular, uh, behavioral health provider, they can get the care that they need.

What we have found works really well and we would love to in the future replicate around is, is to actually have behavioral health services embedded in Women's Health. That's not always possible, whether it's due to physical constraints or other workforce-related constraints, but ideally, we found that that's a model that works really well.

However, ensuring that patients are following up with their behavioral health provider while also receiving their prenatal care is a model that we follow.

CHAIRPERSON NARCISSE: Have you found it difficult for patients going through pregnancy and seeing their mental health providers?

DR. WILCOX: I think it depends on what the clinical scenario is. If it's something like depression, that's a little bit different than someone who's bipolar or schizophrenic or some of the other mental health conditions that we see.

CHAIRPERSON NARCISSE: Okay. Many medications used to treat mental health conditions are not evaluated for side effects during pregnancy,

leaving some clinicians unwilling to prescribe medication or deferring to another clinician, which effectively delays treatment for the patients. What training or support does H&H provide to clinicians to be educated and confident in treating pregnant patients?

What policies does H+H have to ensure pregnant patients receive the necessary medication? And I don't want to make a joke. You know, recently there was something "acetal". Whatever, let's go on. (LAUGHS) I just have to say...

DR. WILCOX: I'm not sure that there's hospital-specific training. Definitely, my professional organization, which is ACOG, certainly supports mental health treatment during pregnancy and certainly not stopping it.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. WILCOX: I think we can all acknowledge that there are silos in medical care, and not all disciplines, or you know, are aware of medication use in pregnancy. Certainly, if we look in the Micromedex or other pregnancy, lactation, there's a Pregnancy/Lactation Encyclopedia. It's fairly accessible online. And most medications do receive a

pregnancy rating about whether or not they can be taken during pregnancy. Generally, medications that are A, B, or C can be taken safely during pregnancy. Certainly, a D or below would not be recommended. And it certainly involves a conversation with the patient, obviously.

So I'm not aware of any specific training other than what we would receive during our medical training in terms of how to access that information. But certainly, we can get guidance through our professional organizations.

CHAIRPERSON NARCISSE: The approach that I use is just, if a patient has to deal with the GI problem, acid thing, so I will get the GI input before even the doctor prescribes it. I will check for it. So I don't know if we still do that. And if it's something with a heart, then you check with the cardiologist and combine it together.

DR. WILCOX: Right, so what you're suggesting is that our behavioral health colleagues contact us and consult us, right, if a patient is pregnant?

CHAIRPERSON NARCISSE: They should.

DR. WILCOX: And they do.

CHAIRPERSON NARCISSE: Mm-hmm.

All right, pregnant patients who struggle with substance use may be afraid to tell their clinicians. What policy does H&H have to offer to support patients in disclosing important information without fear of immediate intervention by their Administration for Child Services?

DR. WILCOX: So we screen patients for substance use disorders. And by screening, I mean we offer a standardized questionnaire to ask about substance use; it is a standardized questionnaire that is validated. It's a validated tool. If a patient reveals that they have a substance use disorder, we will direct them to care——medical care.

CHAIRPERSON NARCISSE: And about the concern for the Administration of Child Services?

DR. WILCOX: So we've really steered away, and we have policies for both maternal testing and newborn testing that will not allow us to order testing on a patient without specific informed consent. And that informed consent would include a discussion about the potential involvement of Child Protective Services. So we really try to steer away from testing and just offer a consultation to a

patient and referral to substance use services so that they can get the treatment that they need.

CHAIRPERSON NARCISSE: Okay, thank you.

New York State law, the Maternity Information Act, requires every hospital and birth center to distribute to all prospective maternity patients at the time of pre-admission and to members of the general public, upon request, a statistical profile of that hospital's birth-related practices. Do H&H hospitals comply with this law? If not, why not?

DR. WILCOX: H&H provides a data profile of birth practices at the facility level.

CHAIRPERSON NARCISSE: You comply? Okay.

Now it has been a long process, my colleagues, do you have any more questions?

DR. WILCOX: Do I have any questions?

CHAIRPERSON NARCISSE: No, no, no. Actually, I was asking her if she had any questions. Do you have any questions? You're done?

So I want to say thank you so much for your time, Dr. Wilcox. You're a good friend, and I thank you for coming. And you're not in the principal's office.

DR. WILCOX: Thank you, Chairwoman Narcisse. Thank you, Chairwoman Louis. Thank you all very much. Appreciate it... (CROSS-TALK)

CHAIRPERSON NARCISSE: (INAUDIBLE) at the next conference.

DR. WILCOX: Thank you.

CHAIRPERSON NARCISSE: All right, bye. Thank you.

I now open the floor to public testimony. Before we begin, I remind members of the public that this is a formal government proceeding and that decorum shall be observed at all times. As such, members of the public shall remain silent at all times.

The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table.

Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of such recordings to the Sergeant at Arms for inclusion in the hearing record.

If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant at Arms and wait for your name to be called. Once you

have been recognized, you will have two minutes to speak on today's hearing oversight topic on Improving Maternal Health in New York City.

If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant at Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of this hearing—audio and video recordings will not be accepted.

When you hear your name, please come up to the witness table.

The first panel will be: Patricia Loftman and Bruce McIntyre.

(PAUSE)

CHAIRPERSON NARCISSE: Thank you. You may begin.

PATRICIA LOFTMAN: Before I begin, I would respectfully request that I be allowed to exceed my time limit. I know that you had a lot of questions to ask of the previous individual—with your permission.

CHAIRPERSON NARCISSE: Can I say no to someone who (INAUDIBLE) so much time, so much time in

this process. So, I will allow you to finish your statement.

PATRICIA LOFTMAN: Okay, thank you.

CHAIRPERSON NARCISSE: Thank you.

PATRICIA LOFTMAN: Greetings, Chairpersons Narcisse and Louis, and Council Members Gutiérrez, Vernikov, and I think that's it.

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

I speak in support of Resolution 1082-2025, introduced by Deputy Speaker Ayala, a Resolution calling on the New York State Department of Health to confidentially share data regarding adverse maternal health events from the New York

Patient Occurrence Reporting and Tracking System with the NYC Maternal Mortality Review Committee.

Every year in New York City, between 50 and 60 women and birthing people die from a pregnancy-associated death. Black non-Hispanic women are about five times more likely to experience a pregnancy-associated death than white women. As many of you know, the New York City Department of Health and Mental Hygiene first convened the Maternal Mortality Review Committee in January 2018, and it was then signed into local and state legislation through the New York City Council and New York State legislation. The New York City Department of Health and Mental Hygiene provides operational support to the Committee, conducts data analysis, and produces collaborative reports with the New York City Maternal Mortality Review Committee.

The New York City Maternal Mortality Review Committee is an independent, diverse, multidisciplinary team, including 40 specialists with expertise in midwifery, family medicine, nursing, psychology and psychiatry, anesthesiology, maternal-fetal medicine, and obstetrics and gynecology; doula services and patient advocacy; social work; health

systems; addiction treatment; and violence prevention. In total, 70% of members self-identify as Black or Hispanic women, the two groups most affected by these deaths, and 65% of members identify as clinical and 35% identify as nonclinical. We meet monthly to review each maternal death in New York City to understand the contributing factors leading to the death, as well as opportunities for prevention. Since 2018, the New York City Maternal Mortality Review Committee has reviewed almost 400 deaths. We have actually reviewed 319.

According to the New York City and New York State legislation, two MMRCs were established— The New York City MMRC reviews deaths that occur in New York City. The New York City MMRC then shares data with the New York State MMRC.

According to the New York State legislation, the New York State MMRC should provide "information and assistance to the New York City MMRC for the performance of its functions". And the New York City MMRC "may request and shall receive upon request from any department, division, board, bureau, commission, local health departments, or other agency of the state or political subdivision thereof or any

public authority, as well as hospitals established pursuant to Article 28 of this chapter, birthing facilities, medical examiners, coroners, and coroner physicians and any other facility providing services associated with maternal mortality such information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records and any other information that will help the department under this section to properly carry out its functions, powers and duties."

Since 2018, the New York City MMRC has requested access from the New York State MMRC and other New York State DOH representatives to a critical data source-the New York Patient Occurrence Reporting and Tracking System (NYPORTS). NYPORTS is a statewide mandatory reporting system that collects information from hospitals and diagnostic and treatment centers about adverse events, including data on maternal deaths and serious injuries.

NYPORTS requires hospitals to report adverse events that were not the result of the natural course of an illness and caused an undesirable development in a patient's condition.

Reporting must be done within 24 hours or one business day of becoming aware of the event, and must include the date, nature, classification, and location of the event, as well as affected patients' medical record numbers. Severe incidents, like wrong-side, wrong-patient, or wrong-procedure surgery, unexpected deaths, and certain equipment malfunctions, have specific, stricter requirements, including an in-depth root cause analysis and corrective action plan, according to a New York State Department of Health document.

An expert New York State Department of Health Committee assembles to conduct the Root Cause Analysis (RCA) and develop an action plan for the hospital or facility in response to a severe incident or unexpected death, including maternal deaths. For example, NYPORTS codes 911 and 912 are specific categories for reporting wrong-site, wrong-patient, and wrong-procedure medical events within New York's mandatory healthcare reporting system. These codes are used by NYPORTS to log errors that occur in hospitals and other treatment centers. These are then grouped into categories of root causes, such as the level of the clinician providing care, was this an

intern, the patient-to-staff ratio, was there adequate staffing, the time of day or night, communication failures, noncompliance with existing procedures, inadequate orientation or training.

Some of the categories might overlap within cases. We noted that most Code 911 and Code 912 events had at least three root causes (suggesting a specific and direct causal relationship), as well as multiple contributing factors such as environmental conditions increasing the chance of an adverse event. Complex cases had as many as 10 root causes.

In sum, this data source is critical to the New York City MMRC's understanding of what occurred in the hospital and what was recommended as a corrective course of action after a maternal death occurred. The New York State MMRC already has access to this data and has presented it in public in past public forums.

The New York City MMRC also requires access to this data. Access to NYPORTS data would support the New York City MMRC's full understanding of hospital deaths and provide critical information on issues that may have affected the decedent's

course of care that are not routinely documented in the medical records, such as staffing.

I am requesting on behalf of the New York City MMRC that the City Council assist us in gaining access to this crucial data source to enable us to fully understand and make determinations and recommendations for maternal deaths to enable us to give full justice and honor to the women and birthing people who have died and their families and communities who have lost a loved one.

And we just listed all of the different causes that would be included under NYPORTS. Any questions?

CHAIRPERSON NARCISSE: What I can say is thank you. This is very detailed for me and I was listening every step of the way. So, how long have you been doing this work?

PATRICIA LOFTMAN: For 43 years.

CHAIRPERSON NARCISSE: For 43 years. And you have seen it all.

PATRICIA LOFTMAN: I've seen it all.

CHAIRPERSON NARCISSE: So, what, besides the access you need, what else do you think we can do as a community under the climate that we are in right

now?—about to lose so much, and the cuts are ridiculous.

PATRICIA LOFTMAN: You know, I've always said, I worked at Harlem Hospital, and we took care of the first women who suffered with HIV/AIDS. And in 1984, we didn't have a lot of money in Harlem Hospital. But we had really good outcomes. So, often it is not money. Money is important, but it is not always money. We had a culture at Harlem Hospital that promoted excellence. We had a midwifery service that was well integrated into the department.

What generally happens throughout the Health + Hospitals Corporation Midwifery Services depends on the culture that is established at the leadership level. So not all midwifery services practice the same. Not all midwifery services are-- the midwives in the services are enabled to practice to the full extent of their education, of their training. They're not always supported. So I think what we-- In terms of what we are going to experience now, it's going to challenge us as to how solid we can be as clinicians, as colleagues, and as departments.

CHAIRPERSON NARCISSE: Thank you—any questions from my colleagues?

COUNCIL MEMBER GUTIÉRREZ: Thank you, Chair. And thank you so much, Pat, for the 43 years of volunteer service, and this really, really thoughtful testimony, detailing the amount of work that goes into this review committee, and the goals of what the product is supposed to be. I was not aware that you all have been meeting monthly since 2018, and I think that is incredible.

PATRICIA LOFTMAN: We meet monthly, and we review approximately five to six cases every month. And I can share with you that it is taxing on everybody.

I'll give you an example: One case that we reviewed was a woman who was experiencing a mental health illness. And she was on a subway platform. And as the train came in, she locked eyes with the motorman, the conductor of the train, and she mouthed to him, "I'm sorry", as she jumped onto the train tracks. And so when we talk about the availability of mental health care, one of the recurring themes that we see in the cases that we review is, number one, the fact that most of these women experience mental

health illness very, very early in their lives. It did not begin when they became pregnant. It began long before pregnancy, and then they became pregnant, and then what? We do not have sufficient mental health services, either psychiatrists or mental health nurse practitioners who have prescriptive privileges, who can prescribe medication, because often these women are in crisis, need to be stabilized before they can even begin to be treated.

COUNCIL MEMBER GUTIÉRREZ: I thank you so much again, and thank you for volunteering your time and being so detailed in your testimony.

My one question is, I know you're ask for the Council's assistance to help you gain access to this data. Can you share what the response has been in the past? Like, what is the reasoning that it's not already shared with the review committee? What is the challenge?

PATRICIA LOFTMAN: We do not have the answer to that. We have requested. It just has not been provided.

COUNCIL MEMBER GUTIÉRREZ: And this is from the State?

PATRICIA LOFTMAN: Yes.

COUNCIL MEMBER GUTIÉRREZ: Okay, Okay. Thank you. Thank you, Chairs.

CHAIRPERSON NARCISSE: We hear you. And we are going to find out. I know she's gonna determine-- That's crazy because you need it.

COUNCIL MEMBER GUTIÉRREZ: Unacceptable.

CHAIRPERSON NARCISSE: That's the word. Unacceptable. Because you need the data for a good purpose. So it's not something you want to do just to do. It is to save lives.

All right. Thank you.

So now we're gonna hear from Mr. McIntyre.

BRUCE MCINTYRE: Hello, peace to the City Council Members. It is good to see you all. Peace and Love.

So, I just wanted to share testimony when it comes to patients and mental health as well. When it came to me and my situation with my partner, who passed back in April 2020, Amber Rose Issac, who the hospitals grossly neglected—two hospitals grossly neglected her under the same branch, Montefiore Moses, and Montefiore Einstein. She received the same treatment at both facilities, which was truly gross

neglect. After her passing, there weren't any services that were made available to me in her passing. There were more services that were made available to her mother, the grandmother, than there were for me as a father. And while seeking help, the hospital was trying to offer me therapy, but without even being properly evaluated by the therapist, she was so quick to try to throw drugs at me, like Xanax and other stronger antidepressants, which is a vicious cycle that we have seen through our time within the Black and brown communities, especially the underserved communities. During that time, I was questioning how I was supposed to take care of my newborn child, who had just lost his mother, if I was doped up on drugs and left incompetent to take care of my child? And then it becomes a whole other issue with my child being taken away by the state. And families experience that, unfortunately.

So, I was wondering what the City and New York State are going to do with situations like those when it comes to fathers who suffer from maternal mortality or morbidity. What services are going to be made available to parents like them who present in a more holistic approach? It was the midwives and the

doulas who actually offered me grief counseling without taking a cent out of my pocket. Because they truly cared. And instead of the System that was working against me, it was the midwives and it was the doulas who were presenting services to me to assure that I was able to take care of myself and sustain myself as well as my child. They introduced me to lactation consultants. After my partner passed, who held a strict vegan diet, I wanted to make sure and assure that my son was receiving the same nutrients and vitamins that he was receiving from his mother, which the doulas-- the lactation consultants partnered me with other donors who matched the same diet that my partner had been receiving. And I was able to get free breast milk for almost two years.

So, I was wondering what the hospitals are doing to implement services like that. And also how the hospitals are preparing birthing partners for a maternal loss. Of course, with my situation, we were not made aware of what was going on with Amber. We were not told that she had HELLP syndrome until the day that she passed away, which should never have happened. We were not told what she had until the day that she passed away. And the hospital allowed me to

be in the hospital with my partner, because they knew I was the father. So, after her passing, they told me that due to her passing, she was no longer allowed to attest that I was the father, which made me go through this extensive process just to be able to gain my rights to my son. And it took almost two years for me to gain the rights to my son. And it took me almost four years to receive the birth certificate with my name on it. And you have to get all of that processed before you can open a legal case against the hospitals.

So, I was wondering how the hospitals are preparing people for situations like that to make that a smoother process for parents like me. Because, due to not having those things available to me, my son wasn't able to receive the child tax credit. I wasn't able to receive stimulus checks for my child. And I was forced to struggle because of how the system viewed me as a Black father. And instead of making that process a lot easier for me, which they should have, which should have been done, I was forced to take a very hard route with the force and pressure of the hospitals working against me. Even to

this day, they are still refusing accountability for the loss of my partner.

So, I was wondering what the hospitals are doing to present truth and reconciliation, and how that is being implemented in the hospitals. Amber's head surgeon, who was grossly neglecting her, was the one who performed the autopsy on Amber, which is a huge red flag. And the medical examiner never stamped off on the autopsy report as well. I was told by the funeral director to reach out to the police and file a report, which I tried to do. But, they told me it was malpractice, which means it was being guarded by malpractice insurance, and that it was a malpractice case, so that I couldn't file the report with the police.

So there are a bunch of red flags that were going on in my situation, which made me suffer. And I suffered a great, immense, emotional loss, which the City has not recognized, because we don't have systems-- we don't have polices in place like the Grieving Families Act that would allow truth and reconciliation and also accountability against the hospitals. My partner was supposed to graduate with her master's degree. She wanted to open up her own

school. She was cut short. She passed away the month before she was supposed to graduate. But the City only recognizes her from the last job that she worked. And they do not recognize the potential earnings that she was also going to gain, which also put a huge strain on me and my family.

So, I believe that, with the support of the Council in helping to pass the Grieving Families Act, and supporting the Grieving Families Act, we can create a safety net for families like mine, so that they don't have to suffer.

CHAIRPERSON NARCISSE: I have to say, my apologies for all of the struggles you have to go through.

BRUCE MCINTYRE: Thank you.

CHAIRPERSON NARCISSE: And, yes, there is a culture where males were most of the time not part of the conversation. But there are a lot of legal things that we talk about, which I cannot answer, because I am not a lawyer; I am a nurse, and I don't have the background actually to talk about those legal aspects of it, but as far as the policies that we can put in place, we will work with you. We will try to do our very best, because I appreciate your

advocacy, because what you are doing actually will prevent the next person-- you took your pain and put it into advocacy. That is why I love New Yorkers. Because when things happen, we don't just sit on it, we try to do our very best to prevent it from happening to somebody else, from learning the hard way like you had to learn it. Like my grandmother would say, if you got hit or your foot got caught in a pothole, why would you let somebody else go into the same pothole and hurt themselves? Because you care.

So you are showing that you care. So, I thank you, and Dr. Wilcox is still sitting here listening to you. So I am sure we will be in collaboration to do our very best. And since you are talking about being a single dad, it is not that easy. Being a single mom is not easy. So a being a single dad is very difficult, quite difficult. So, my apologies, and we will do our very best to put something in place.

BRUCE MCINTYRE: Thank you.

CHAIRPERSON LOUIS: Thank you, Co-Chair. Just to echo some of what she shared, Bruce, you never said any of this. Every time I saw you, you never shared this.

BRUCE MCINTYRE: I know.

CHAIRPERSON LOUIS: So there are a lot of legal aspects to this, and I would love to talk to you after the hearing to see what resources we can provide to you. Besides the bill, which we will fight and advocate for, it sounds like you need some additional restitution.

BRUCE MCINTYRE: Yes.

CHAIRPERSON LOUIS: With regards to what happened to you over time. And I'm very sorry that you went through all of those obstacles while going through everything that you were already going through.

So, I would love to talk to you afterwards to see what additional resources and support we can provide to you.

BRUCE MCINTYRE: Of course, thank you.

CHAIRPERSON NARCISSE: We hear you.

BRUCE MCINTYRE: Thank you.

CHAIRPERSON NARCISSE: Like, we said, we can see you, we hear you, and thank you for sharing. My colleague, Jennifer, anything?

COUNCIL MEMBER GUTIÉRREZ: (UN-MIC'D) Thank you so much for your advocacy (INAUDIBLE)

CHAIRPERSON NARCISSE: Thank you.

BRUCE MCINTYRE: Of course, thank you.

CHAIRPERSON NARCISSE: Thank you.

The next panel is Lacey Tauber, Judith Cutchin, and Elizabeth Grellier.

(PAUSE)

LACEY TAUBER: Hi, everyone.

CHAIRPERSON NARCISSE: You may begin, thank you.

LACEY TAUBER: Thanks, it is really hard to follow that. So, I just wanted to say thank you to the two previous speakers for their advocacy.

And I also want to thank you all for holding this hearing today and calling attention to this issue. I don’t think it’s a coincidence that we’ve got three female council members from Brooklyn at the dais right now, especially because four out of the five community districts with the highest rates of pregnancy-associated deaths are in Brooklyn. And that is why the Borough President, whom I'm here to represent today, has made this such a high priority for his work.

And we want to thank the Speaker for really always being a leader on this, our own Maternal Health Task Force, which, as Dr. Wilcox mentioned, she's a part of, as well as some other folks in this room, and also Tanisha, who's our Maternal Health Policy Analyst, who's here.

So I'm going to summarize our testimony for time. And I don't think I can add anything about how critical the NYPORTS data is. So, just wanted to say, you know, it's smart for the Council to put forward these resolutions calling for this data to be audited and readily available. And ultimately, the purpose of collecting this data is to inform choices about funding and programming that aim to improve outcomes.

We already know that the majority of pregnancy-associated deaths are preventable. And the Borough President really hopes to continue to partner with the council on a number of solutions, including investing in public hospitals; investing in fair wages and adequate staffing, so that people don’t feel that they need to leave the borough for access to quality care; and investing in midwifery care.

Maternity care provided by midwives has been associated with improved birth outcomes, fewer C-sections, lower preterm birth rates, lower episiotomy rates, and higher breastfeeding rates. However, Woodhull is the only Brooklyn public hospital, as you heard, that is really centered on

midwives in obstetric care, and the last one is expanding the perinatal mental health workforce.

Just quickly, this year, BP Reynoso was proud to announce a partnership with Brooklyn College to design and implement an advanced certificate in perinatal mental health, and just wants to keep working with the Council on this and other initiatives. Thank you so much.

DR. JUDITH CUTCHIN: Hello, my name is Dr. Judith Cutchin, and I am an elected First Vice President of the New York State Nurses Association. I have worked at Woodhull Hospital for over 34 years, where we provide high-quality healthcare coverage for all New Yorkers, regardless of their background and legal status or their ability to pay.

As frontline healthcare workers, we strongly support immediate action to address racial and economic inequities in care. We are especially outraged by the persistence of unacceptably high maternal mortality and morbidity rates for poorer mothers and for women of color.

We all know the statistics about maternal health in New York and across the US. I

don't need to go into detail. But we think it is unacceptable that the US maternal mortality rate is more than three times that of similar developed countries. And while New York State has made some progress, total rates of maternal mortality and morbidity remain high. In addition, it is alarming that in New York, the mortality rate for Black mothers is five times higher than that for white mothers. The State Department of Health admits that higher rates of harm suffered by Black mothers show longstanding health disparities resulting from inequitable care and systemic racism. The DOH also recognizes that racial disparities and access to quality care are a public health emergency.

As nurses, we know that maternal deaths and harms are almost entirely preventable with proper staffing, culturally sensitive care training, and funding. If we are going to fix this crisis, we need to have information and data. We need to assess the scope of the problem and the factors that cause it. That means that the State Department of Health must share its data with the New York City Health Department and the City Maternal Mortality and Morbidity Review Committee.

The State must also make sure that the data we are getting is accurate, timely, and detailed enough for us to begin (TIMER) to get this crisis under control.

For these reasons, we urge the City Council to pass Resolutions 1082, 1085, 1086, and 1087. Thank you for holding this hearing to address this (INAUDIBLE) and giving me the time to speak. Thank you.

CHAIRPERSON NARCISSE: Thank you. Next?

ELIZABETH GRELLIER: Good afternoon, Chairs and Members of the Committees on Hospitals and Women and Gender Equity. My name is Ebee (phonetic) Grellier, and I am the Government Affairs Operations Specialist at VNS Health, New York’s largest nonprofit home and community-based healthcare organization. Thank you for the opportunity to testify today and for holding this hearing on maternal health.

VNS Health helps New Yorkers live, age, and heal at home and in their communities. They are a Bronx Nurse Family Partnership. We support low-income, first-time mothers from early pregnancy through their child's second birthday. This work is

partially supported by the City Council's discretionary funds, and we're greatly appreciative to the Council for that.

While nurse home visiting is one of the most effective ways to improve maternal health, it works best alongside system-level measures that strengthen the continuum of care. Transparent data collection and coordination, like the Council has talked about today, as well as my fellow panelists, are essential to ensuring that our mothers receive the care they need. We want to highlight Resolutions 1085 and 1086, especially. Through our Nurse Family Partnership program, we have served more than 7,600 families in the Bronx since 2006, and that's 7,600 mothers that our nurses have worked extremely closely with. They know that adverse health effects for mothers happen both before the pregnancy and after the pregnancy, both before birth and after birth. Resolution 1085 takes those realities into account and makes sure that adverse maternal health effects and issues are taken into consideration.

As a home health agency, VNS Health has also seen firsthand how new occurrence codes can improve how health issues are tracked and addressed.

We appreciate Resolution 1086's use of existing technology to establish new occurrence codes and better identify and track adverse maternal outcomes.

We know that these resolutions may add additional administrative responsibilities, but all four proposed resolutions represent sound public health practice that we absolutely support.

We thank the Council for its ongoing leadership and investment in maternal health, including our nurse family partnership work. Thank you for the opportunity to provide testimony today.

CHAIRPERSON NARCISSE: Thank you.

I would like to disclose, full disclosure, that I work for Visiting Nurse Services and I work for H&H Elmhurst Hospital Emergency Room. So I just have to let it be (LAUGHS) (INAUDIBLE). So I'm not favoring it, but I want to say thank you for being here.

ELIZABETH GRELLIER: Thank you.

CHAIRPERSON NARCISSE: Thank you.

The next panel is Beth McGovern, Mia Wagner, and Sarah March. And if I butchered your name, you can kind of clarify for me. That’s all right.

BETH MCGOVERN: It's McGovern.

CHAIRPERSON NARCISSE: Thank you.

(PAUSE)

CHAIRPERSON NARCISSE: Sorry, you may begin.

BETH MCGOVERN: Good afternoon, Chairs Narcisse, Louis, and Members of the Committee, my name is Beth McGovern, and I serve as Associate Vice President, Quality and Clinical Initiatives at Greater New York Hospital Association (GNYHA). I am also a registered nurse with a Doctorate of Nursing Practice and certification in Inpatient Obstetrics. And I thank you for the opportunity to testify here today on maternal health.

Greater New York Hospital represents all hospitals in New York City, both public and not-for-profit, as well as many more throughout New York, New Jersey, Connecticut, and Rhode Island. We're proud to serve on Speaker Adams' Maternal Health Steering Committee with partners across the City and State.

We've all heard the statistics today; I don't need to repeat them, but we agree they're not acceptable. Black women die at a rate of 5.3 times higher than white women in New York City during and

after pregnancy. And these disparities persist regardless of income, education, or insurance, showing that they stem from systemic inequities. Hospitals provide most of the perinatal care in the state, especially for Medicaid and uninsured patients. And we know that one of the major issues in the care of this population is addressing social determinants of health. Approximately 80.3 birthing people experience at least one social and emotional stressor before, during, and after pregnancy. Many health challenges are tied to housing, food insecurity, transportation, and childcare.

Greater New York Hospital Association supports the state's social care networks under the 1115 Medicaid waiver to connect hospitals with community-based organizations to assist in mitigating these factors. But as we're all aware, we're worried about the federal cuts under the “One Big Beautiful Bill” Act that threatened to worsen these challenges and may force some hospitals to reduce their maternity care services.

I wanted to take a few minutes to highlight some of the initiatives that Greater New

York has been a part of with our partners throughout the city and state:

As mentioned earlier by Dr. Wilcox, we participate in the Safe Motherhood Initiative, which is a collaborative effort to address the leading causes of maternal mortality and morbidity.

We participate in the New York Perinatal Quality Collaborative NTSB Cesarean Reduction Project, which focuses on safely reducing primary cesarean sections, as well as looking at race and ethnic disparities that persist among cesarean delivery rates.

We've also been a part of the Hospital Doula Friendliness Project, and we support the Maternal Mortality Review Boards.

We're really asking for you to continue to partner with us to protect hospitals from federal funding cuts, strengthen Medicaid, and invest in the social safety net that's available.

Thank you for your leadership and the opportunity to testify today.

CHAIRPERSON NARCISSE: Thank you.

MIA WAGNER: Good afternoon, and thank you for the opportunity to testify. My name is Mia

Wagner, and I am Director of Health Policy at the Community Service Society of New York. CSS is a 180-year-old organization that aims to build a more equitable New York for low-and moderate-income individuals. Our health programs assist over 130,000 New Yorkers annually through a live answer helpline and partnerships with community-based organizations.

CSS supports the proposed resolutions to improve the reporting and tracking of adverse maternal health events in New York City, with several recommendations to enhance transparency and ensure thorough data collection. I've included those in detail in my written testimony.

We also have three other evidence-based recommendations to prevent maternal deaths that I haven't heard discussed yet today:

First, requiring all patients who have given birth in New York City to be discharged with an automatic blood pressure cuff. The 2025 report found that the second leading cause of pregnancy-associated deaths in the city was cardiovascular conditions. A national study found cardiac conditions make up over half of postpartum deaths occurring between 43 days

and one year after birth. The NIH found that the risk of postpartum cardiomyopathy is six times higher among Black women compared to white women. A previous New York City report included a table of the underlying causes of pregnancy-associated deaths by maternal race and ethnicity from 2016 to 2020. While the report finds that overall, the most common cause of pregnancy-associated death is mental health conditions, the most common cause of death for Black women was cardiovascular conditions, which was shielded in the overall findings. This new report did not have that breakdown, which is critically important to understand different outcomes. Sending patients home with an automatic blood pressure monitor is a proven method to catch postpartum hypertension early. It's cost-effective and leads to decreased emergency department visits.

Second, we're recommending that all patients with Medicaid who have given birth in the city be discharged with a (TIMER) scheduled home visit.

And lastly, we're asking that the City leverage its surveillance systems to document and

investigate near misses and preventable maternal deaths. Thank you.

CHAIRPERSON NARCISSE: Thank you. Next?

SARAH MARCH: Good afternoon, Chairs Narcisse and Louis. Thank you for the opportunity to testify today.

My name is Sarah March, and I am the Director of the Young Mothers Program for Samaritan Daytop Village. We serve pregnant and parenting women with mental health and substance use disorders and have been doing so for more than 50 years.

I'd first like to thank you for your leadership on maternal health and for the new funding supporting our program. Your investment recognizes that improving mental health must include mothers facing behavioral health and addiction challenges.

Across the city, overdose is now a leading cause of maternal death, and Black and Latino women remain far more likely to experience serious complications. Yet stigma continues to prevent too many mothers from seeking help for depression or addiction for fear of judgment or family separation.

Beyond these numbers lies a deeper barrier: stigma. Too many mothers fear that seeking

help for depression or addiction will lead to judgment or family separation. If we want to save lives, we must create a system where mothers are met with compassion, not punitive punishment.

We want to bring the Council's attention to City Hall's new maternal health initiatives, the Family Focus Maternal Behavioral Health Clinic at Lincoln Hospital, and the CRIB (Creating Real Impact at Birth), connecting 300 pregnant New Yorkers to housing. These are very important steps forward. As the City expands this work, we are urging health and hospitals and DOHMH to partner with community-based programs like the Young Mothers Program. We bring decades of experience, culturally responsive care, and lived experience that can strengthen clinical systems and ensure that no mother falls through the cracks.

Every day, we see our mothers rebuilding their lives, staying with their children, and returning to our community as strong, self-sufficient parents. With your continued partnership, New York City can become a national model for maternal health that treats every mother with dignity and compassion. Thank you.

CHAIRPERSON NARCISSE: Thank you so much. Do my colleagues have any questions?

So, I just want to say thank you for coming out to share your testimony with us. I appreciate you.

Thank you to all of you who came here to share your thoughts and experiences today. If there is anyone in the Chamber who wishes to speak but has not yet had the opportunity to do so, please raise your hand and fill out an appearance card with the Sergeant at Arms at the back of the room. Anyone else? I guess none.

Seeing no hands in this Chamber, we will now shift to the Zoom testimony. When your name is called, please wait until a member of our team unmutes you and the Sergeant at Arms indicates that you may begin.

We will start with Tori Newman Campbell.

SERGEANT AT ARMS: Starting time.

TORI NEWMAN CAMPBELL: Good afternoon, can you hear me?

SERGEANT AT ARMS: Yes.

TORI NEWMAN CAMPBELL: Good afternoon, can you hear me? Okay.

CHAIRPERSON NARCISSE: Yes, we can, thank you.

TORI NEWMAN CAMPBELL: Good Afternoon, Members of the City Council; my name is Tori Newman Campbell, and I am testifying on behalf of 1199SEIU.

1199SEIU would like to thank the City Council Committees on Hospitals and Women and Gender Equity for holding this hearing on this extremely important issue of maternal health in the city.

Many of the people who went before me have already highlighted many of the issues around maternal mortality and morbidity, particularly for women of color, so I will just summarize my testimony for the sake of time.

As a union representing many women of color working in healthcare, this issue is twofold for 1199. The vast majority of our members are women of color, so many have or will experience the joy of childbirth, along with the fear of knowing that they are at greater risk of complications.

From issues of access to affordable prenatal and perinatal care, discriminatory and

racist maternal care practices, and limited support for postpartum mental health, we must do more to ensure the experience of giving birth is positive and safe for all demographics. As healthcare workers, they face the daily struggle of providing care to low-income New Yorkers in settings that often struggle to recruit and retain needed staff and struggle to keep the doors open. With the increasing divestment from healthcare, such as the $1 trillion the federal government just stripped from Medicaid funding, workers are consistently being tasked to do more with less.

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

The City also needs to continue to prioritize the growth of the healthcare workforce, specifically for maternity care, so it looks more like the people being cared for. 1199 SEIU's Training and Employment Funds runs a Career Pathways program that works to support and empower New Yorkers to join the healthcare workforce by providing accessible, high-quality training...

SERGEANT AT ARMS: (INAUDIBLE) time.

TORI NEWMAN CAMPBELL: and educational opportunities at no cost. This program is made possible through collaboration at the state, federal, and city levels. And programs like this will help continue to strengthen the healthcare workforce.

I would like to thank you guys for your attention to this issue and for allowing me to testify here today.

CHAIRPERSON NARCISSE: And thank you for your time.

Next will be Eman Rimawi-Doster.

SERGEANT AT ARMS: Starting time.

EMAN RIMAWI-DOSTER: Hi, thank you so much. My name is Eman Rimawi-Doster. I was invited

to this hearing, and I wasn't sure I was going to be able to make it, so I also submitted my testimony.

I heard a lot of great information during this hearing. Still, I didn't hear enough information about accessibility and the training for medical providers to support more people with disabilities with chronic illnesses. Yes, mental health is super important, and so is chronic illness.

I am both Black and Palestinian. I have lupus, I have a heart issue, and I have a blood-clotting issue, I have a nerve damage issue, and I'm a double amputee. I also lost three pregnancies, and my second pregnancy caused me to become a double amputee 13 years ago when the doctors at Bellevue didn't listen to me at the time, which caused the blood clots to turn my feet black.

My third pregnancy was caught at six weeks—*six weeks*, which caused my doctors-- my heart doctors and my rheumatologist to suggest I get a DNC rather than continuing my pregnancy because of my heart. It was incredibly traumatic for me. And

they said that if I stayed pregnant, neither I nor my baby would survive.

The gynecologist that I saw after my procedure was incredibly nasty and insensitive towards me, and he had no care for me whatsoever. This was at New York Presbyterian; I lost my legs at Bellevue. Nothing was reported, and I was actually blamed for my treatment.

Not only do these trainings need to require more cultural sensitivity, but they also need to include disability sensitivity. There are over 116,000 parents who have given birth in New York City with disabilities, and we're not getting any of that support.

This also needs to be done in an intersectional way, and if there are language access needs, those also need to include ASL. Since I have active lupus and I've had it in my body for the last 26 years, I've gone through a number of issues with doctors and all these hospitals, and I've been seen a hospitals in Queens as well, which have also been awful.

It's amazing to me that the Mayor's Office for People with Disabilities isn't here, and

it's amazing that we're not speaking about this in a more intersectional, holistic way. Because yes, I am Black, I am Palestinian; I am also physically disabled, and I also have a chronic illness. And unfortunately, I won't ever be able to give birth because of the issues that I've had before. So I'm hoping that we're considered next time for this hearing, but also considered for the Hospital Committee (TIMER) since we are here, and we do give birth, and we are parents. So thank you so much.

CHAIRPERSON NARCISSE: You are so right. I am sitting here; I'm embarrassed not having touched on that. I promise you that the next time we work, we will think thoroughly and not leave anyone out. You matter, and everyone else in our world matters. So we have to pay attention and ask questions that address disabilities. Especially, I know about lupus firsthand, because I have a colleague who always talks about her struggle with lupus and any kind of disabilities. So, if you find that we did not address it enough, or we kind of fly over it, my apologies. So, thank you for your testimony, and thank you for your time. Advocates

like you make a difference in New York City. So, thank you again.

Next, we will hear from Alex Stein.

SERGEANT AT ARMS: Starting time.

(NO RESPONSE)

CHAIRPERSON NARCISSE: All right, moving forward, and I am so happy that this young lady was able to correct me on some aspects, and moving forward, we will look into it.

If you are currently on Zoom and wish to speak but have not yet had the opportunity to do so, please use the raise hand function, and our staff will unmute you.

(NO RESPONSES)

CHAIRPERSON NARCISSE: Seeing no hands, I would like to note that anyone can submit written testimony to testimony@council.nyc.gov for up to 72 hours after the close of this hearing.

To conclude, I am grateful to be part of a council that has taken action to address the maternal health crisis in this city. And I look forward to contributing to that work in the future. And all of you, I hope, just like this young lady who stood up and told us-- I would like to thank

everyone who has taken time to testify today. Thanks to healthcare professionals who take care of our fellow New Yorkers. And thank you to all of the staff, especially Rie Ogasawara, who has helped me so much, and all of my staff, for helping us to prepare for this hearing. I want to thank everyone. I know Josh is not here, but thank you, Josh.

And now I will turn it over to my colleague if she has any additional words to close.

CHAIRPERSON LOUIS: I just want to thank you, Co-Chair Narcisse, for partnering on this hearing today. It definitely provided us with a lot of information on what different folks are going through. And I know it is something that we can tackle with our colleagues.

I want to thank everybody who came out to testify today, whether digital or in person. And we look forward to continuing to work with you.

CHAIRPERSON NARCISSE: Thank you to my co-chair, Farah Louis, for being awesome as the Women and Gender Equity chair. It is very important to us. And thank you to Madam Speaker, who had to leave. She is very passionate about this, and, of course, we have been pushing forward with mental

health—any kind of disability. And most importantly, I want to say thank you to the Sergeants at Arms who keep everything flowing.

With that, I will close today's hearing.

[GAVEL]

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 no interest in the outcome of this matter.

Date November 15, 2025