NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

Dr. Leslie Hayes
Deputy Commissioner, Division of Family and Child Health
New York City Department of Health and Mental Hygiene

before the

New York City Council

Committee on Mental Health, Disabilities and Addiction
Committee on Women and Gender Equity
On

Oversight: Physical and Mental Health Supports for New and Expecting Parents

And

Int. 651-2024
Int. 867-2024
Int. 869-2024
Int. 890-2024
Int. 891-2024
Int. 892-2024
Int. 893-2024
Int. 912-2024

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Good morning, Chairs Lee, Louis, and members of the Committees. I am Dr. Leslie Hayes, Deputy Commissioner for Family and Child Health at the New York City Department of Health and Mental Hygiene (the Health Department). Thank you for the opportunity to testify today. I am pleased to be here with my colleagues Marnie Davidoff, Assistant Commissioner for Children, Youth, and Families; Laura Louison, Assistant Commissioner for Maternal, Infant, and Reproductive Health; Dr. Zahirah McNatt, Assistant Commissioner for Brooklyn Neighborhood Health; and Carlos Ortiz, Deputy Commissioner for External Affairs from the Department of Consumer and Worker Protection, to discuss the Health Department's role in supporting the health, wellbeing, and mental health of expecting and new parents in New York City.

As the Council is aware, HealthyNYC is the City's vision for how to improve life expectancy and create a healthier city for all. The Health Department is working with partners across the city to ensure New Yorkers are able to realize their full health potential, regardless of who they are, where they are from and where they live. Supporting the health of birthing people is a critical aspect of this work. Extreme racial disparities persist in maternal mortality. Black birthing people are four times more likely than their White counterparts to die from pregnancy-associated causes. Our goal is to address this disparity by reducing maternal death rates among Black birthing people by 10% by 2030. This guides our strategies for health promotion of birthing people and their families.

The Health Department is focused on ensuring that every child, birthing person, and family recognize their power and is given the opportunity to reach their full health and development potential. This requires access to comprehensive, respectful care and accurate health information to empower families to make healthy choices.

The Department offers a number of programs that support the health of families who are expecting or have young children. The **New Family Home Visits Initiative (NFVI)** provides citywide access to high quality home visiting services for new families with a focus on maternal mental health, chronic disease and early childhood development. The Initiative prioritizes first-time families in Taskforce on Racial Equity and Inclusion (TRIE) neighborhoods, those who live in NYCHA in these neighborhoods, and those who are engaged with the Administration for Children's Services (ACS).

NFHV home visiting programs include the **Nurse-Family Partnership**, which is an evidence-based home visiting program that connects first-time expectant parents with trained nurses to promote healthy pregnancy outcomes, child development, and economic self-sufficiency and independence. We also have the **Newborn Home Visiting Program** which was significantly expanded over the last few years. Newborn Home Visiting provides educational home visits conducted by community health workers to address health needs, safe homes, and safe sleep support, and connects families to social services that are essential to the well-being of parents, children, and families. Home visitors are part of a a multi-disciplinary approach supported by nurses, lactation consultants, and social workers, as well as referrals to ongoing external clinical services.

The third component of NFHV is the **Citywide Doula Initiative (CDI)**, launched in 2022 to increase access to no-cost doula care to promote critical birth support at a sustainable wage for doulas. The initiative develops and sustains the doula workforce in NYC with free doula training for community residents, an apprenticeship program for new doulas, and a fair wage to doulas for time spent in professional development and program meetings. Trained doulas support families in planning for childbirth and welcoming their newborn. They also provide education, screening, and referrals on infant feeding, safe sleep, bonding and child development, mental health, chronic disease, community health, and social services, to provide a well-rounded array of support for families. Our hope is that the CDI becomes a replicable model for cities and states seeking to reduce inequities in perinatal health outcomes.

The CDI also supports hospitals in creating doula-friendly environments through a collaboration with the Maternity Hospital Quality Improvement Network (MHQIN). MHQIN is a clinical-community initiative that focuses on enhancing clinical awareness and practice change; elevating community voices and power; and supporting antiracist hospital systems. MHQIN collaborates with community-based doula programs and maternity hospitals to integrate doulas into the maternity care team.

Additionally, the NYC Health Department's Action Centers offer an array of services dedicated to reducing health inequities and improving health outcomes of New Yorkers. Family Wellness Suites, located at Action Centers in Tremont, East Harlem and Brownsville provide welcoming physical spaces for families and babies to receive services, health education and community resources. The suites offer programs such as: birthing classes, breast feeding support, childbirth education, newborn care classes, parenting classes, infant massages, reproductive health workshops and referrals to social services.

Additional services offered at the Action Centers include fitness classes, nutrition and cooking classes, parenting workshop series, evidenced-based diabetes workshops, introduction to therapy and referrals to culturally congruent mental health providers. These Family Wellness Suites are staffed by community health workers, lactation counselors, social workers, and other public health professionals. Our Family Wellness Suites are integral to disrupting systemic inequities and are part of the City's plan to prioritize maternal and infant health. These suites help to give parents-to-be the skills they need to thrive on their journey and the strongest start for their babies before and after their birth.

Another important pillar of our work is promoting access to comprehensive and respectful reproductive healthcare, which also is critical to family health. The **Abortion Access Hub** is a cornerstone of the City's effort to ensure abortion access. The Hub is a small, confidential call center at the Health Department accessed either through 311, or by phone at 1-877-NYC-AHUB. The Hub assesses caller needs and provides referrals for abortion care in New York City. This is one of the many ways we provide outreach, education, support, and services regarding contraception, reproductive health care, abortion, and family planning.

Supporting the mental health of birthing people is also critical. To effectively promote the mental health and development of children and youth, we must also make sure the caring adults in their lives are receiving the mental health and substance use care they need. Mental health conditions (suicide and overdose) are also the leading cause of death for pregnant and postpartum people in NYC. Addressing mental health conditions is central to promoting healthy maternal health outcomes. Access to mental health and substance use care that is stigma free and supports people during pregnancy and as parents is critical.

The Health Department is scaling up our investments in this area. We recently launched the **Perinatal Mental Health Initiative,** which supports training and capacity building for Health Department teams who serve pregnant and birthing people (such as - home visitors, doulas, nurses, and social workers) to improve their ability to recognize and respond to mental health and substance use needs. We have expanded the capacity of the Early Childhood Mental Health Network to provide perinatal mental health support to new and expecting parents. We've also begun to provide social work services through the New Family Home Visits Initiative. These social workers incorporate case management and referral to mental health care into newborn home visits. Additionally, the Nurse Family Partnership social workers provide up to 15 sessions of short-term therapy and connect patients with long-term mental health care.

I'll now discuss the foundation for the Health Department's current strategies in promoting the health of birthing people. The **Maternal Mortality Review Committee (MMRC)** monitors maternal health outcomes throughout the city. Structural racism and inequities in care, access, and quality contribute to extreme inequity. The *Maternal Mortality and Severe Morbidity Surveillance Reports* document the crisis

of inequities in maternal health and the Committee uses this information to provide recommendations to address them.

The Health Department reports on maternal mortality and morbidity data annually every September, in accordance with Local Law 188. This September, we will release a report covering the 5-year period from 2016 to 2020. The Health Department will also release the annual updated data and new review committee recommendations based on deaths in 2021. We will hold a symposium to discuss these findings and promote the work needed to achieve the HealthyNYC 2030 goal.

I want to share some examples of the kinds of recommendations the MMRC makes. Based on the review of 2020 deaths, the Committee selected 11 priority recommendations related to the top causes of death of Black and Latina women and birthing people. These 11 Committee recommendations are a citywide call-to-action for systems, facilities, providers, and communities working to eliminate preventable maternal mortality and end racial/ethnic disparities in these deaths. These recommendations include training around anti-stigma; racialized and class-based responses to behavioral health disorders for providers who treat substance use or mental health disorders; patient-centered changes and oversights mechanisms for facilities; and community-based education and outreach around health implications of chronic illness in pregnancy and postpartum periods.

Before we answer your questions, I'd like to briefly discuss the legislation being heard today.

Introduction 651 relates to the creation and distribution of pamphlets identifying mental health resources available to individuals experiencing pregnancy loss. The Health Department agrees with the intent of supporting the mental health of birthing people at any stage in their life and appreciates Councilmember Riley's attention to this topic. We are grateful for the dialogue with Councilmember Riley and his staff. We look forward to continuing our conversation to work on the bill draft and provide information on mental health resources in a sensitive and impactful manner.

Introduction 867 relates to prohibiting the sale of menstrual and intimate care products that contain unsafe ingredients. Our colleagues at the Department of Consumer and Worker Protection would be tasked with enforcing this legislation; we defer to them on the enforcement piece of the bill. The Health Department does not have the expertise to determine which products or chemicals are unsafe — these products are regulated by the federal government. We would like to discuss this legislation further with the Council and our partner agencies.

Introduction 869 relates to the Mayors Office of Community Mental Health (OCMH) providing a public campaign on parental mental health resources. The Administration is supportive of the goals of this legislation in ensuring new parents know what resources are available to them.

Introduction 890 relates to the establishment of a pilot postpartum support group program. The Health Department supports the intent of the legislation. We are always exploring innovative ways to promote the health and wellbeing of birthing people. Support groups generally can be great resources and sources of validation and support for people experiencing challenging periods of life – which postpartum can sometimes be. We do want to note that the Department maintains several programs related to maternal and parental support, including the Council-funded Healthy Women, Healthy Futures program, which includes postpartum doula support. We also offer breastfeeding support groups, as well as 1-1 consultations during pregnancy and the postpartum period. Additionally, we have several programs that support individuals' mental health during the postpartum period, several parenting support groups, and group-based support through Nurse-Family Partnership and Newborn Home Visiting. We would like to have a further conversation with Council on the scope of this legislation. As written, this bill would require contracting with a community-based organization to provide clinical aspects in a manner beyond the scope of the

multiple, existing programs DOHMH maintains to support mothers during pregnancy and the postpartum period.

Introduction 891 relates to the maternal mortality and morbidity review committee. As previously mentioned, the Health Department's annual maternal mortality and severe morbidity surveillance report already captures the activities of the review committee. We are unsure of the intent behind posting the names of such review committee members online and would want to ensure those individuals provide consent to have their names published. We look forward to working with the Council on the specifics of this bill.

Introduction 892 relates to employers posting their lactation accommodation policies online. The Administration supports the intent of this legislation to increase employee awareness of their rights but would suggest a more flexible approach so that employers can effectively reach their employees.

Introduction 893 relates to establishing a screening program for endometriosis and polycystic ovarian syndrome (PCOS). The Health Department supports reproductive health care, health literacy, and preventative services for PCOS and Endometriosis. We have concerns with this bill for the following reasons: it is not clinically appropriate or possible to "screen" for endometriosis or PCOS as described in this bill. This bill proposes a "screening" program; however, a "screening" is done when there are no presenting symptoms. These conditions require diagnostic tests. PCOS diagnosis may require multiple specialist visits, blood tests, and ultrasounds. Diagnosis requires a clinical team approach because there is not a singular test. Endometriosis diagnosis also may require multiple visits, imaging tests, and surgery. The Health Department does not provide the clinical diagnostic and treatment services required and is not the appropriate entity to house such a program. A diagnostic program as proposed would need to be conducted by a health care facility or hospital.

The Health Department does promote public education regarding endometriosis, PCOS, and other reproductive health conditions. Our website provides information about these two conditions and their symptoms. The webpage includes links to find clinicians to help diagnose and manage these conditions, as mandated by Council. We actively provide outreach, education, support, and services on reproductive health, contraception, abortion, family planning, HIV and STI testing, prevention, and treatment. This includes related health education to individuals with low incomes, who are undocumented, and/or without insurance through our Sexual Health Clinics, Abortion Access Hub, and NYC Teens Connection.

Introduction 912 relates to requiring the department of social services to develop parenting resource materials and the Health Department to distribute such materials to new parents and guardians. The Health Department already includes health and safety resources for parents in mailings of newborn birth certificates. We would like to have further discussions with Council on the scope of this legislation and the most appropriate way to reach new parents and guardians to provide this information.

The Health Department remains committed to promoting the health and wellbeing of birthing people and their families. Thank you for the opportunity to be here today to address this important topic. We look forward to answering your questions.

JUMAANE D. WILLIAMS

STATEMENT OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEE ON
WOMEN AND GENDER EQUITY JOINTLY WITH COMMITTEE ON MENTAL HEALTH, DISABILITIES, AND ADDICTION
June 25, 2024

Good morning,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. Thank you very much to Chairs Louis and Lee and members of the Committee on Women and Gender Equity & Committee on Mental Health, Disabilities and Addiction for holding this hearing and allowing me the opportunity to provide a statement.

New parents need support and resources to build healthy thriving families. This is why I have introduced Intro 974 which requires the department of health and mental hygiene to create a training program for providers of pregnancy and postpartum-related services informing patients about perinatal mood and anxiety disorders. People can't receive the necessary help if their conditions aren't being accurately diagnosed. This is true of all health conditions, but women of more color are five times as likely to die from pregnancy related outcomes as their white counterparts.[1] Two pieces of legislation introduced by Council Member Gutiérrez would have a huge impact on many new parents or guardians, especially their ability to take care of themselves. Intro 869 introduced by would establish and implement a public outreach and education campaign to raise awareness about resources available addressing mental health challenges faced by parents. Many parents, especially in immigrant communities and communities of more color may be unaware of existing resources. Intro 912 would require the department of social services to develop parenting resource materials and the department of health and mental hygiene to distribute such materials to new parents and guardians. People cannot access resources they aren't aware exist. Making such materials available is only one part, we must also ensure new families know how to access programs and services, and where to find them. To this end, Intro 890 introduced by Chair Lee implements a three-year pilot program to establish postpartum support groups. This legislation requires specific focus on areas with the highest rates of postpartum mental health issues, and at least one group established in each of the three community districts with the highest risk factors for social determinants of poor mental health. This focus on the most impacted and already underserved communities is an essential step to help push towards equity of resources for families in New York City.

In 2016, the Council passed two bills, Local Law 82 and Local Law 83. Local Law 82 required the Department of Correction to provide menstrual hygiene products to all female incarcerated individuals. The second, Local Law 83 required the provision of feminine hygiene products to shelters to meet the needs of residents. It is even more significant today to continue this discussion. We have witnessed

[1] https://www.health.ny.gov/press/releases/2024/2024-03-14_maternal_mortality.htm

Republican legislators in Idaho blocking a bill that provides free menstrual products to public school students.[2] In Florida, Republican legislators are introducing a bill that will ban learning about menstruation and having any discussion about it in schools.[3] This is horrifying and absurd. It is our duty to always fight on this matter and speak about it.

The lack of access to menstrual products can cause discomfort and emotional distress as well as lead to dangerous health outcomes. New Yorkers should not have to pick and choose whether they will be buying food or menstrual hygiene products, and period poverty impacts many New Yorkers. When people are provided or buy these products, it is essential they are made safely, without any dangerous fillers. Intro 867 by Council Member Farías would prohibit the sale, offer for sale, and distribution of menstrual products or intimate care products that contain ingredients harmful to human health, including specified chemicals and fragrances. All people who menstruate should be safe from harm from using a basic hygiene product. Confidence in the safety of using necessary menstrual products is vital, but people who menstruate also face risk in taking time off from the sometimes pain and discomfort that can be associated with menstruation. For young people experiencing severe discomfort the decision can be between going to school too unwell to learn, and truancy. I applaud Chair Louis for introducing Res 0409 which calls on the New York City Department of Education to permit students excused absences while experiencing symptoms of menstrual disorders.

As a parent myself, I know how much effort and support are needed to raise healthy families, and I am grateful to the New York City Council for holding this important conversation today.

Thank you.

[2] https://thehill.com/homenews/state-watch/3916205-idaho-republicans-block-woke-free-tampons-in-schools-proposal/
[3] https://www.washingtonpost.com/politics/2023/03/17/florida-bill-girls-periods-school-gop/

OFFICE OF THE BROOKLYN BOROUGH PRESIDENT

ANTONIO REYNOSO
Brooklyn Borough President

City Council Committees on Women and Gender Equity and Mental Health, Disabilities, and Addiction
Oversight Hearing: Physical and Mental Health Supports for New and Expecting Parents
6.25.24

Good afternoon Chair Louis and Chair Lee, and thank you for holding this valuable hearing today. I am Brooklyn Borough President Antonio Reynoso, and maternal health is one of my top priorities. Brooklyn is one of the boroughs that consistently sees the highest rates of pregnancy-related deaths and morbidity, and it is time that we reversed this. Fortunately, 78% of pregnancy-related deaths are preventable, and mental health-related deaths are 100% preventable. It is no coincidence that the first majority female City Council is shining a spotlight on this long-overlooked issue, and I would like to thank my Council colleagues for putting forth these proposals to begin to make the changes we need. The proposals on the table are an important step forward to ensuring that all pregnant New Yorkers have access to mental health care. At the same time, I want to ensure that we are investing in equity by making our public hospital system the best they can be and ensuring a high quality of care for pregnant patients. We must also invest in the birthing teams at our public hospitals, including midwives, obstetricians, and nurses, by providing a salary that reflects the critical work they do for our city.

I want to focus on my testimony today on a few key proposals: Intros 912 and 869, and Resolutions 402, 403, 404, and 405. I also want to share concerns about Resolution 299.

Intros 912 and 869:
Intro 912, or the Newborn Navigator Act, which I had the pleasure of working on with Councilmember Gutierrez, calls for the creation of targeted resources to support maternal health and connect people to available services. Currently, there is a lack of readily accessible resources to support expecting and new parents, and diverse levels of linguistic and digital literacy complicate this further. The Newborn Navigator Act will allow for the equitable distribution of resources so that every parent has access to the same information before and after childbirth.

Because mental health supports are critical for new parents, I suggest adding resources focused on mental health screening, identification, care, and treatment. According to the The New York State Report of Pregnancy-Associated Deaths in 2018, mental health conditions are the third leading cause of pregnancy-related deaths statewide. In New York City, such conditions were among the leading causes of maternal deaths between 2016-2020. Available data regarding pregnancy-associated deaths during this time shows that 23.3% of deaths were attributed to

mental health, which the DOHMH defines to include suicide and overdose. For this reason, I also support Intro 869, which would create a public outreach campaign on parental mental health.

Two important provisions of Intro 912 leave implementation to DSS, and I would like to make specific recommendations for them. In consulting with various agencies and community-based organizations to develop materials, it is critical that they include people who have first-hand experiences with birthing people. DOHMH should create a working group to determine the full scope of the materials to be included, including topic-specific sub-committees.

Additionally, the bill includes creation of a searchable database of information on City-contracted community-based organizations supporting maternal healthcare. In addition to what the bill language now requires, this site should incorporate the ability to search for organizations based on payment requirements, and should include hours of operation, contact information, and insurances accepted (if applicable). Parents as well as providers should be able to print each listing into an easy-to-read document, which will also enable providers to provide efficient resource referrals. This website should have language translation in multiple languages and include links to the materials developed as a part of the resource campaign. Users should also be able to create personalized accounts where they can save organization profiles and relevant resources.

Res 402

Implementing a standardized maternal mental health quality management program would expand access to quality care, improve rates for providers, and incentivize providers to expand the available of essential services to pregnant and postpartum New Yorkers.

Ensuring that pregnant and postpartum patients, especially those who have experienced racism, violence, and exclusion at the hands of the medical establishment, are screened and can access quality and affordable care is a necessary step to reducing maternal mortality and morbidity. In 2022, the California state legislature similarly passed SB 1207, requiring health insurance plans to create a measure to promote high quality and affordable care to include screening, diagnosis, treatment and referral for maternal mental health services – including provider training incentives and enrollee outreach – a model that New York State should replicate.

This measure should work hand-in-hand with initiatives to increase Medicaid reimbursement rates for mental health providers and to increase the pool of perinatal psychiatrists and psychiatric nurse practitioners.

Res 403

One of the primary reasons why people who are pregnant or postpartum are not getting the care they need is due to the sheer lack of clinicians with prescriptive powers, such as perinatal psychiatrists and psychiatric nurse practitioners, who treat these groups. According to the American Hospital Association, 75% of birthing people diagnosed with Maternal Mental Health disorders do not receive treatment in part due to the shortage of mental health practitioners who treat pregnant patients.

Another structural issue facing the fields of perinatal psychiatry and psychiatric nursing is a lack of diversity. The maternal mental health crisis is multifaceted and has its roots in historical and contemporary forms of oppression that disproportionately impact Black and Brown birthing people; it is one that can no longer be ignored. Studies indicate that diversity and representation are not simply a matter of affirmation. They have decisive repercussions on the experiences and well-being of individuals and communities.

Despite 2016-2020 maternal mortality review reports showing that an average of 47.36% of maternal deaths were Black, Black psychiatrists make up only 2% of the profession, while only 10.4% of all psychiatrists are Black, Latino, or Native American. The psychiatric nurse practitioner workforce faces many of the same issues with racial and ethnic diversity as psychiatrists. At 77.5% White, 6.7% Latino or Hispanic, 6.3% Asian, and 4.7% Black, the psychiatric nurse practitioner profession is overly homogenous in terms of both New York City's population and the United States' population as a whole. Both providers and patients of color seeking mental healthcare services can face a lack of representation, microaggressions, medical racism, unconscious bias, and other forms of discrimination.

Resolution 403 brings attention to the critical lack of perinatal psychiatrists in New York City. There are currently only 19 perinatal psychiatric fellowships in the entire country. New York City houses three of these programs in private institutions, including NYU, Columbia and Weill Cornell, with no programs housed in public institutions. With one in five people experiencing mental health concerns while pregnant or in their postpartum period, the lack of programs leads to deadly outcomes for pregnant people.

Requiring all accredited psychiatry residency programs to offer a one-year, post-residency fellowship program focused on Perinatal Mental Health would be a positive first step in ensuring access to highly-needed, specialized training. However, there are several related considerations that I would like to highlight for any potential legislation:

1. *Financial Sustainability* – The State should create a plan for dedicated and sustained investment to ensure that fellows have a strong compensation and benefit structure allowing for pay parity with their peers in existing programs. (Currently, Weill Cornell's Perinatal and Infant Psychiatry Fellowship offers a base salary of $145,000.)
2. *Diversity* – The fellowship should incorporate measures to increase diversity among applicants from racial, ethnic, and linguistic backgrounds reflecting the communities most impacted by maternal mortality.
3. *Post-Fellowship Employment* - To meaningfully address maternal mortality and morbidity, the legislation should build in provisions to ensure that fellows completing the program work in communities that are most disproportionately impacted by the crisis, namely Black and Brown neighborhoods. This can include strengthening the psychiatrist employment and residency pipeline within our public hospital system, as well as offering other employment incentives.
4. *Infrastructure* - There are currently only three general psychiatric residencies in Health + Hospitals, which limits the opportunities for building a fellowship pipeline from the public hospital system. In order to do so, more funding must be invested in Health + Hospitals

to increase the number of psychiatrists, and therefore psychiatric preceptors, to train psychiatric residents who can understand the nuanced needs of diverse and historically underserved communities.

5. *Reporting* – Fellowship programs should incorporate reporting on fellow demographics and post-employment statistics, including the communities where fellows work.

Another consideration is expanding access to perinatal mental health training for Psychiatric Nurse Practitioners (pych NPs) through similar fellowship programs; unfortunately, data on the number of psychiatric nurse practitioners who center their work on pregnant and postpartum populations is not publicly available, which makes it difficult to identify the number of psych NPs focusing on maternal health.

Res 404 and 405

In 2018, the New York State Maternal Mortality Review Board deemed that all pregnancy associated deaths due to mental health problems were preventable. According to the 2020 Healthcare Effectiveness and Information Set (HEDIS) analysis, nationally, less than 20% of privately insured and Medicaid patients were screened for prenatal and postnatal maternal mental depression, with only 16% of Medicaid patients screened and given follow-up care during pregnancy and 17% in postpartum. This disparity leads to the majority, between 50% and 70%, of maternal mental health disorders remaining undiagnosed, making preventative intervention more difficult.

Res 404 and 405, which call for integrating maternal mental health screenings into routine OB/GYN perinatal care and Medicaid to cover those screenings, along with proper reporting of depression screening data, would ensure that preventative measures are provided throughout the pregnancy and the postpartum period. Together with the NYS legislature's recent passage of S.2039-B/A.2870 to require the NYS Health Commissioner, in consultation with stakeholders, to release guidance and standards for incorporating maternal depression screenings into routine perinatal care, there is a clear focus on centering screenings related to prenatal and postpartum depression. While perinatal depression occurs in 10-15% of prenatal and postpartum women, perinatal mood and anxiety disorders also affect approximately 20% of pregnant women and new mothers. Depression and anxiety disorders are highly comorbid, with over 40% of individuals experiencing depression and an anxiety disorder at the same time. Anxiety can also be a symptom of major clinical depression or lead to depression at a later time. Therefore, in addition to ensuring the incorporation of depression screenings into perinatal visits, the resolutions should also call for the incorporation of anxiety screenings such as the GAD-7 into routine perinatal visits, with the appropriate reporting and Medicaid coverage.

Res 229

High-quality midwifery birth centers enable a birthing process that emphasizes respect, autonomy, and informed decision-making in a community setting. According to a Giving Voices to Mothers survey, women and birthing people cared for at birth centers have starkly better experiences, including more time spent and less cases of medical mistreatment; they were also 14 times more likely to report having enough time for prenatal visits. Midwifery birth centers improve autonomy, improve prenatal care outcomes, and reduce c-section rates for low-

risk women and birthing people when proper measures are put in the place to ensure high-quality care, safe and proper staffing, safe birthing environments, and proper hospital transfers when needed.

However, I do not support Res 229 because I am concerned that it reverses the original intention of the amended midwifery center bill (S.1414-A/A.259-A of 2021), which was to create a more robust licensure review process, by removing Commission for the Accreditation of Birth Centers (CABC) as the singular pathway to obtaining a license. This bill not only ensures that national, evidence-based standards of care are met through CABC accreditation, but that by undergoing a Certificate of Need (CON) review process, the facility meets New York State standards for safe and high-quality healthcare facilities and is eligible for Medicaid billing, increasing access for low-income communities. It is important to ensure that facilities for out-of-hospital births exercise best practices to ensure that the environment is safe and clinical staff are experienced and highly qualified to create a safe birthing experience; patient safety cannot be compromised for efficiency.

This resolution should be discussed in partnership New York Midwives and NYC Midwives, who have been spearheading efforts to open up safe and high-quality midwifery birth centers on the state level. I also support a resolution to call for a midwife to be appointed to serve on the Public Health and Health Planning Council (PHHNC), especially if they will review midwifery birth center CONs; currently membership and vacancies do not include midwives.

Thank you again for the opportunity to testify and for this Council's work in reversing the maternal mortality crisis. It is important that we continue to assess the recommendations from the New York City and New York State Maternal Mortality and Morbidity Review Committees' annual and five-year reports to develop evidence-based policy changes. My Maternal Health Taskforce and I look forward to continuing working with you to make Brooklyn -- and NYC -- the safest place to give birth.

Testimony of Bronx Borough President Vanessa L. Gibson
New York City Council Committee on Women and Gender Equity
Jointly with the Committee on Mental Health, Disabilities and Addiction
June 25, 2024

Thank you, Chairs Louis and Lee and the members of the Women and Gender Equity and Mental Health, Disabilities, and Addiction Committees for convening this important hearing to address women's health as it relates to physical and mental support for expectant parents, maternal mortality and morbidity, and menstrual hygiene.

Our borough of The Bronx is one of two epicenters of maternal mortality in New York State. When analyzing the issues around maternal mortality and morbidity, it is clear this is a healthcare crisis rooted in racial discrimination and bias. We cannot turn a blind eye to the systemic racism and bias that has historically plagued our healthcare system and contributes to disproportionately negative health outcomes.

As women of color, this issue is very personal to both me and our Deputy Borough President. Our administration is committed to advocating for more equitable access to care, with an emphasis on incorporating culturally competent care practices into new and changing maternal health programs and policies in the borough. Today, I am proud to join with my colleagues in the City Council in support of a series of bills and resolutions that aim to improve access to vital maternal and reproductive health resources and continued conversations to understand the impact of this legislation on the birthing community.

Resolution 229 aims to ease the systemic barriers to opening birth centers in New York City and State. My team has spent nearly two years researching and understanding the landscape of birthing centers in our city, including funding, operational models, and licensure processes, as well as envisioning how a birthing center in The Bronx could provide diverse options of care and wraparound services for birthing persons. I look forward to seeing birthing centers open in The Bronx, and I believe that enacting new regulations as this resolution calls for is a strong step towards achieving that goal. I commend Councilmember Gale Brewer for her leadership on this issue.

Birth centers are one part of a strategy to offer Bronx women professional birthing services at low or no cost in a Culturally Competent Care Model. Recently, Governor Kathy Hochul visited The Bronx and hosted a maternal health roundtable with maternal health advocates and elected officials, including myself, Councilmember Pierina Sanchez, and Assemblymember Yudelka Tapia. The Governor committed $8 million in capital funding to expand the Morris Heights Health Center with an all-inclusive Maternal Health Center of Excellence, and we look forward to partnering with the state on further initiatives to improve maternal and infant health.

Resolution 402 calls for health insurance to plans develop and implement a comprehensive maternal mental health quality management program. Mental health conditions including substance use disorder are among the leading underlying causes of pregnancy-associated deaths. It is critical that we prioritize integration of mental health services into the overall healthcare system to help reduce the incidence of untreated mental health conditions and support

a healthier family dynamic. Pregnant women are counting on us to help provide them with the opportunities to find the treatment that they need to ensure a safe and healthy pregnancy.

I commend the city and statewide efforts to improve maternal health. I thank Governor Hochul for signing a law creating a state doula directory as well as allocating $4.5 million to support the state's Regional Perinatal Centers to provide high-level perinatal and infant care throughout the state. The State Health Commissioner has also issued a standing order which will expand access to much-needed doula services for birthing people across the state.

However, we must do more to ensure all birthing persons regardless of their race or background have access to culturally competent and patient-centered care. In addition to bringing more diverse health professionals such as doulas and midwives into the care delivery infrastructure, we must also increase public health campaigns promoting information regarding breastfeeding, providing affordable access to baby items such as diapers and formula, and other supportive resources to help mothers and their infants maintain healthy and happy lives.

Intro 893 would require the Department of Health and Mental Hygiene (DOHMH) to establish a menstrual health program that would offer screenings for endometriosis and polycystic ovarian syndrome to patients displaying symptoms of these disorders. I urge the Council to also include fibroids in this legislation. We must raise awareness of the need to provide improved care for individuals with uterine fibroids, a condition which is underfunded and overlooked in research. Approximately 26 million Americans ages 15 to 50 have fibroids, making it one of the most common gynecological conditions nationwide and a growing and overlooked public health issue. This is also an issue that disproportionately affects Black women, who are more likely to be diagnosed with fibroids.

Thank you to Chair Louis and Lee and the members of the New York City Council for prioritizing this important issue. Together, we will strengthen our commitment to supporting healthy pregnancies, improving women's health, and increasing access to wraparound services as part of the healthcare infrastructure. I urge the Council to pass the legislation under consideration to achieve better health outcomes for all women in our city.

Res 0229-2024 - *By Council Members Brewer and Schulman - Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation to ease systemic barriers in opening birth centers in New York City and New York State.*

I am grateful for the support of the city council members advocating for free standing birthing center facilities as an alternative to a hospital delivery. Birth centers are midwifery led and have demonstrated safe, quality care, better outcomes, lower cost, and high patient satisfaction. There are still challenges and barriers to birth center integration in the healthcare delivery system, however this resolution misrepresents the achievements that have advanced birth centers and midwifery birth centers in NY. Its passage will be a detriment to the advancement of the birth center model of care. Please consider this testimony as evidence of the misinformation presented in this resolution. I do not support passage of this resolution.

I write this as an experienced birth center administrator and consultant to birth center owners across the United States. Between 2012-2016, I was the Executive Director and CEO of the Brooklyn Birthing Center, the only licensed and accredited birth center in NY. I was elected to the National Board of the American Association of Birth Centers and dedicated 10 years to Committees developing standards, government regulations, insurance industry relations, and advocating for birth centers to Medicaid, business coalitions and stakeholders nationally. In my consulting, CEO of Integral Healthcare for Women, I have represented clients opening birth centers in over a dozen states, including states with certificate of need requirements. I was appointed to the Committee reviewing the Midwifery Birth Center (MWBC) proposed regulations by DOH in 2016. Additionally, due to Covid, in March of 2020, I co-founded the Jazz Birth Center in Midtown, converting a hotel into a birth center, under emergency regulations allowing operators to open temporary facility extensions to keep people outside of the hospital. Within 3 weeks of submission, I had an approval from DOH and a written transfer agreement with Mt. Sinai.

The Resolution lacks the understanding and the intent of the MWBC regulations thereby potentially causing confusion and delay:

To recap, the primary purpose of MWBC S.1414-A/A.259-A was to remove the requirement of a physician as the Medical Director and allow midwives instead. The other considerations were relative to streamlining the process, decreasing barriers, and lessening the cost of application. In her press release of Jan 2, 2022, Gov Hochul said Legislation S.1414A/A.259 will provide a streamlined process for an operating certificate as an Article 28 facility for a midwifery birth center which is accredited by a recognized accrediting organization. She *amended* the Midwifery birth center bill at the final hour removing CABC as the named accreditation body or identifying any third-party accrediting body because it is under the discretion of DOH whether to relinquish its site approval inspections to an outside agency, and which one.

Accreditation is NOT allowed as a singular pathway to obtaining a license. The only path of licensing in NY for either a birth center or midwifery birth center facility is an Article 28 application under the Department of Health which entails applicants show their ability to cover the costs of funding, renovation, construction, and the ability to meet safety standards at the time they submit their request for a particular building location intended for use as a birthing center because it is an existing standard in place for hospitals and all Article 28 facilities. Further, there must be a ruling by the New York State's Public Health and Health Planning Commission (PHHPC) regarding the

license operator's character and competency to run a healthcare facility for the protection of the public.

It should be noted that a birth center may only be accredited under the Commission for Accreditation of Birth Centers (CABC) if the birth center adheres to the licensing requirements of the state. The 'advocates' who bemoan the CON process are activists attempting to eliminate the CON process for licensing and insisting on accreditation in lieu of licensing. To that end, they are spewing lies and deceptions:

1. The CON application required by PHHPC does not entail a two year process. Since the last quarter of 2023, there is, on public record, three CON applications for birth centers. In my representation of a birth center client before the PHHPC on June 6, 2024, she received her conditional approval in only three (3) months. Another application for a MWBC in Rockland County was approved in five (5) months from submission. The 3rd application is for a limited birth center in Green Point presently under review.
2. The possession of the site is not required under the MWBC regs. Once a location is identified and confirmed by a Letter of Intent from the Applicant, there is no need to sign a lease for empty commercial space, pay any security deposit or outlay costs.
3. The PHHPC has been reviewing completed birth center applications and speedily scheduling the applicant at the next public hearing.
4. There is no reason for applicant midwives to argue 'their case' that CABC's standards should be adopted because the CABC has been identified as an acceptable accrediting body. The activists would have you believe that midwife applicants may argue accreditation in lieu of licensing, but there are no circumstances under which it can be approved in this manner.
5. There is no worry that the applicant would be denied an operator's license due to any bias of the Committee members who are described as only hospital representatives. In fact, I was present at these hearings and witnessed unanimous approval of two birth center applications as well as an expressed appreciation and deep support for the growth of birth center applications in the future.
6. The mentioned financial and opportunity costs by midwives wanting to open birth centers is a barrier, but, in fact there does exist unlicensed birth centers operating in NY, so the question is really not financial costs of opening a birth center, but only the cost of the application, which is part and parcel of gaining approval for a license under Article 28 by anyone wanting to run a healthcare facility in NY.

The resolution was not shared with midwifery or birth center organizations, locally, regionally or nationally. This indicates a clear intention by the activists to negatively impact the present process by advocating an agenda of accreditation in lieu of licensing.

This resolution should not pass. The present path should be continued and maintained for the benefit of midwives and operators to receive licensing under NY Article 28 for birth centers and midwifery birth centers.

Thank you for your kind consideration in this matter.

A Frances Schwartz, JD, CEO
Integral Healthcare for Women
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www.integralhealthcare.com
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New York City Council Oversight Hearing - Physical and Mental Health Supports for New and Expecting Parents

before the

Committee on Health and Mental Health, Disabilities and Addiction

Jointly with the Committee on Women and Gender Equity

on

Tuesday, June 25th at 10:00am

Testimony By: Caitlin Garbo, MPA
Manager of Public Policy & Advocacy
National Alliance on Mental Illness of New York City (NAMI-NYC)

Good morning Chairs Lee and Louis and Members of the Committees on Mental Health, Disabilities and Addiction and Women and Gender Equity. My name is Caitlin Garbo and I am testifying on behalf of the National Alliance on Mental Illness of New York City, NAMI-NYC, which is the *only* nonprofit providing free, direct, and extensive peer support *and* family support to New Yorkers who care for someone living with serious mental illness.

NAMI-NYC has been around for over 40 years and equips families with knowledge, skills, and ongoing support to better identify symptoms, improve access to care, enhance communication with their loved one, and heal family relationships. We know that especially with new children, the focus on a parent's health and wellbeing can be put on a back burner. We applaud the Council for this hearing bringing forward many relevant and important issues that parents face. We would like to highlight a few bills we are excited to see.

We support Intro 0869-2024 and Intro 0912-2024 (Gutiérrez). Both pieces of legislation aim to raise awareness for new parents about resources, information, and community-based organizations they can utilize for any mental health challenges they may be facing. In particular, Intro 0869-2024 intersects quite well with our scope of work. We have support and educational services for parents with children living with mental health challenges. Moreover, we understand that there are many situations parents deal with regarding their mental health from the toll of a child's other medical issues, intergenerational trauma, and beyond.

We support Intro 0890-2024 (Lee) which would establish postpartum support groups focused on the mental health of individuals who are up to one year postpartum. Some of the ways NAMI-NYC provides support to families and peers, or people living with mental health conditions, is through our free programs and services including our Helpline, classes, and over 40 support groups. We know the importance of support groups and their impact on an individual's mental health and those surrounding that person. We at NAMI-NYC are well

positioned to support this initiative and can provide invaluable insight into the creation of informational materials and the hosting of groups themselves. We stand ready to work with the City Council and the Health Commissioner to implement this important piece of legislation.

We thank the Committees for their consideration of our testimony and look forward to working together towards solutions around the mental health of parents and all New Yorkers.

Caitlin Garbo, MPA (she/her/hers)
Manager of Public Policy & Advocacy
National Alliance on Mental Illness of New York City (NAMI-NYC)
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Personal Care Products Council
Committed to Safety, Quality & Innovation

June 25, 2024

Majority Leader Amanda Farias
New York City Council, City Hall
City Hall Park
New York, NY 10007

RE: Oppose Intro 867

Majority Leader Farias and members of the Women and Gender Equity Committee,

On behalf of the members of the Personal Care Products Council (PCPC)[1], I am writing to express our opposition with New York City Intro 867, which would ban safe preservatives and other important ingredients in intimate personal care products.

PCPC is the leading national trade association representing cosmetics and personal care products companies and serving as the voice on scientific, regulatory, legislative and international issues for the global cosmetics industry. The cosmetics and personal care products industry is one of the most dynamic and innovative industries driving the U.S. economy. Our commitment to social well-being starts with our support for women at work and in their personal lives. Women make up nearly 80% of our industry's workforce and hold more than half of management positions – significantly more than in other industries. Our industry employs thousands of science, technology, engineering and mathematics (STEM) professionals dedicated to ensuring product and ingredient safety.

New York is an extremely important state for this industry, with many cosmetics and personal care companies calling it home. The industry supports more than 273,000 jobs in New York and contributes more than $23.2 billion to the state's GDP. In the greater New York City area alone, the cosmetics and personal care products industry generates $11.8 billion in labor income and supports 193,450 jobs.

While we understand and appreciate the intent of your bill, we must oppose in consideration of recent action at both the federal and state level. The FDA has been granted extensive new authority to exercise oversight of the cosmetics and personal care industry under the Modernization of Cosmetic Regulation Act of 2022 (MoCRA). This law includes new requirements for manufacturers as well as increased enforcement authority for the FDA. PCPC was proud to support MoCRA, which was signed into law by President Biden on December 29, 2022. MoCRA specifically addresses key topics such as facility registration and cosmetic ingredient listing, fragrance allergens, professional use labeling, and a report of PFAS in cosmetics, among many others.

In addition to this enhanced federal oversight, industry has worked collaboratively with stakeholders in key jurisdictions on policy impacting industry. PCPC worked with a diverse coalition in California to ban ingredients (including a few in your proposed bill) and the entire class of PFAS as of 2025. This action has since morphed to other states and California has set the de facto standard in this area regarding ingredient restrictions.

The personal care product industry holds sacred the trust families have put in the safety of their products. PCPC's member companies invest tremendous resources in scientific research and safety

processes to ensure they are complying with all laws and regulations while providing safe products to consumers.

For all the reasons above, PCPC respectfully opposes Intro 867. Thank you for your continued work on this important issue and for your consideration of our position. We would welcome the opportunity to continue working with you on this legislation.

Sincerely,

Kelsey Johnson
Vice President, State Government Affairs

Planned Parenthood
Care. No matter what.
Planned Parenthood of Greater New York

26 Bleecker Street
New York, NY 10012
t: 212.274.7200
ppgreaterny.org

Testimony of Planned Parenthood of Greater New York Before the New York City Council Committees on Women and Gender Equity and Mental Health, Disabilities and Addiction on Addressing Physical and Mental Health Supports for New and Expecting Parents

June 25th, 2024

Greetings, my name is Elise Benusa, I am the Government Relations Manager at Planned Parenthood of Greater New York. Thank you to the Committee Chair Council Members Louis and Lee for holding this important hearing to explore how the city can support the physical and mental health of new and expecting parents. We also thank the bill sponsors for introducing legislation that moves us closer to achieving reproductive justice for the most marginalized in our communities.

PPGNY has been a leading provider of sexual and reproductive health services in New York City for more than 100 years, conducting over 124,000 patient visits per year. PPGNY provides a wide range of health services including access to birth control; emergency contraception; gynecological care; cervical and breast cancer screenings; colposcopies; male sexual health exams; testing, counseling, and treatment for sexually transmitted infections; the HPV vaccine; HIV testing and counseling; and pregnancy testing, options counseling and abortion. We also provide PrEP and PEP, transgender hormone therapy, vasectomies, and menopausal hormonal therapy. We are a trusted name in health care because of our commitment to comprehensive, inclusive care

It is imperative to address the challenges new and expecting parents face in terms of physical and mental health. According to the National Alliance on Menal Illness "Each year, **500,000** pregnant women in the U.S. will experience a mental health condition either before or during pregnancy and as many as **75%** of pregnant individuals with mental health symptoms do not receive treatment. Additionally, adverse childhood experiences can **increase risk** for prenatal depression symptoms, especially in low-income women and **1 in 10** men experience postpartum depression."[1] We applaud the Council for prioritizing mental health for parents through informational materials, awareness and support groups.

For Black people, specifically Black women, the compounded identities of race, gender, and often economic status makes seeking reproductive health care increasingly difficult. Studies show major racial disparities in maternal mortality, with Black women being four times as likely to die in childbirth than white women in New York State.[2] In New York City, the situation is far worse -

[1] Maternal & New Parent Mental Health | NAMI

[2] Lazariu, Victoria and Marilyn Kacica. New York State Maternal Mortality Review Report: 2012-2013. New York State Department of Health. New York State Maternal Mortality Review Team Division of Family Health. August 2017. https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_20

Black women are 12 times more likely to die from pregnancy-related causes than white women. These outcomes are a result of institutionalized medical racism and implicit bias within our healthcare systems that lead to the unique needs of Black women being ignored and a lack of cultural competency to effectively provide care to this community. Studies suggest that Black women are more likely to have their health issues ignored by their doctor than their white counterparts and are treated differently than white patients when they present the same symptoms.[3] We support legislation addressing the racial inequities birthing folks, especially Black women, are facing.

Studies indicate that the presence of support individuals, including doulas, while giving birth lead to positive health outcomes for both mother and baby.[4] Birth doulas are trained individuals who work with their clients to provide continuous emotional and physical support throughout the pregnancy and during birth. Doulas also provide advocacy and inform their clients about what is happening during their labor and ensure that their clients can make informed decisions in their birth experience.[5] The impact of doula care is especially pronounced amongst individuals who are low income, socially disadvantaged, are giving birth in a hospital alone, and have language and cultural barriers. Studies suggest that doula support reduces the need for medical interventions, leads to fewer complications, and a more satisfying birth experience.[6] A study of the By My Side Birth Support Program, a Brooklyn based initiative that connected Black and Latinx individuals from high poverty areas to doulas for free, found that program participants had better birth outcomes when compared to individuals of similar backgrounds who were not connected to doula care.[7]

In recent years, doula care and other birth support services, often provided by Black and Brown women-led organizations, have become increasingly available to birthing people who could not otherwise pay for free or very low-cost. However, there are structural barriers including cost and low reimbursement rates for doula care that still do not allow many in need to access these vital

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12-2013.pdf [2] Pregnancy-Associated Mortality: New York City 2006-2010. New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant, and Reproductive Health. https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf

[3] Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Edited by Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. National Academies Press (US), 2003. https://www.ncbi.nlm.nih.gov/pubmed/25032386.

[4] Gruber, Kenneth J, Susan H Cupito, and Christina F Dobson. "Impact of Doulas on Healthy Birth Outcomes." The Journal of perinatal education. Springer Publishing Company, 2013. find.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[5] University of New Mexico. "Doulas: An Alternative Yet Complementary Addition to Care... : Clinical Obstetrics and Gynecology." LWW. Accessed December 3rd, 2020. https://journals.lww.com/clinicalobgyn/Citation/2001/12000/Doulas__An_Alternative_Yet_Complementary _Addition.9.aspx.

[6] Gruber, Kenneth J, Susan H Cupito, and Christina F Dobson. "Impact of Doulas on Healthy Birth Outcomes." The Journal of perinatal education. Springer Publishing Company, 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[7] Thomas, Mary-Powel, Gabriela Ammann, Ellen Brazier, Philip Noyes, and Aletha Maybank. "Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population." Maternal and child health journal. Springer US, December 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5736765/.

services. PPGNY supports ensuring pregnancy and birth are safer for all by reducing barriers to doula care.

PPGNY supports efforts to create alternative options for folks to give birth such as Birthing Centers which are independent of medical hospitals. They are run by midwives who are skilled in understanding what a pregnant person needs before, during, and after labor. Birthing centers provide quality medically trained midwives to assist mothers through the birthing journey in a comfortable and natural setting.[8] Giving new and expecting parents all the options for their birthing journey will lead to healthy birth outcomes.

Additionally, PPGNY supports legislation that equips new parents with all the resources and support they need to lead healthy and safe lives including resources for parents experiencing pregnancy loss, postpartum support groups for new parents, and support for lactating individuals. PPGNY supports birthing people having access to information and options to make their own decisions about their care.

PPGNY applauds legislation that meaningfully addresses the barriers that new and expecting parents face in NYC. Regardless of the outcome of the birth, parents deserve to have all the relevant information to make informed choices about their bodies. We applaud the Council for advocating that all pregnant people have access to the information and services they need to have healthy births. We look forward to working with the Council to strengthen our public health system and growing healthcare access for all.

Thank you.

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Planned Parenthood of Greater New York (PPGNY) is a leading provider, educator, and advocate of sexual and reproductive health care in New York State. PPGNY offers a wide range of services across 65% of NYS - including gynecological care; birth control; cancer screenings; pregnancy testing; STI testing and treatment; HIV prevention, testing, and counseling; transgender hormone therapy; and vasectomy. PPGNY is also proud to provide abortion services to anyone who needs compassionate, non-judgmental care. PPGNY is a trusted source of medically-accurate, evidence-based information that allows people to make informed decisions about their health and future. As a voice for reproductive freedom, PPGNY supports legislation and policies that ensure all New Yorkers have access to the full range of reproductive health services and education.

[8] American Association of Birthing Centers. Retrieved from American Association Of Birth Centers | AABC

Testimony for the New York City Council Committee on Mental Health, Disabilities, and Addiction and the Committee on Women and Gender Equity

June 25, 2024

Thank you for the opportunity to testify Chairwomen Lee and Louis, as well as other esteemed Councilmembers. I'd like to take a moment to thank the Council for the topic of today's hearing. The crisis of maternal and infant mortality and how it intersects with maternal mental health is urgent and deserves the attention of policymakers.

My name is Sara March, and I am a Credentialed Alcoholism and Substance Abuse Counselor as well as a Licensed Mental Health Counselor with over 10 years of experience in residential treatment facilities. As the Program Director of Samaritan Daytop Village's Young Mothers Program, I supervise our treatment facility in the Upper West Side. This **unique** program focuses on providing residential care to pregnant and parenting women diagnosed with co-occurring mental health and substance use disorders & their families.

We are proud to utilize a family systems, trauma-informed, and gender responsive lens for this work, and serve about 75 women and families annually, most of whom are women of color from communities with high infant mortality rates across the entire City. We ensure that our participants foster healthy bonds with their children during their journey to recovery while simultaneously learning essential life, vocational, and parenting skills. Additionally, we provide critical education, employment, and medical services. Our residents are positively impacted by our work as they are taught to become self-sufficient and confident caregivers for their babies and families. Some even end up coming back to work for Samaritan Daytop Village.

I'd like to highlight a pivotal gap in maternal health services, a gap which the Department of Health and Mental Hygiene Commissioner Vasan actually referenced during the May Executive budget hearings. Specifically, the commissioner cited the need for investment in postpartum addiction services, as overdoses are an **increasing morbidity** for postpartum mothers. **In fact, overdose deaths are a leading cause of Black maternal deaths. Through my work, I see the need for these services everyday. I applaud Chairs Lee and Louis and the city council for your leadership in this area remembering the critical needs of this population.**

In addition to the Council's efforts, the administration is also responding to demonstrated need . In March of this year, NYC Health and Hospitals announced plans to open the first family substance use disroder clinic in the system, an $8 million health and substance use disorder clinic for pregnant and postpartum women at Lincoln Hospital. This initiative aligns with the City's dual goals to reduce Black maternal mortality by 10 percent and opioid deaths by 25 percent by 2030. Funded through the "Women Forward NYC: An Action Plan for Gender Equity", the project addresses this gap in existing services. Commissioner Vasan is quoted in the press release: "With overdose a leading cause of Black maternal deaths, and the tragic ripple effects, **stigma-free access to substance use disorder and mental health treatment for expecting families is a must**."

Samaritan Daytop's Young Mothers Program has addressed this need since 1973 – but we and others like us need additional support to meet the needs of the mothers we serve. To that end, **we hope you will consider our Young Mothers Program for inclusion in the Maternal and Child Health Citywide Council initiative,** which the Council included in its Preliminary Budget Response.

Samaritan Daytop Village is grateful for the Council's support in elevating the need to support postpartum indivuals through its Young Mothers Program. We hope you will come see the community program in action for yourself and learn about the strengthening and empowerment of these young women whose lives are being saved and making families stronger. I thank you, on behalf of our agency and our clients.

June 27, 2024

New York City Council
Committee on Women and Gender Equity
Council Member Farah N. Louis, Chair
250 Broadway, Suite 1810
New York, NY 10007

Re: Requested Amendments to Intro 867 on Menstrual Products

Dear Chair Louis and members of the Committee on Women and Gender Equity,

The Center for Baby and Adult Hygiene Products (BAHP) represents manufacturers of absorbent hygiene products in North America such as menstrual products, disposable diapers, and companies that supply materials for those products. Our members represent over 85% of the market for personal hygiene products in North America.

BAHP appreciates the opportunity to write to comment on Intro 867, which would ban the use of fragrance and a number of substances in menstrual products. We want to be clear that BAHP members are NOT intentionally adding any of the listed substances outside of fragrance to their products and nothing is more important to our members than the safety of their products and the people who use them.

BAHP respectfully requests two changes to Intro 867 if the Committee chooses to advance the bill:

We urge the Committee and bill sponsor to limit the scope of this bill to substances that are intentionally added by the manufacturer. Other jurisdictions that have passed bills restricting the use of certain substances in consumer products have taken this approach and it is essential for compliance. BAHP members follow rigorous processes to assure the safety of the ingredients used in their products. With the exception of fragrance, our members do not intentionally add any of the substances included in Intro 867 to menstrual products**.**

In some cases, substances not added by a manufacturer can be present in very low amounts due to factors outside the manufacturer's control (such as naturally occurring presence in the

environment). These low, trace levels do not present an objective safety risk to consumers. Absorbent hygiene product manufacturers assess the safety of their finished products, assessing both intentionally added ingredients, and substances that may be present as trace contaminants in raw materials.

Laws affecting consumer products in other jurisdictions recognize this and as our members manufacture and ship products nationally, it is essential that ingredient restrictions be addressed in a clear and consistent manner. The application to intentionally added substances would align this bill with existing chemicals laws across the country and also to other areas of NY law that place restrictions on certain substances. NY laws on PFAS in food packaging, PFAS in certain outdoor apparel and chemicals in children's products all apply specifically to intentionally added substances.[1]

We also respectfully ask the Committee to exclude fragrance from any ingredient restrictions. New York state has an ingredient disclosure law in place for intentionally added ingredients in menstrual products, which includes fragrances. Products that contain fragrances are labeled clearly so that consumers can make an informed decision and choose for themselves whether they would like to use a fragranced or fragrance-free product.

Fragrances have been enjoyed for thousands of years and contribute to people's individuality, self-esteem and personal hygiene. Consumer research indicates that fragrance is one of the key factors that affect people's preference for products. Thousands of fragrances are used every year in consumer and personal care products sold in countries all over the world. Fragrance suppliers and BAHP members constantly monitor International Fragrance Association (IFRA) Standards, the scientific literature and relevant legislation to assure the safety of all materials used in their hygiene products, including fragrances. Like all other ingredients used in menstrual products and diapers, fragrances are thoroughly evaluated for safety prior to use.

Thank you for your attention to our comments and we look forward to further engagement on this matter. Should you have any questions, please contact us at info@bahp.com.

Respectfully submitted,

Eric Stewart
Executive Director

[1] N.Y. Envtl. Conserv. Law § 37-0121; N.Y. Envtl. Conserv. Law § 37-0209; N.Y. Envtl. Conserv. Law § 37-0901

New York City Council Committee on Women and Gender Equity

Testimony of Patricia O. Loftman, CNM, LM, MS, FACNM
June 25, 2024

The Honorable Farah N. Louis, Chair
Committee on Women and Gender Equity

Greetings Chairperson Louis and members of the New York City Council Committee on Women and Gender Equity. Thank you for this opportunity to provide testimony on the topic of Requiring the Department of Health and Mental Hygiene to create pamphlets identifying mental health resources available to individuals experiencing pregnancy loss.

My name is Patricia Loftman. I am a Certified Nurse Midwife and a Fellow of the American College of Nurse Midwives. I graduated from Columbia University Graduate School of Nursing with a specialty in midwifery in 1981. I practiced full scope midwifery caring for women as a midwife and am the former Director of Midwifery Service at Harlem Hospital in New York City for three decades. During my thirty years at Harlem, I cared for women whose pregnancies were complicated by substance use, for ten years, developing an expertise in this area.

Today, I speak as a representative of New York Midwives, the State Affiliate of The American College of Nurse Midwives, the Professional Organization that represents midwives across the United States. I also speak as a member of the New York City Department of Health Maternal Mortality and Morbidity Review Committee. The number one cause of maternal mortality in New York City is substance use, overdose and suicide.

Parenthood, for many couples and families, is considered the most significant period in their lives. Consequently, a pregnancy that does not result in a live birth, as planned, can be traumatic and have lasting emotional and psychological reactions.

Perinatal loss is not uncommon and can occur and affect women and birthing people at various periods in a pregnancy. Perinatal loss can occur early in pregnancy before 20 weeks. It can occur after 20 weeks or it can be the result of an anatomical defect incompatible with life. Pregnancy loss can unexpectedly end in a stillbirth at the end of a term pregnancy.

Regardless of when the pregnancy loss occurs, it is often a profound experience. Couples, women and men can exhibit:

- Anxiety
- Depression
- Mild to severe to complicated grief
- Post traumatic disorder
- Attachment disorder to subsequent pregnancies
- Excessive or irrational worry
- Trouble sleeping, concentrating, or taking care of yourself
- Trembling, muscle tension, sweating, or nausea
- Loss of interest in normal activities

- Tearfulness
- Feeling hopeless, worthless, or numb
- Flashbacks or nightmares
- Thoughts of hurting oneself

While much of the discussion about pregnancy loss centers women, men, too, can experience psychological distress. Attachment, the emotional and psychological adjustment to the developing fetus is customarily centered on the woman. Thus, there are unique issues for women who lose a pregnancy. The result is that the unique emotional and psychological needs of men are often forgotten. How women and men respond as individuals and as a couple depends on cultural norms and societal expectations. Men and women might be in separate places when the loss occurs resulting in different coping capabilities that may or may not result in marital difficulties and conflict. Many pregnant and postpartum women who experience a pregnancy loss are already living traumatized lives. Many have experienced adverse childhood events that were ignored and/or never treated that can lead to toxic stress.

How women, men and couples grieve a loss is personal. Healing often involves access to a mental health clinician to assist with the emotional, physical, spiritual and social healing necessary to sustain the family unit. Mental health practitioners such as a psychiatrist or psychiatric nurse practitioner who can prescribe medication not to place them in a catatonic state but to stabilize them so that the mental health work can begin.

There has been considerable attention and discussion, recently, about the mental health crisis in New York City. Recently, to enhance mental health services, Governor Kathy Hochul identified and announced the allocation of $39.1 million to nine community-based hospitals to develop comprehensive psychiatric emergency programs. Among the recipient hospitals in New York City were:

- St. Barnabas Hospital: $5 million
- Montefiore Medical Center: $4.6 million
- Maimonides Medical Center: $4.9 million
- Flushing Hospital Medical Center: $4.5 million
- NYU Langone Health: $5 million

These comprehensive psychiatric emergency programs will serve as an entry point to mental health care for individuals in crisis, providing a range of psychiatric services including admitting individuals for up to 72 hours if extended observation is required. Referrals will come from various sources, including clinicians, emergency medical services, police transport, and walk-ins.
https://wnynewsnow.com/2024/06/13/governor-hochul-unveils-39m-boost-for-psychiatric-emergency-programs/

The Honorable Farah N. Louis, Chair
Committee on Women and Gender Equity

The programs will also feature mobile crisis services to respond to community-based behavioral crises designed to reduce the necessity for emergency evaluations or admissions and supporting individuals as they await follow-up services.

While funds are being allocated at the state level, funds are also being allocated for comprehensive psychiatric treatment at New York City institutions. Unfortunately, however, among the challenges associated with implementing the proposed legislation is the lack of a mental health infrastructure. A mental health infrastructure does not exist. This is the legacy of the destruction of the mental health infrastructure during the 1980's and 1990's and the policy of mainstreaming people with mental health difficulties from institutions into the community. Mental health departments are underfunded and care is not reimbursed at the rate of a surgical procedure, for example. A few months ago, the New York City Council Mental Health Roadmap accurately identified that 40 percent of mental health jobs in the NYC Health Department are currently vacant. There is a dearth of mental health practitioners. Consequently, while funds are being allocated for treatment, with no provider capacity, who is going to do the work? Mental health care is not sexy. It is long, slow, arduous work for both the clinician and the individual. The public and politicians want overnight success. Yet, anyone who has ever had a family member with mental health challenges knows that this is often a lifelong process. But while mental health care is in progress, the person, the community and society are safe.

Increased funding for mental health care including commensurate salaries to recruit and retain mental health clinicians especially clinicians of color is imperative. Not only is there a dearth of mental health clinicians, but there is also a desert of mental health clinicians of color. Persons of color will not share the information needed to provide them with treatment as sharing information might be used against them by agencies such as ACS. Investment in the education of psychiatric nurse practitioners with federal and state scholarships and loan repayment for working in underserved areas together with salaries commensurate with their education and experience is the fastest way to rebuild the mental health infrastructure. The customary psychiatric nurse education occurs over two years compared to a total of eight years for a psychiatrist- four years of medical school plus four years of internship and residency.

Before pamphlets identifying mental health resources are developed and made available to individuals experiencing a pregnancy loss, clinician capacity must be developed because it does not currently exist. Recommendations to seek mental health treatment will be elusive as the earliest appointment one can customarily obtain is twelve weeks or more whether pregnant or not. It is not uncommon for individuals to alleviate grief and pain by using substances. The pamphlet will provide information and recommendations individuals cannot access because mental health resources are not easily accessible.

An immediate, evidence-based solution is to expand the number of Crisis Respite Centers throughout the five boroughs by at least two per borough, prioritizing areas with high need and open by appointment, walk-in, or referral. Crisis Respite Centers are Preventive and Supportive Services developed for pregnant and postpartum women and women with children. Needed are more Peer Bridgers, persons with lived mental health experience who have experienced a pregnancy loss or who are in recovery to help people connect to services. Currently, there are Peer Specialist and Social Workers at the Crisis Respite Centers.

However, a person with mental health challenges is more likely to connect and develop a supportive relationship with a Peer Bridgers Specialist, a person with lived similar mental health experience and who is in recovery.

In closing, while the intent of a legislation is always laudable the impact must also be considered.

Res 0229-2024 - *By Council Members Brewer and Schulman - Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation to ease systemic barriers in opening birth centers in New York City and New York State.*

While this resolution demonstrates the passion and commitment of city council members to make midwifery birth centers more integral to the New York City maternal health landscape, it presents some concerns and misinformation that need to be carefully considered. I do not support passage of this resolution.

I write this as an experienced licensed midwife (LM) with 14 years of practice in the NYC municipal health system - NYC H+H. I have also been actively involved in advocating and leading efforts to open more midwifery birth centers (MBC) in NYS. As a midwife, I have trained in both birth centers and in home birth - and have a great deal of respect for the value of all three birth settings. I wrote the definition of midwifery for the NYC DOHMH and I was a grantee of the Commonwealth Fund as I conducted the first even assessment of midwifery services in NY and continue to support their work on expansion of midwifery care in the US. I am a tenure track Assistant Professor at NYU and my area of expertise is midwifery research, critical feminist theory, public health, and birth equity. I was also actively involved in the passage of the MBC law in NYS.

1. This resolution lacks consideration of the history of this legislation and runs the risk of causing further confusion and delay for those of us who are strategically working to open high quality, evidence based birth centers. Gov Hochul *amended* the Midwifery birth center bill at the final hour and removed CABC accreditation as the singular pathway to obtaining a license. Now this resolution is asking to return us to square one - without any consideration of the work that continues to happen as we educate legislators and the NYS DOH on how to best support birth center openings. We have been working tirelessly for 10 years on the goal of building birth centers - what is the history of this resolution? Where did it originate? Was any effort made to speak to leaders at the NYS DOH? Where is the spirit of collaboration and coordination?
2. To date, THREE birth centers are slated to open in the state of NY (Kings County (2) and Rockland County (1)) so the blanket statement that the current pathway is untenable is inaccurate.
3. It is also concerning that this resolution bypassed any vetting from one of the largest state midwifery organizations in the country - **New York Midwives** as well as the local midwifery organization- **NYC Midwives**. The resolution states “According to advocates,” - however midwifery organizations were not included in this resolution, and we are our own best advocates. Any resolution in this city and state related to midwifery care should be inclusive of the expert opinions of the city and state professional organizations. Midwives have been working tirelessly for 15+years to get birth centers opened across this state and while this resolution is intended to support this work - it is disrespectful, non-collaborative and exclusionary. It is also an example of midwives being sidelined and marginalized - a long standing example of the pervasive power of gendered oppression.

4. A CABC accreditation is a process that communicates to consumers and other healthcare professionals that national, evidence-based standards of care are being met by the birth center. However, NYS has its own set of standards for ALL healthcare facilities that must be met and are part of ensuring a larger strategy of making sure birth centers are part of the regional perinatal care system and that they are billable to Medicaid. Making sure birth centers are reimbursed by Medicaid is essential to ensuring that birth centers are accessible to all payers.
5. NYS will not support accreditation in lieu of the revised CON process. One main component of the CON process is the *'character & competency'* requirement. This is a way to ensure that safety standards are met at all levels of care. While giving birth outside of the hospital is a viable option for essentially healthy people, ensuring the competence of the clinical director and staff is essential to the safety of the clients, especially in light of the current maternal health care disparities that exist in our state. The state DOH will not forego this component in ANY healthcare facility. We hope the City Council is in alignment with protecting and ensuring the safety of New Yorkers and that the competence of providers is coeval to the safety of patients.
    a. NYS DOH has made it evident that accreditation is acceptable in lieu of a site visit. This suggests their support and trust of the accreditation process.
6. Please also note, for now, gaining licensure requires a CON. The CON application is reviewed at the Public Health and Health Planning Council sessions. A more supportive resolution is to ensure that PHHPC and NYS DOH employ and appoint a licensed midwife (LM) to support midwives in this city and state in all midwifery related initiatives - including birth centers would be a more strategic mode of support.
7. It's worth noting that the resolution cites the Commonwealth Fund's report on maternal mortality and the role of midwifery care in providing essential services. I have served as a technical midwifery consultant for the Commonwealth. Please see my own Commonwealth report on midwifery integration here. The study cited in the resolution cites the recent Commonwealth Issue Brief - which comes from the primary study led by Nove and colleagues[1] that looked at global projection rates in countries where birth centers are not common (low and middle-income countries). While birth centers, led by midwives, is a viable pathway for *some* childbearing people with little to no risk in their pregnancies, there is no data or research to suggest that those giving birth in birth centers would match the numbers cited in the Nove studies.
    a. In fact, looking at singleton, term, normal births, a study by Snowden and colleagues[2] found poorer outcomes at home and in birth centers—specifically, a neonatal mortality rate of 1.6 per 1,000 in home birth and birth center births compared with 0.6 per 1,000 in hospital births.

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[1] Nove, Andrea, Ingrid K. Friberg, Luc de Bernis, Fran McConville, Allisyn C. Moran, Maria Najjemba, Petra ten Hoope-Bender, Sally Tracy, and Caroline S. E. Homer. 2020. "Potential Impact of Midwives in Preventing and Reducing Maternal and Neonatal Mortality and Stillbirths: A Lives Saved Tool Modelling Study." The Lancet Global Health 1–9. doi: 10.1016/S2214-109X(20)30397-1.

[2] Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-of-hospital birth and birth outcomes. New England Journal of Medicine. 2015;373(27):2642–2653

This resolution should not be passed without further information gathering from a representative pool of practicing midwives (LMs), midwifery leaders, and midwifery care experts in New York City.

Dr. Paulomi Niles, PhD, MPH, CNM/LM

Testimony Regarding the NYS Certificate of Need and Its Impact on Freestanding Birth Centers

To the New York City Council:

My name is Trinisha Williams, and I am here to provide testimony on the impact of the New York State Certificate of Need (CON) requirement on Freestanding Birth Centers (FSBCs). I am a Certified Midwife on the front line of New York City (NYC) maternal health crisis for 20 + years. I am the President-Elect of the American Association of Birth Centers, a Board Member of Lamaze International, and a Board Member of the American Midwifery Certification Board. The opinions I am expressing are mine and independent of these organizations.

I am in the process of building NYC's first BIPOC non-profit birth center, Haven Midwifery Collective where I sit as the Founder and President. I am deeply invested in the maternal and child health crisis; I believe it is crucial to address the significant barriers the CON requirement poses to the establishment and operation of FSBCs in our communities. I am especially concerned about the safety of the birthing people and having options for their care.

When examining the availability of FSBCs across various communities, it becomes evident that one of the primary obstacles to birth center owners is the requirement to obtain a Certificate of Need. The CON is a state-level law that mandates approval for capital expenses related to healthcare facilities, including the establishment, construction, renovation, and acquisition of major medical equipment. While this regulatory framework aims to control healthcare costs and ensure the need for services, it inadvertently creates substantial challenges for FSBCs.

Certificate of Need: the issue with the CON process is that it is controlled by the Public Health and Health Planning Council which does not prioritize birth centers. First, the application for a CON is onerous requiring birth centers to have hospital-like architectural standards. These include amenities such as ambulance parking spaces, and elevators to fit gurneys which are not used in birth centers and have not been proven to increase safety. Further, the process through PHHPC is unnecessarily lengthy and applications have been delayed for years. This leads to increased costs to undergo the application process that runs into several hundred thousand dollars. The DOH was supposed to release new guidelines by July 2021 but has missed the deadline. The reasonable alternative would be for NYDOH to adopt the Commission for the Accreditation of Birth Centers (CABC) guidelines for licensure which have been proven time and again to be safe across almost all states in the U.S. As a small

business, Haven cannot undergo a capital campaign to build a hospital-style facility or undergo the lengthy and expensive CON process.

Regulations: The national CABC regulations have been proven to have a safety record across the U.S. time and time again. The guidelines vet providers and birth center safety protocol. However, the CON regulations such as requiring hospital transfer agreements have not been proven to increase safety for birthing people. Instead, they serve as barriers to opening birth centers. This is obvious in the fact that all states with CON applications have far fewer birth centers than states without CON with no compromise to patient safety. It is a misnomer to say birth centers have "lax" regulations. We have national regulations and standards in place for birth centers that are the gold standard and have proven safety records and should follow those, not create new ones that are not proven, and decrease access.

Finances of birth centers: Birth centers can operate in New York State, even without state licensure. However, without state licensure, they cannot apply for insurance and Medicaid reimbursement and facility fees. Hence state licensure is imperative to creating equitable access and for the financial stability of birth centers. The Kirkwood Institute, a self-described "conservative public-interest law firm" that operates as a tax-exempt public charity, is alleging that requiring birthing centers to obtain a certificate of need – just as hospitals, medical centers, and nursing homes must do – violates the U.S. Constitution.

Key Issues with the CON Requirement for FSBCs:

1. **Financial Barriers:**
    1. FSBCs are typically small, community-based practices that serve low and middle-income birthing individuals. Unlike hospitals, FSBCs do not have access to significant capital, investors, or institutional resources. Their primary purpose is not to generate revenue at a rate that would attract potential financiers.
    2. To satisfy the CON requirement, an FSBC must secure projected capital prior to the application process. This is a daunting task for FSBCs, which often operate on thin margins with lower levels of capital. The high capital expenses required for CON compliance are disproportionately burdensome for these smaller entities.
2. **Discrepancy in Competition:**
    1. States that have a CON requirement generally have fewer birth centers, like New York State. Hospital regulations under the CON

framework hinder competition between hospitals and FSBCs, placing FSBCs at a significant disadvantage. Hospitals possess the infrastructure and resources that FSBCs lack, making it difficult for birth centers to compete on an equal footing. I would encourage this committee to lean into states like Texas where there is no CON and they have 90 birth centers and have regulations that are specific to birth centers. https://www.hhs.texas.gov/providers/health-care-facilities-regulation/birthing-centers

2. The CON process does not account for the unique nature of FSBCs. Unlike hospitals that offer a wide range of medical services, FSBCs provide a specific, essential service to the community. The requirement for a full year of operating costs, or the need to obtain permission from competing hospitals, further compounds the difficulty for FSBCs to establish themselves.

3. **Administrative Burden:**
    1. The CON application process is often lengthy and complex, taking several months to years for review. This extensive documentation burden is a significant barrier for FSBCs, which typically do not have the administrative resources of larger healthcare institutions.
    2. The competitive relationship with hospitals and the bureaucratic hurdles of the CON requirement are often insurmountable for FSBCs. These challenges hinder the ability of highly qualified community birth providers to meet the financial and administrative demands of the CON process.

Impact on Birthing People:
The restrictive nature of the CON laws adversely affects birthing individuals who prefer alternatives to hospital births. FSBCs offer a personalized, community-centered approach to childbirth that is highly valued by many. However, the current CON framework limits the availability of FSBCs, depriving vulnerable urban and rural communities of vital healthcare options and potentially driving up costs due to reduced competition.

Policy Recommendations:
To better support the establishment and operation of FSBCs, I urge policymakers to consider the following actions:

- **Exempt FSBCs from the CON Requirement:** Introduce legislation or remove the CON requirement for FSBCs. This exemption would alleviate the financial and administrative burdens that currently hinder the establishment of birth centers.
- **Streamline the Application Process:** Simplify and expedite the application process for FSBCs to ensure timely review and approval. This would enable FSBCs to serve their communities more effectively.
- **Promote Equity in Healthcare:** Recognize the unique role of FSBCs in providing equitable healthcare to low and middle-income birthing individuals. Adjust regulations to support the sustainable operation of these essential community resources.

It is with respect and urgency to protect birthing people that I am demanding the CON process be removed from NYS Birth Centers. In conclusion, the current CON requirement poses significant challenges for FSBCs, limiting their availability and accessibility in many communities, especially BIPOC-birthing families. By revising these regulations, we can promote a more equitable and diverse healthcare landscape that better serves the needs of all birthing individuals.

Thank you for your attention to this critical issue.

Sincerely,
Trinisha Williams, CM, MPH, LC, FACCE, LCCE
Haven Midwifery Collective havenmidwiferycollective@gmail.com
trinishaw@gmail.com

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I represent: NYC DOHMH

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I represent: Maternal, Infant and Reproductive Health

Address: NYC DOHMH

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I represent: Children, Youth and Family (Mental Health)

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I represent: Neighborhood Health

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I represent: NYC DCWP

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Name: ODESSA FUNN

Address: [redacted]

I represent: NEW YORK CITY MIDWIVES

Address: _____

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I represent: _____

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Name: Sheindel Ifrah Goldfeiz

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Name: Sarah Marh

Address: [redacted]

I represent: Samaritan Daytop Village

Address: 136-02 Queens Blvd. Briarwood, NY

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Name: Patricia Loftman

Address: 788 Columbus Ave NYC 10025

I represent: New York Midwives

Address: _____

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Name: Paige Bellenbaum

Address: 205 Lexington Ave.

I represent: The Motherhood Center

Address: 205 Lexington Ave.

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Date: 06/25/2024

(PLEASE PRINT)

Name: Lorena Kouvousias

Address: 245 23rd Street, Brooklyn, NY

I represent: Mixteca Organization, Inc.

Address: 245 23rd Street, Brooklyn, NY

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I represent: SBLF

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