CITY COUNCIL
CITY OF NEW YORK

---------- X

TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

---------- X

November 13, 2013
Start: 1:12 p.m.
Recess: 4:49 p.m.

HELD AT: 250 Broadway - Committee Room
14th Floor

B E F O R E:
Maria del Carmen Arroyo
Chairperson

COUNCIL MEMBERS:
Inez E. Dickens
Mathieu Eugene
Julissa Ferreras
Rosie Mendez
Joel Rivera
Deborah L. Rose
Peter F. Vallone
James Van Bramer
Albert Vann

A P P E A R A N C E S (CONTINUED)

Dr. Deborah Kaplan
Bureau of Maternal, Infant and Reproductive Health at New York Department of Health and Mental Health

Dr. Lorraine Boyd
Bureau of Maternal, Infant and Reproductive Health at New York Department of Health and Mental Health

Dr. Tamisha Johnson
Maternal Health Project Coordinator

Dr. Machelle Allen
New York Health and Hospitals Corporation

Dr. Ross Wilson
New York Health and Hospitals Corporation

Rita Henley Jensen
Women’s eNews

Beverly Fetman

Karina Lozer
Public Health Solutions on behalf of Marci Rosa

Jaqueline Gilbert
Harlem Hospital

Joyce Hall
Director of Practicum and Career Development at Long Island University Brooklyn

Ihotu Ali
Northern Manhattan Perinatal Partnership Central Harlem

Pamela Davis
Queens Comprehensive Perinatal Council

A P P E A R A N C E S (CONTINUED)

Nan Strauss
Director of Policy and Research at Choices in Childbirth

Robert Lederer
The Bronx Health Link

Chanel Porchia
Ancient Song Doula Services

Gerogianna Glose
Brooklyn Infant Mortality Task Force/CCEIM

CHAIRPERSON ARROYO: That's an order, right, Sergeant? Good afternoon everyone and thank you for joining us. My name is Maria Carmen Arroyo. I chair the Committee on Health in the Council, and today we are conducting an oversight hearing entitled Examining Women's Preconception Care and Health Outcomes for Moms. This hearing will investigate an issue of vital importance to our city, the health of women and moms. As we have learned from a 2010 report by the New York City Department of Health and Mental Hygiene, mental health-- maternal health in the City in a dire state. For the last 40 years the City has been consistently ranked above the National Maternal Mortality Ratio, a ratio that refers to the number of deaths per 1,000 live births. The report found that there were 161 pregnancy related deaths in the City between 2001 and 2005. As of the time of the 2010 DOHMH report, the City was among the highest in the nation in mortality, maternal mortality ratio. For example, in 2008 the City's maternal mortality ratio of 30 was about double the state-wide

rate in California. But this is just the tip of the iceberg. In addition to a generally high rate of maternal mortality, the City has startling and shocking racial disparities in maternal deaths. In the City, black women are more than seven times likely to die during or right after pregnancy than a white woman. Hispanic women also have higher rates of maternal mortality than white women, though not nearly as high as that of black women. How such disparities exist in this country and in the City is preposterous and totally unacceptable. We applaud DOHMH for drawing our attention to these high mortality death rates and ratio disparities, and much more needs to be done. Today's hearing we will not only examine these rates and disparities, but we'll also examine the extent to which pre-existing conditions and the quality and presence of pre-conception care impact the health outcome for women and many of you know that this is an issue that's near and dear to my heart. After--several years ago my daughter Omi and that's spelled Omi, was diagnosed with lupus while she was pregnant.

Somehow the signs of this illness went undetected until she became pregnant. The consequences were severe. Her daughter, my granddaughter, was born not at 27 weeks pregnant. I am so grateful that she and Princess Elisa [phonetic] is developing--she's fine and Princess Elisa is developing into this incredibly wonderful individual that still is confronting a great many health challenges. But I can't help believe that this is an example that speaks to the experience that so many women have, that some underlying health condition emerges during pregnancy jeopardizing health, the health of mom and baby. And we can agree that by then it's too late. So the conversation that we want to have is about what we can do beforehand to help mom prepare for a better outcome. With this in mind we need to explore and understand the dimensions and needs of preconception care. While pre-natal care has been a major focus of programs addressing infant and maternal mortality, experts are coming to the conclusion in recent years that pre-conception care may be as important as

prenatal care if not more so. I recognize that it's not totally clear how to move forward on these issues, and I'm looking forward today to hearing from a wide variety of experts who help to help shed light on these problems and to understand what policies can be put in place. This is a beginning of a conversation about what steps the City can take to improve the health of mothers and all women. We are particularly interested in hearing from the provider community, health advocates, and women's organizations on how to move this conversation forward. Some of these solutions may be beyond the control of the Council, but even those recommendations are something that we can and must advocate for, whether it be at the state or the federal level, and I believe that we are in a very good position to be able to move those conversations forward because I'm not taking no for an answer. We must learn how to advance preconception and prenatal health in New York City so that pre-existing conditions are addressed and that all women regardless of race, class, what neighborhood they live in,

whatever, begin and end pregnancy in a much healthier place. And what I didn't say to you during my daughter's experience is that she was an active member of the United States Marine Corps, so lack of health insurance was not an issue for her. It was how well the providers taking care of her may have handled her as patient not--and less as a Marine, right? But it wasn't access to care that was issue for her. So I think this is a much deeper and broader conversation that we need to have. Before we hear from our first panel, I want to remind you guys that if you want to testify, you have to see the Sergeant in the corner and fill out one of these slips. Otherwise, we will not know that you want to talk to us and we want to hear what you have to say. We are also experiencing a little bit of an unusual circumstance. This happens in the City Council, but not too often, is that we're going--we're pending a vote on an unrelated conversation. Once we have quorum in the Committee we'll pause this hearing to take a vote and then quickly resume, and the vote will

be on proposed resolution number 1260A which calls on the federal government to reclassify marijuana as a less dangerous substance. That's important too. So we will take a minute as soon as we have quorum. I'll interrupt the proceedings and then we'll take the vote and we'll jump right back to this hearing. So please accept our apologies for any inconvenience that that may cause for any of you. So we are going to--hi, we have some of my colleagues here, Council Member Joel Rivera. Thank you for joining us, Council Member Peter Vallone, and I'll announce members as they come in. Okay. So let's hear from the Department of Health, and is HAC going to testify? We're going to do them separately? Okay. And they say I'm the boss. Okay. Doctor Deborah Kaplan, Doctor Tamisha Johnson and Doctor Lorraine Boyd, please join us. Thank you for being here. If you've done this before, you know, hopefully you've decided who's going to testify first. The mics have a little button in the back that puts them on. Speak into the mic as you're testifying because the hearing is

recorded and if you're not--on the stem in the back. Feel it. Get personal with it. Sergeant, I think they need some help. Okay, begin when you're ready.

DEBORAH KAPLAN: And we have some materials that we brought with us to share. Copies of the report you referenced and a couple of other materials. So my--is the mic on? Can you hear me? Okay. Good afternoon, Chairperson Arroyo and members of the New York City Council Committee on Health. I'm Doctor Deborah Kaplan, Assistant Commissioner of the Bureau of Maternal Infant and Reproductive Health at the New York Department of Health and Mental Hygiene, and I'm joined by Doctor Lorraine Boyd on my left who is the Bureau's Medical Director and Doctor Tamisha Johnson on my right who's our Maternal Health Projects Coordinator. Thank you for the opportunity to submit testimony on the subject of Women's Preconception Care and Health Outcomes for Moms. Although this topic is somewhat broad, I'd like to spend my time today focusing on maternal morbidity and mortality and in

particular the reasons for racial disparities in maternal morbidity and mortality rates. This is a very important issue to the department and we are pursuing a number of initiatives to help address it, which I will also be discussing today. Maternal mortality is internationally recognized as an indicator of the community's health and the Department has for decades routinely reported the City's maternal mortality rates. For or most recent data which includes surveillance through 2010, we know that tragically approximately 30 women die in New York City annually from conditions that were either caused by or exacerbated by pregnancy, a rate that has been consistent for the past two decades. From the surveillance we also know that black women are three times more likely to die from conditions related to childbirth than non-Hispanic white women. This disparity is consistent with national trends. To supplement this data, we conducted in-depth reviews of maternal deaths from 2001 to 2005 using an even broader definition of maternal death. The results of our review of these

maternal deaths were published in the Department's report that you referred to earlier on pregnancy associated mortality in the City. The leading causes of maternal mortality identified in this report included post-partum hemorrhage, embolism and pregnancy induced hypertension. As you're aware and noted the report also noted significant racial disparities in maternal deaths. Another finding highlighted in the Department's report was the high prevalence of pre-existing chronic diseases among women who experienced a maternal death. Among the cases reviewed, 56 percent of all women who had a pregnancy related death had a chronic health condition prior to becoming pregnant. These conditions included chronic hypertension, asthma, and cardiac disorders among many others. Additionally, almost half of the women who suffered a pregnancy related death were classified as being obese. We know from survey data that more than one-third, 37 percent of New York City women, are overweight or obese before pregnancy and two percent have pre-existing diabetes. Compared to non-Hispanic

white women, non-Hispanic black women are two times more likely to be overweight or obese and to have diabetes prior to pregnancy. Additionally, non-Hispanic black and Hispanic women are also less likely to have access preventive health services. There are similar disparities by insurance status. For instance, women with no insurance or those on Medicaid are less likely to access preventive health services prior to pregnancy compared to women with non-Medicaid insurance. We also know that among women 25 to 44 years of age in New York City many of whom will go onto become pregnant and give birth, 12 percent have had hypertension, 12 percent have high cholesterol and six percent currently have asthma. These factors, along with overweight and obesity are risk factors for adverse pregnancy outcomes including maternal mortality and not surprisingly there are racial and ethnic disparities in many of these indicators. Obesity can directly impact pregnancy related illnesses such as pregnancy induced hypertension, pre-eclampsia/eclampsia and/or

gestational diabetes, even in women who are otherwise well. Research indicates that these conditions can also impact birth outcomes for the child such as pre-term delivery and birth defects. Our Department carefully monitors and seeks to prevent maternal deaths. For instance, in response to the number of maternal deaths due to post-partum hemorrhage, a condition which in many cases may be survivable with timely and appropriate clinical interventions, the Department in collaboration with the New York State Department of Health and the American Congress of Obstetricians and Gynecologists issued a health alert letter for clinicians caring for maternal patients encouraging them to ensure that effective drills were in place to manage post-partum hemorrhage. This letter was followed in subsequent years with the development of a hemorrhage poster with clinical management guidelines to be displayed on labor and delivery wards and a set of educational slides with information on obstetric hemorrhage management which was distributed to maternal

health providers. We plan to assess how effective this outreach has been in preventing maternal deaths due to hemorrhage. Other educational efforts to address maternal mortality include presenting our data and guidance at meetings hosted by the American Congress of Obstetricians and Gynecologists and the New York Academy of Medicine. These sessions were attended by New York City-based obstetricians, researchers, midwives, nurses and other health care providers, including staff from HHC hospitals. In 2009, the New York State Department of Health announced the formation of a Maternal Mortality Review Committee to assume responsibility for reviewing all cases of maternal deaths in New York and to develop guidelines and interventions to prevent maternal death. Staff from our Department sit on this committee, ensuring that concerns specific to New York City are addressed. Recently, one departments--I'm sorry. Recently our Department staff on the committee helped prepare a guidance document on the management of hypertensive

conditions in pregnancy for obstetric care providers. That document was released in May of this year and we distributed a couple copies of that report to you. In developed nations, a more accurate picture of maternal health may be gleaned from studying severe maternal morbidity, as opposed to solely maternal mortality. Severe maternal morbidity includes complications during labor and delivery, for example, a ruptured uterus or an unplanned hysterectomy. Cases of severe maternal morbidity are approximately 100 times more common than maternal death. From national studies we know that the incidents of such cases is rising and that this is likely due in part of to the rising chronic disease burden among the reproductive age population. Consequently, the Department is planning to examine hospitalization data to better understand non-fatal, severe, adverse clinical events which occur during hospitalization for infant delivery. We believe it will help us better understand the factors that place women at serious pregnancy--at risk of serious

pregnancy complications and the factors associated with racial and ethnic disparities. This data will be disseminated widely and used to inform program and policy recommendations to reduce negative pregnancy outcomes. Both the Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists acknowledge the importance of preconception health and health care in reducing the risk of adverse pregnancy outcomes by working to optimize a woman's health prior to her conceiving a pregnancy. Improving the pre-conception health and medical care of women is directly related to improving the primary care system generally and to this end, the Department works with clinicians and other providers to improve the quality of preventive health care for all New Yorkers. Through the Department's Primary Care Information Project, known as PCIP, we work with over 3,000 providers serving more than three million patients to improve the quality of the primary care they provide. PCIP focuses on treatment of common medical conditions that can adversely

affect pregnancy, such as hypertension and diabetes, and has demonstrated that it can improve treatment of these conditions. In addition, the Department's efforts to broaden health care access among vulnerable populations will undoubtedly allow more women of reproductive age to obtain primary care coverage, enabling them to obtain proper screening and risk assessment, early diagnosis, and adequate management of chronic health conditions before they become pregnant. The Department recently developed a fact card, also distributed to you, in many languages which uses--for use in health centers and other community health settings to raise awareness of the connection between women's overall health and having a healthy pregnancy. This card is available in multiple languages and can be obtained online or by contacting the Department. Finally, current Department initiatives which encourage New Yorkers to consume a healthy diet, engage in regular physical activity, maintain a healthy weight, and quit smoking are also well in line with the

goal of optimizing women's preconception health. Many of the Department's initiatives in these areas, including the Shop Healthy, Green Cards, and Stellar Farmers Markets programs, are focused on communities that have higher rates of many of the chronic diseases that can contribute to negative maternal health outcomes. In its Healthy People 2020 objectives, the United States Department of Health and Human Services set a goal of 10 percent reduction--set as a goal a 10 percent reduction in both maternal mortality and a maternal illness and pregnancy complications. As it became increasing clear that a woman's health prior to conception can greatly affect her pregnancy outcomes, the need to focus on preconception care and even more generally on women's health as a whole is of the utmost importance if we are to meet these goals as a city and as a nation. Making certain these efforts are appropriately targeted to ensure that we not only reduce the rates of maternal mortality and morbidity, but that we also reduce racial disparities in these rates, is

equally important. Thank you again for the opportunity to submit testimony, and we're happy to answer any questions.

CHAIRPERSON ARROYO: Thank you, Doctor Kaplan. We've been joined by Council Member Vann. I just wrote a couple of notes on the--you didn't mention age as one of the factors that can impact pregnancy outcome. The report doesn't highlight that as one of the major issues. Do you find that, that can contribute?

DEBORAH KAPLAN: Yes, that's a very good point. There is a--there are--is a higher proportion of births to older women, and in New York City about 17 percent of births are two women ages 35 to 39 and about five percent are the women over the age of 40, and we know that chronic conditions, which adversely affect pregnancy outcomes such as I described earlier, increase with age. So in fact that is a factor and we think may help contribute to why the rate of maternal mortality in New York City is higher than the national rate.

CHAIRPERSON ARROYO: What about younger age women?

DEBORAH KAPLAN: That is not--in terms of contribution to maternal death, that is not a factor in New York.

CHAIRPERSON ARROYO: You didn't find that that--

DEBORAH KAPLAN: [interposing] No.

CHAIRPERSON ARROYO: a contributor? So the teenage pregnancy issue in the City and/or unplanned pregnancy are not--of women under a certain age are not a major concern as it relates to the outcome of pregnancy?

DEBORAH KAPLAN: There are concerns, but not in regards to maternal morbidity and mortality.

CHAIRPERSON ARROYO: What are the concerns there?

DEBORAH KAPLAN: Well its concerns around teens having access to preventing pregnancy and prevention of sexually transmitted infections, other health outcomes in terms of teens. Delaying, whether they delay

initiation of sex or prevent unintended pregnancies.

CHAIRPERSON ARROYO: Sounds like a subject for another hearing. Okay. The--I'm going to go through your testimony. [off mic] The second page, second to last paragraph where you indicate the New York State Department of Health and the American congress of Obstetricians and Gynecologists issued a health alert letter for clinicians caring for maternity patients, encouraging them to ensure effective drills to manage post-partum hemorrhage. When did that happen? And you're planning to assess, or you the Department is planning to assess the effectiveness of the recommendations and how hospitals implemented them. Do you have data or can you tell us when was the alert issued, and how long before we can hear a report about the benefits about that strategy?

DEBORAH KAPLAN: So the first alert was issued--sorry?

CHAIRPERSON ARROYO: The benefits of the strategy, did we improve or--

DEBORAH KAPLAN: So we initially issued the alert in 2004, and then we sent it out again in 2009, and we are currently assembling data from case reviews from pregnancy associated deaths from 2006 to 2010. The report that--the 2010 report went up to 2005. So we are currently assembling that data and as just to say that the lag is related to reviews being very detailed and time consuming. We review the complete records. And so we don't have that data fully compiled. We will have a report in the next several months we are hoping and will be completed, and we'll be able to look at that now. We do know that there was uptake in terms of the processes in hospitals and hospitals posting this information and having drills where they had a chance to practice what would--what they would do since this may not happen every year and any particular hospitals. They may not have an opportunity to have to practice those specific protocols.

CHAIRPERSON ARROYO: So it's possible that we'll hear from your colleagues from HHC

on what their experience has been? Hint, hint. Okay. On the page three of your testimony, second paragraph, you indicate--last sentence, recently the Department staff on the Committee help prepare a guidance document on the management of hypertension. Is that the only condition that you're preparing some guidance on?

DEBORAH KAPLAN: So we--this is in partnership with the New York State Department of Health which is the lead on this and we're working with them to produce those--

CHAIRPERSON ARROYO: [interposing] Well you know how we feel about the state and how they do what they do.

DEBORAH KAPLAN: Just saying they're now in charge of Maternal Mortality Review, and we make--by our being part of those committees, we have an opportunity to really raise New York City issues. So it's very important that we go up to Albany and participate. In terms of other reports, I'm going to ask Doctor Boyd to answer what else they're working on.

CHAIRPERSON ARROYO: State your name for the record before you speak.

LORRAINE BOYD: Lorraine Boyd.

CHAIRPERSON ARROYO: Pull the mic a little closer to you, from the base. Don't handle it from the-

LORRAINE BOYD: Okay. As a member of the committee they are interested in at least three major risk factors or three major causes. They're working on deep venous thrombosis or DVT in order to prevent women from getting emboli, which are clots that go to the heart. There are also--

CHAIRPERSON ARROYO: [interposing] Did you all get that, because I thought I was the only one that did know what she was talking about. Okay. Assume we don't have a clue what you're talking about. Be as detailed as you can.

LORRAINE BOYD: They've not yet begun to work on hemorrhage, but that's certainly something that the Department of Health in New York State and us and other members throughout the state are very

interested in. So the idea is that just as we've done in the past, which is to take on one particular entity at a time, make sure we disseminate the information as accurately--

CHAIRPERSON ARROYO: [interposing] And when you say entity, you mean condition?

LORRAINE BOYD: Yes, conditions, yes. That's right.

CHAIRPERSON ARROYO: One of--for those in the audience who have gone through my history with my history with my daughter and the baby, it was not until she developed a rash on her face that the doctor went, "Oh, what is that thing?" And her question to me was, "Mom, why aren't women, pregnant women screened for Lupus?" And I said, "Well, I don't know. Let's go find out." And I reached out to friends who are sitting in the audience here, people who I've developed relationship over the last few years chairing this committee, and I was really troubled by the lack of information that came back, not because they didn't try, but because there really was not any real good information that I can go back to my daughter

and say, “Sweetie, this is the reason why.” It kind of sits in the realm of, well, insurance companies don’t pay for it so doctors don’t order the screening, which was started, prompted the conversation about, “Wow, that’s really interesting. What else are we not doing for pregnant women?” And then later as I had conversations with the advocates and providers, we recognized that if you wait until you’re pregnant, then it’s probably already too late to have a good outcome. So hypertension is the only conditions that we’re ready to make a recommendation about how to handle better?

DEBORAH KAPLAN: Well, hypertension is the one that we distribute and there’s now an official report that’s out, and it’s being disseminated through the state and through ourselves as well, but as Doctor Boyd mentioned there will be--

CHAIRPERSON ARROYO: [interposing] That’s this one?

DEBORAH KAPLAN: Yes. That’s that one.

CHAIRPERSON ARROYO: DO you have extra copies of this?

DEBORAH KAPLAN: We can get you copies--

CHAIRPERSON ARROYO: [interposing] You can get it online as one of those things--

DEBORAH KAPLAN: I have one more here.

CHAIRPERSON ARROYO: No, no, but the question is for the audience, anyone who might--

DEBORAH KAPLAN: It’s available online.

CHAIRPERSON ARROYO: Online. Anyone who might watch the hearing?

DEBORAH KAPLAN: Yes, it’s available on the New York State Department of Health website.

CHAIRPERSON ARROYO: New York State. Hypertensive disorders in pregnancy is the name of the report for those who might be interested to access it online.

DEBORAH KAPLAN: And we anticipate other reports as Doctor Boyd described on blood

cots, DVT, and potentially hemorrhage down the road. We'll see where the state is going with that.

CHAIRPERSON ARROYO: We're joined by Council Member Van Bramer. Thank you for joining us. On further down on the page, the Department is planning to examine hospitalization data to better understand non-fatal, severe, adverse clinical events and this data will be disseminated widely and used to inform program and policy recommendation to reduce negative pregnancy outcomes. When was the time frame for you to do that?

DEBORAH KAPLAN: We are very pleased to note that we just in the last two weeks received a two year 650,000 dollar grant to do maternal morbidity surveillance. When we noted from reviewing the research that for every maternal death, there's likely 100 severe maternal morbidity cases or women who have very serious complications that could include death, but often they're not, but yet they're quite serious. We submitted a--prepared a proposal to receive funding so that we could get a better

understanding of that, and so we just received--haven't even received the funds, we just learned that we will receive them. Our hope is to [cross-talk]

CHAIRPERSON ARROYO: Is that going to be managed by the Department or are you going to be contracting with providers at the community level to engage in that work?

DEBORAH KAPLAN: Well, we--the implementation is still to be determined, but we know we will be hiring folks through staff to work in the Department. We have a research and evaluation unit that is led by an epidemiologist and so they will be under her direction and we will certainly work with, as we always have, partners in the community, clinicians, and community providers to both inform our decisions on how we're going to proceed, but also to plan on the best way to share the results through many, many different avenues.

CHAIRPERSON ARROYO: Okay. And when will folks in the audience know they should be

bothering you about how that's going to roll out.

DEBORAH KAPLAN: Give us a year. I can't--

CHAIRPERSON ARROYO: [interposing] Give 'em a year.

DEBORAH KAPLAN: I can't--you know.

CHAIRPERSON ARROYO: Give them a year. Okay.

DEBORAH KAPLAN: Yes, at least.

CHAIRPERSON ARROYO: Okay. We've been joined by Council Member Eugene, and okay. So I'm going to as promised stop the hearing and address the issue of the resolution. Nope, false alarm. Okay. Okay. On the bottom of your--the last page of the testimony. Well, is that true? No, it's not. The PCIP, you're dealing with 3,000 providers serving more than 3 million patients to improve the quality of primary care they provide. Where are these providers? Do we have a list of who they are?

DEBORAH KAPLAN: I don't have it with me, but that's something that we can easily give to you, get back to you.

CHAIRPERSON ARROYO: Okay. So we'll look forward to that, and what I'm going to look forward to seeing in that list of providers is a good representation, in particular in the communities that have been highlighted as communities of concern, where the disparities are, and if that's not the case, then we're going to have another conversation about why not. We'll save that for another day. Okay? And you know, the access to care, and as I said earlier in my opening in referencing my daughter's story is access to care and insurance was not an issue for her. She was presumably getting some fairly good care, as good as the Navy provides care in the military. I think they do a pretty good job, and the issue of what was missed. You know? And the conditions, because she's a military member. She was, you know, high physical activity. Her body is recovering from workouts she confused for--or she confused the conditions of joint pain and fatigue and it wasn't until the pregnancy that the rash developed on her face. So, I don't--I didn't

hear in your testimony conversation about how to--nuances in care that providers ought to be focusing on as well, and I'm certainly looking forward to the public testimony because I'm looking for recommendations on how we can strengthen what providers are paying attention to so that if a women comes at the age of 29 and she's experiencing, you know--does she--will she ask, "Are you feeling fatigued? Do you have joint pain? Do you, you know?" There are some things that are just being missed, opportunities that are being missed for us to understand the condition of the health of the patient that can ultimately impact the outcome of the pregnancy. My granddaughter's care has cost the US government upwards of 2.5 million dollars at this point, and when you think about that kind of investment and how we could have maybe invested differently in how the care is provided in the long run, and I know I'm going to see heads bob up and down, that in the long run the care would have been a whole lot cheaper for both my daughter and the baby. So, we're, you know, some how we can't kick the can

down the road, and we need to have some real enlightening conversation so we can deal with not only us locally here, because I think we get it, and I think we understand what has to be done, but at the state and the federal level some policy changes and some of the things that drive insurance companies to do what they do, how they do what they do. That would enable providers to be more aggressive about how they can identify benefits and care that could improve the care of the women or the condition of the women. The last paragraph, it has become increasingly clear that women's health prior to conception can greatly affect her pregnancy outcome and the need to focus on preconception care and even more generally on women's health, which is why you were talking about it. And then how do we do that do that? How do we best do that in a way that makes sense and it becomes part of how we live and breathe and provide care to women, generally. So, I want to go back to two points, my previous question. There are, I guess we can agree that there is some connection between

unplanned pregnancy and health outcomes, right? Can we agree on that?

DEBORAH KAPLAN: And health outcomes?

CHAIRPERSON ARROYO: Yeah, of the pregnancy outcomes, the condition of the child and the health of the child. One of the things that I found really extraordinarily concerning is that when Alisa spent four months in neonatal ICU, and then she was transferred to Blythedale Children's Hospital, beautiful facility in Westchester County. There was not an empty crib in the infant ward of the hospital. All children that were born, some full term but with some very serious conditions, and others for the most part premature and, you know, by the grace of God and the miracle of medicine, their life was sustained. Not all of them made it, but a lot of them did, and I'm sure if we visit Bltyhedale today, we'll probably find the same situation where there isn't an empty crib in the infant ward. And the numbers are just, to me, so concerning. And I met a lot of Bronx

residents there from different areas of the borough. I guess because of the location, maybe, but the numbers are just staggering and it just bothered me greatly. It wasn't just about Elisa and my daughter but the number of children and families that are being effected. Because something is not being caught on time. And on a--in my opening statement I referenced that the 2010 report found that black women were seven times more likely to experience maternal mortality. In your testimony you said three times. Why are we saying two different things?

DEBORAH KAPLAN: Well, although the report came out in 2010, the seven times greater rate black comparing black women to white--to non-Hispanic white women refers to the period 2001 to 2005. And the three times higher refers to a single year 2011. The 2000--

CHAIRPERSON ARROYO: [interposing] Oh, I see.

DEBORAH KAPLAN: Just to try to not make--the 2010 report used a different broader

definition of maternal mortality that included deaths occurring up to you one year after the end of the pregnancy instead of 42 days. And you have to--we need to keep in mind that when we look at disparities, they're based on--while as we said earlier, about 30 women die a year, and what a terrible tragedy each death is, and yet because the--anytime there are numbers less than 50, every year they can be a swing. That said, I think the bottom line is whether three times or seven times, these disparities as you stated earlier are unacceptably high. There are variations by year and that always happens when you have numbers that are lower than 50 or so.

CHAIRPERSON ARROYO: Were you done?

DEBORAH KAPLAN: Yes, we're done.

CHAIRPERSON ARROYO: Okay. So the disparity is health condition prior to pregnancy, access to care, and the disparity between women of color and their white counterparts, so we're getting ready to hear some incredible recommendation from the Department of Health about how to close this gap?

DEBORAH KAPLAN: Well it’s a complex issue, and we want to reiterate what I said in response to the question in the testimony, that we know that it’s women’s health prior pregnancy is a key to assuring healthy outcomes for mothers and babies, and as one step of many that need to be done, we develop this fact card that we’ve distributed and that we are hoping will be up in clinicians offices that serve women of reproductive age. We know that many women don’t know there’s a connection between their overall health and a healthy pregnancy, and the more we can both raise awareness among women of reproductive age as well as to make screening for even thinking about becoming pregnant a routine part of care. The more successful we are in getting the message across and practices that help women know that they need to--their--what they can do before they become pregnant to assure a healthy pregnancy if they plan to become pregnant as well as help control those conditions before pregnancy occurs. So that is our focus and that’s one area as I mentioned during the testimony. We

are also looking at our general work around chronic obesity and other chronic health conditions that the department does through many of our other--through other bureaus as key because that's about overall women's health, and the more we can look at overall women's health so that women enter pregnancy healthy, the more likely we are to both reduce overall rates of maternal morbidity and mortality as well as to narrow the disparity.

CHAIRPERSON ARROYO: Now, access to care is one of the other factors noted in the report, and I would imagine having insurance is a major consideration there. What's your anticipation in terms of health care reform and how that can open up the possibility for women to access care, because they have coverage?

DEBORAH KAPLAN: I remain optimistic that the--you know, we know there are many challenges, but we, you know, hope that this will allow many women who are not covered to develop coverage, not just during pregnancy, because we know that in New York City most women are covered during their pregnancy

through some other insurance or through Medicaid.

CHAIRPERSON ARROYO: That's true.

DEBORAH KAPLAN: And it's--

CHAIRPERSON ARROYO: It's prior to that, though.

DEBORAH KAPLAN: But it's prior to pregnancy that we know many women will not qualify and that is, as we discussed, a key point. Both are important, but we want to make sure that women who are not covered before pregnancy have coverage and can be screened for and know possible risks to a healthy pregnancy. So I am hopeful that more uninsured women will be covered and have access to primary care.

CHAIRPERSON ARROYO: And with that role out, some best practices for providers about how else they can view the patient in term. And, you know, I keep coming back to my daughter and her experience, and that you know, a relatively healthy young woman whose providers didn't really see the need for digging any deeper than what was in front of them, and that's where this conversation needs

to lead us. There--the disparity between, among women of color, can we drill down in terms of neighborhoods, areas of the City where you see the incidences higher than that of other areas?

DEBORAH KAPLAN: I mean, when we look by borough, and I think that somewhat reflects the percent of people who are either poor or also women of color, we see differences in the maternal mortality rates by borough, with the lowest rate being in Manhattan, the highest rate--and this is for looking at three years together, 2009 to 2011. The highest rate was in Brooklyn followed by the Bronx and Queens were about the same. And Staten Island was lower and the lowest was Manhattan, and I think as with many disparities, health disparities around the City, we see the distribution looking similar in terms of where the poorest neighborhoods are.

CHAIRPERSON ARROYO: My colleagues, any questions? Okay. Because I'll dominate this conversation if you let me. Do we know

what hospitals has a higher incidents of mortality rate?

DEBORAH KAPLAN: We don't find looking by hospital. To be--because with 30 deaths in the City and because we have a system in the State with regional perinatal centers meaning that there's some hospitals that provide more specialized care and where women with the most complicated pregnancies are seen and often deliver. We know that some of the var--much of the variation isn't about necessarily--isn't necessarily about care, but about where are the sickest women getting care. And so--

CHAIRPERSON ARROYO: [interposing] I'm sorry, we're trying to negotiate here. Council Member Van Bramer has to go chair a committee and I was like, we got to vote. We got to vote. Don't leave yet. We'll do the vote tomorrow. There you go. Okay. So I'll take that off the radar.

DEBORAH KAPLAN: So continue?

CHAIRPERSON ARROYO: Awesome.

DEBORAH KAPLAN: It would really be unfair to call out individual hospitals and the reason we feel that is because they cases are too rare for that and may not be reflective of the population served. Maybe, I'm sorry, maybe more reflective of the population served than the quality of care. And we know that over 80 percent of deaths occurred in obstetric facilities that are prepared to provide the highest level of care for the most complicated deliveries. So just to stress that that's why we look at it by neighborhood, by community, by race, ethnicity and age, by pre-existing conditions, but and while we know the data by hospital, that looking by individual hospital is not in our review a fair way to look at what is going on.

CHAIRPERSON ARROYO: Now, one of the notes that was prepared for me by the staff is that there seems to be a higher rate of mortality for C-section than vaginal deliveries, and the spread is significantly high for C-sections. That's 79 percent versus 19 percent.

DEBORAH KAPLAN: So, from our case reviews, it appears that C-sections, that the rate of C-section, the overall higher rate of mortality for C-sections is your question. From our case reviews it appears that Cesarean deliver occurred either due to fetal distress or maternal inability to go through labor, and in fact sometimes, the C-section occurred was performed at or near the time of the mother's death as a last resort to save the mother and--

CHAIRPERSON ARROYO: [interposing] Say that again.

DEBORAH KAPLAN: Sometimes C-section was conducted at or near the time of a mother's death, when it was known that she would not survive as a way, a last attempt to save the infant. When all efforts to save the mother herself had not succeed--had not--had failed. And it's exceptionally rare in our case reviews to find a death that was directly precipitated by Cesarean delivery. For in other words, if the mother had hemorrhaged after surgery--

CHAIRPERSON ARROYO: [interposing] Is there a footnote to this--

DEBORAH KAPLAN: [interposing] That's quite rare.

CHAIRPERSON ARROYO: number, somewhere?

DEBORAH KAPLAN: What I just said?

CHAIRPERSON ARROYO: Yeah.

DEBORAH KAPLAN: Do we have that data?

CHAIRPERSON ARROYO: Well, you know, just on the--

DEBORAH KAPLAN: [interposing] Yes.

CHAIRPERSON ARROYO: Just on looking at the number, it's--something's desperately wrong with how C-sections are being done or given the explanation you've just provided, you put it in perspective and understand it differently.

DEBORAH KAPLAN: Right. I mean, I think it's really important to just finish and make it clear that we are concerned about the high C-section rate. That is--that's not--that remains a concern of ours, but we don't want to conflate that issue. We don't want to--with maternal death. We know that C-sections

during--when there are serious maternal complications, are often life-saving procedures that need to be done.

CHAIRPERSON ARROYO: It saved my granddaughter's life without a doubt.

DEBORAH KAPLAN: So there, case in point. And that is a very separate issue.

CHAIRPERSON ARROYO: So, Doctor Kaplan, I'm sorry. Let me take you back. So, my question is not about whether C-section rate is high in the City, it's just that the number of deaths associated it seems to be higher for C-section patients given just the pure number that I read, 79 percent versus 19 percent, and with the explanation you're giving me or giving us, that it's usually an attempt at a last ditch effort to preserve the life of the infant.

DEBORAH KAPLAN: Well I put a--add to that, and say that the ultimate goal for any pregnancy is clearly an outcome which results in a healthy mother and healthy baby. And C-sections should only be performed when they are medically necessary, as they can contribute if

not medically necessary to poorer neonatal child birth outcomes. And addressing the issue of unnecessary C-sections is a separate issue that we are involved in and work is going on across the country, but we--but C-sections as the cause of maternal mortality is true in less than five percent of maternal deaths.

CHAIRPERSON ARROYO: And is there any racial disparity among in the rates of C-section between women of color and their white counterparts?

DEBORAH KAPLAN: I'm going to ask Doctor Johnson to take that question.

TAMISHA JOHNSON: We know that black women in general have a higher level of morbidity, so if they actually go into a pregnancy in a sicker state--

CHAIRPERSON ARROYO: [interposing] I'm sorry. I was trying to cheat with--

DEBORAH KAPLAN: I just asked Doctor Johnson to take this question.

CHAIRPERSON ARROYO: Yes.

TAMISHA JOHNSON: So we know black women on a community level actually have a

higher rate of morbidity and complicating conditions, so they actually may go into a pregnancy more ill, and consequently they may actually require a C-section to be either life saving for themselves or the infant. So that's the--

CHAIRPERSON ARROYO: [interposing] Do we know individual rates for those subgroups?

TAMISHA JOHNSON: We actually had put it in the report. I think you have it.

CHAIRPERSON ARROYO: Okay, so I'll pay attention to it. And--[off mic]

TAMISHA JOHNSON: I'm sorry. If we--I'm not sure if we actually did put it in by race, It's been a while since I handled that.

CHAIRPERSON ARROYO: Now--

DEBORAH KAPLAN: [interposing] We can check on that and can get that to you.

CHAIRPERSON ARROYO: I know we're going to hear from the advocates when they testify that reproductive age, what is reproductive age? What are we considered?

DEBORAH KAPLAN: There's--

CHAIRPERSON ARROYO: [interposing] Clinically and appropriate reproduction.

DEBORAH KAPLAN: Fifteen to 44. Certainly women can--there are teens who can conceive before age 15 and women who are older than 44 who have conceived and can conceive, but when we talk about it and when we target it in this educational material, we developed--we look at 15 and standard is to look at 15 to 44.

CHAIRPERSON ARROYO: And as a clinician, do you have a different approach to a woman and her prenatal care based on her age?

DEBORAH KAPLAN: Yes.

CHAIRPERSON ARROYO: What are the differences?

DEBORAH KAPLAN: And I'm not a--I should be clear that I am a Physician Assistant, and but I'm--as a doctor I'm here with a non-medical doctor.

CHAIRPERSON ARROYO: It's okay--

[cross-talk]

CHAIRPERSON ARROYO: And I know we have midwives and all the other levels of care providers who we're going to hear from. My

background as a health care administrator, I remember that younger patients were put in a high risk category. I never quite understood why. Older women were put in a high risk category. I never understood why, and is there just a practice or is there a nuance in the body that's different that could potentially result in negative things happening?

DEBORAH KAPLAN: As women reach--get older, there are higher, greater chances of complications. That can be related to age or the exist--more likely existence of other underlying conditions that can put them at further risk.

CHAIRPERSON ARROYO: What about younger, teenagers, 15?

DEBORAH KAPLAN: Very young there can--you know, lower than 15 there can sometimes be increased risk, but for a 15 year old, there's unlikely to be additional risk.

TAMISHA JOHNSON: In terms of actual maternal morbidity and mortality, adolescents actually do very well in this county in terms of outcomes. They actually don't have the kind

of rates we see for other countries in terms of poor outcomes in pregnancy.

CHAIRPERSON ARROYO: Is the preconception care a part of the Infant Mortality Reduction Initiative that the Council puts out and I guess one of the things that we're going--I'm hoping to hear from the advocates in the audience, is are we at a point now where we need to redefine not only funding, I'm sure that you're all going to agree that more funding is necessary, but also the goal of the initiative and how we might need to here at the City level in something we do have direct control over is, how do--is there a need for us to re-examine the purpose and the goal of the funding and begin to have a conversation with the providers in our communities that they need to help us reshape this initiative?

DEBORAH KAPLAN: So we actually in this past year have been in discussion with our partners who we meet with quarterly who are the leading agencies in the Infant Mortality Reduction Initiative and benefit from funding that the City Council has provided over more

than 10 years, and together we have looked at this issue and in revising the work that's done in the community to really look at prenatal--at preconception health as a key part of reducing both maternal poor outcomes for mothers and babies.

CHAIRPERSON ARROYO: And separate from the particular things that you've referenced, the alert or the card to be used by facilities and programs, and the question that I have, this is what's in the community setting for providers, for patients, who's using this card, and how are they using it?

LORRAINE BOYD: It's for women who--

CHAIRPERSON ARROYO: [interposing] Patients?

LORRAINE BOYD: Yes, patients.

CHAIRPERSON ARROYO: So it's sitting out on tables somewhere in the clinic?

LORRAINE BOYD: Yes, so that, you know, what our hope is that they will begin to start to understand that they need to pay attention to their health before pregnancy. This is sort of the first attempt at engaging

women about their health before they become pregnant.

CHAIRPERSON ARROYO: And what work are we doing with providers, the health care professionals that have them in the exam room?

DEBORAH KAPLAN: Well, we're--I mean, the first thing is to distribute and have this in the waiting areas and have it on a stand, we hope, which we--an easel so that it really draws women's attention and hopefully sends the message as well for them to ask about this when they see their provider. Beyond that, we are really exploring and hoping whatever ways we can work directly with providers. We are hoping that our maternal morbidity surveillance that we're embarking on with the new funding will help us better understand the underlying conditions that put women at risk and can really better inform the kinds of initiatives, recommendations we want to make on both the programmatic and policy and in terms of addressing this issue. Other work we're involved in that's been part of our broader work has been around prevention of unintended

pregnancy, and assuring that women of reproductive age and teen, including teens, have access to comprehensive--all the methods that are FDA approved for contraception so that they can plan their pregnancies and prevent pregnancies when they don't want to be pregnant.

CHAIRPERSON ARROYO: So I would love to have some of these in the office, and we often go to community forums and meetings, and I think this is certainly something that we should have a available as Council Members. So I would encourage the Department to work with us, and I think our staff can help you. Translation is important. This is only in English.

DEBORAH KAPLAN: We actually have this in Spanish, Mandarin Chinese, and Creole, and so we would--we don't see this as just being in the clinical office setting. We see this as something to be available by anyone seeing young women and women of reproductive age in their communities and men.

CHAIRPERSON ARROYO: After school programs--

DEBORAH KAPLAN: I mean, we want men to know about this too and make sure that their significant others and family members are aware.

CHAIRPERSON ARROYO: So if we can have--where's John's counterpart here today? [off mic] The nerve of him to take a week off. So that we can identify what languages Council Members need them in so we can get some of these into the offices so we can go out there and do that work as well.

DEBORAH KAPLAN: That'd be wonderful. Thank you.

CHAIRPERSON ARROYO: And I have a tendency of plagiarizing in my newsletter, so if this--hey, if you tell it's not cheating, right? So if it's on an electronic document that we can have access to that we can also use some of this in our newsletters. I think that's also helpful.

DEBORAH KAPLAN: We'd be happy to--

CHAIRPERSON ARROYO: [interposing] I did that in my newsletter with the Animal Care and Control information and my constituents found it useful. Trap, Neuter, Return is something that my district is a little better versed in. And if you don't know what it is, I'll tell you about it after the hearing. Are there certain conditions that women of child-bearing ages should be screened for, vaccinated against as a common practice?

DEBORAH KAPLAN: So definitely tested for--and this is, you know, right here on the card, high blood pressure, cholesterol, diabetes, HIV, cervical cancer, as well as certainly their weight, if they are overweight or obese before pregnancy. We know that that, as I mentioned earlier, we know that that's an added risk for many--for potential complications. In addition, women should note during, in terms of immunization, it's very--the flu--many immunizations, but also the flu vaccine is very important. Women who have developed the flu during pregnancy have often have a much worse course than people who are

not pregnant, especially young people of reproductive age who are not pregnant. So it's very important for women who are pregnant or before they become pregnant to know about the flu vaccine. We go by American Congress of Obstetricians and Gynecologists, and we think for optimal preconception health there are several other issues in terms of screening for any undiagnosed, untreated or poorly controlled medical conditions, that either the women already know she has that or not controlled or has not identified her immunization history. Nutritional issues are a key factor as well. Tobacco and substance use and other potentially high risk behaviors that can affect the baby's growth during pregnancy. Possibly occupational and environmental exposures that could put the mother or the baby at risk. And as critical are social and mental health issues that can greatly impact a mother's health overall and her health during and after pregnancy.

CHAIRPERSON ARROYO: So how should I answer my daughter when she asks me, "Why aren't pregnant women tested for Lupus?"

DEBORAH KAPLAN: Specifically for Lupus, do you have anything? I'm going to--I think overall we--

CHAIRPERSON ARROYO: [interposing] Because we--

DEBORAH KAPLAN: I can't speak--I don't have an expertise specifically.

CHAIRPERSON ARROYO: We're talking about pre-existing conditions that she may not be aware of, and then this is in her case was, seemed to be the most contributing factor to Elisa's poor development.

DEBORAH KAPLAN: I can't speak and I don't have the expertise to speak specifically to lupus, but what I would say is that--

CHAIRPERSON ARROYO: [interposing] Doctor Kaplan, I'm sorry, for the providers in the audience that are going to testify, if you can give me a clue and because it's near and dear to my heart, I want to be able to use my daughter's experience in a way that can help us change the world in some way, or at least this little part of the world in New York City.

DEBORAH KAPLAN: I would just like to say, though, I think in general, the key is that women get--have a very good history taken and in an effort to identify any underlying undiagnosed conditions or conditions that already exist, they receive information that they know what might put them at risk of a complicated or complication during pregnancy, if they are planning a pregnancy, and that they're aware of that, and that I mean there are some conditions that I don't know--I can't say specifically to Lupus, that may not become noticed until pregnancy, and that will always be true, but we want to avoid that as much as possible when we can identify it through history and screening.

CHAIRPERSON ARROYO: Okay. Doctor, I can keep you up here all afternoon, but we have a room full of people that want to testify, and I want to thank you so much for your testimony and the Department for the report that helped us kind of frame the conversation a little bit. We do look forward to continuing the conversation and we will circle back after we

hear some of the recommendations that are--that will come out of the public testimony. So we look forward to--I hope that you're not one of those people that we have to have a going away party for at the end of the year, because I think we lose a lot in transition if we're not consistent with a follow-up, given all the work that the Department has already done around this issue. So thank you ladies very much for your time, and I know that the Department will leave someone in the room to hear the rest of the hearing and take some notes back and give you a sense of where we're going to try to start following the conversation.

DEBORAH KAPLAN: Thank you very much for the opportunity.

CHAIRPERSON ARROYO: Thank you. Okay. So the vote will be tomorrow, probably around 9:30 on the resolution and this hearing will not be adjourned, only recessed. Okay. Doctor Machelle--how am I pronouncing that, Allen? HHC, and Ross Wilson, Doctor Wilson, please join us. I'm sorry to keep you waiting. And hopefully your testimony is going to kind

of weed through some of the questions that we-- that I put forward. I always look forward to hearing what you're up to in HAC, one of my favorite City, quazi[phonetic] city agencies. Thank you for being here.

ROSS WILSON: Thank you. Good afternoon, Chairperson Arroyo and members of the Health Committee and other distinguished members of New York City Council. I'm Doctor Ross Wilson, Senior Vice President and Chief Medical Officer of the New York City Health and Hospital Corporation, and I'm joined today by Doctor Machelle Allen. Machelle is the Senior Assistant Vice President and Deputy Chief Medical Officer of HHC, and has a very long history in HHC in clinical practice of OBGYN. She also heads the perinatal center for HHC. So thank you for the opportunity to submit testimony on women's preconception care and health outcomes for moms in New York City. Just at the beginning, what services do we provide? So we're proud that we deliver more than 20,000 babies in New York City in the last 12 months at 11 of our hospitals. Others who

choose to deliver at an HHC hospital are cared for by experienced by obstetric teams and for completely modernized birthing centers. Labor and delivery suites at our hospitals feature the latest modern medical technology to protect mother and baby during the birth process. The quality of care that is provided is carefully monitored through the leadership locally as well as through the committees of our Board of Directors. The HHC Simulation Center is actively involved in training of clinical teams to improve care for mothers and babies. HHC cares for a population of pregnant women who are predominately are Hispanic or African-American with significant rates of chronic disease, and this--these chronic diseases increase the risk to both mother and baby. Two years ago, 45 percent of our mothers with a Hispanic origin and 35 were of African-American origin. Nearly 11 percent of mothers have hypertension, and almost 10 percent, five times the community rate, have diabetes. These rates are increasing as obesity is increasing problems throughout our society. Clearly HHC

serves a much higher risk population than is reflected in the state and national averages, but still manages to achieve outcomes for mothers and babies that meet or exceed these benchmarks. In 2003, Bellevue Hospital Center and Jacobi Medical Center were designated by the New York State Department of Health as regional perinatal centers. Only 18 hospitals in this state have this designation of which nine are located in New York City. The work of the IPC at HHC is under Doctor Allen's leadership. As an IPC, these hospitals provide the highest levels of specialized care for the most acutely sick and at risk women and newborns. In addition, the IPC's provide quality of care. They provide oversight. The provide education and training to our hospitals based on the needs. The activities of the IPCs include annual site visits to all HHC hospitals, Bellevue, Elmhurst, Harlem, Kings County, Lincoln, Jacobi Metropolitan, North Central Bronx, Queens and Woodhale [phonetic]. During these site visits, the IPC team discusses maternal and neonatal health outcomes

and other issues in the management of labor and delivery. The IPC shares best practice initiatives from local, city, and state level and establishes and works with our leadership to establish guidelines for best practice. They're also regular provider education programs, and twice a year we have a full day perinatal conferences which are educational in nature for all the care team, nurses, physicians, PA's, midwives, etcetera who are involved in the care of pregnant mothers and babies. We have level three and level two perinatal centers. In addition to having two hospitals with the IPC designation, IPC--sorry, HHC has both level three and level two perinatal, level three being the highest level. Elmhurst Harlem, Kings County, Lincoln, Metropolitan, Queens and Woodhull are all designated as having level three perinatal centers. These facilities provide complex care and operate neonatal ICU's to meet the needs of fragile premature infants who require special attention. Our level two perinatal centers at Coney Island and North Central Bronx provide

perinatal services to mothers with uncomplicated pregnancies and healthy newborns. Patients are transferred to a level three for a higher level of care as needed. Sometimes that transfer occurs during pregnancy where the mother is transferred prior to delivery, sometimes it occurs after delivery. In 2010, HHC IPC was awarded a federal Centers for Disease Control and Prevention grant aimed at providing education and awareness to women of childbearing age on the dangers to the fetus from drinking alcohol during pregnancy. This project is entitled Reducing Risk for Alcohol Exposed Pregnancy in federally funded community health center entitled to any programs. Alcohol is a leading cause of morbidity and mortality in United States and New York City and intra-utero alcohol exposure is a major avoidable cause of birth defects and developmental disabilities. Preconception planning, ideally all of our patients who are considering becoming pregnant will consult their healthcare provider. This is the best opportunity to ensure a healthy pregnancy and

baby and allows the review before pregnancy in the following areas and to provide the following recommendations. Firstly, to take folic acid every day to lower the risk of some birth defects of the brain and spine, and providers will also prescribe prenatal vitamins that contain higher amounts of folic acid. The cessation of smoking and the cessation of drinking alcohol, the avoidance of hazards in the home and the work place such as toxic substances, chemicals and cat or rodent feces. Ways to improve the overall health, reaching ideal weight, exercise healthy food choices and good mouth and oral care. The ways to avoid illness, like flu vaccination etcetera. And also family concerns with regard to domestic violence or a lack of support. At that time we conduct a comprehensive health assessment with includes the following, firstly, making sure that all vaccinations are up to date. Make sure that any known medical conditions are under control. To identify common medical conditions that can affect the pregnancy or be exacerbated or made worse during the pregnancy,

specifically diabetes, hypertension, obesity, asthma, epilepsy, thyroid disease, depression and eating disorders are specifically looked for in that time. Next would be to have a current Pap test to screen for sexually transmitted diseases, particularly Chlamydia, gonorrhea, and syphilis, and also cervical cancer. To understand whether there are health problems that run in the mother's or the father's family, to understand problems with prior pregnancies that might affect the current pregnancy, and depending on whether they're identified genetic risk factors, we also may refer the patient to a genetic professional for screening, and this particularly is relevant in areas like the history of sickle cell anemia, thalassemia, Tay Sachs disease, hemophilia, or cystic fibrosis, or some forms of cancer. All of testing and all of this review ideally occurs with the father's involvement. Prenatal or antenatal care--although HHC encourages all of our patience to speak with their health care provider prior to becoming pregnant, the majority of our pregnant patients don't seem to

have done so. Fewer than 70 percent of our patients, even after becoming pregnant actually commence anti-natal care in the first trimester. When a woman first appears for anti-natal care, they receive the same comprehensive health assessment as indicated above with the consideration there's some additional screenings, these include a glucose tolerance test, a test for diabetes, birth defects such as Down Syndrome, Group E Streptococcus, HIV testing and other things that might have come from the comprehensive health assessment. With only 67 to 70 percent of our patients actually engaging in anti-natal care in the first trimester, and about another 20 percent in the second trimester, a number of the opportunities to fix risk factors are lost, and so we can detect the problem, but the chance to actually reduce the harm may be lost. In fact, we have just over one percent of that which is about 200 patients a year who arrive to us in labor without having any anti-natal care at all and without any documented contact with any health care provider that we can

contact or find out about, and those patients are at extremely high risk. In addition to the screenings in the anti-natal care, women are referred to WIC, Woman Infant and Children program for nutrition services, dental services, mental health services, and social services. Health education is appropriate for each stage of pregnancy so that women know what to expect, when to contact the clinic and when to go to the emergency room or to the labor and delivery suite and breast feeding education throughout the pre-natal period. For women who present to us late in pregnancy, we still provide the relevant tests, but as I've said, we've lost the opportunity to provide the best care possible because we've lost the opportunity to modify some of the risk factors like hypertension, diabetes, and smoking. The Prenatal Care Assistance Program or PCAP-- waiting to seek care is particularly unfortunate because all of our HHC facilities participate in the State's PCAP program, which offers comprehensive prenatal care to pregnant women or teens who almost all meet the

eligibility criteria. Ninety-eight percent of patients at HHC meet the PCAP criteria, and therefore are eligible for coverage. PCAP services include all the screenings and risk assessments that I discussed above. In addition, PCAP includes the following, coordination of care for all services required by pregnant women, prenatal or post-partum home visits provided to those women who've identified medical or psychosocial indications for such visits, and follow-up on missed visits. This concludes my written testimony, and we would now be happy to answer any questions that you have.

CHAIRPERSON ARROYO: Thank you for your testimony, Doctor Wilson. I am going to go to points of your testimony, and then I have some general questions. The first page, third paragraph, ten percent of the women presenting have higher than community rates of diabetes. Is it because it's pregnancy induced? Have you looked at that number deeper to understand why that's the case?

ROSS WILSON: So what we know about this is this could be they had diabetes beforehand. It could be that they had a tendency to diabetes beforehand and pregnancy brought out that tendency, or that they just developed gestational diabetes and that 10 percent figure is during the pregnancy. So if we look at the health screening data for the City, the rate of diabetes for his population is closer to one or two percent. So this is a pregnancy, we believe, a pregnancy exacerbated increase in diabetes because of the--it occurred because of the pregnancy.

CHAIRPERSON ARROYO: Are there any plans or do you do some screening follow--at post pregnancy to see if that is indeed a factor, or is there some other underlying concern that we should be looking at?

ROSS WILSON: So, the biggest underlying concern, and this is a profound issue for us is obesity. As we control obesity, diabetes goes down and high blood pressure goes down.

CHAIRPERSON ARROYO: No, okay. Let me ask the question differently. Are we doing-- what follow up are we doing for the women that present, that are screened and identified as having diabetes and post-partum does that range change for that same cohort of patients?

ROSS WILSON: So what we know is that all the patients who have been diagnosed with diabetes during the pregnancy are followed up after the pregnancy by a physician specifically with regard to the diabetes. I'm unable to tell you what percentage of those diabetics no longer require an intervention. We also know that some patients who have gestational diabetes in their first pregnancy may in fact require no treatment after the pregnancy, but when they become pregnant again, require treatment again during the second pregnancy.

CHAIRPERSON ARROYO: It happened to my daughter with hypertension.

ROSS WILSON: And it will happen and it increases the likelihood of those people developing hypertension or diabetes in later life or if they weight gains considerably.

CHAIRPERSON ARROYO: On the regional perinatal centers, you have two in the system, Bellevue and Jacobi, why isn't there one in Queens and one in Brooklyn?

ROSS WILSON: The designation is made by the state.

CHAIRPERSON ARROYO: We would still--we would need to build a hospital in Staten Island to even begin that conversation, but it's--okay, it's designated by the state, but because there's--somebody prompts the state to do a review and say you're worthy or you're not worthy. So are the Queens and Brooklyn facilities not strong in that regard or are they not aggressively pursuing this designation? My bottom line is we should have one in every borough at a minimum.

ROSS WILSON: We have the capacity and the skills in each of the four boroughs that you named to have an IPC. The state designated nine centers in New York City. So they designated a center in every borough. They just wanted all HHC centers.

CHAIRPERSON ARROYO: But we want one HHC facility in every borough to be.

ROSS WILSON: So we've ensured along those lines.

CHAIRPERSON ARROYO: I'm not going tell that--let the state tell us what we're going to have in this city.

ROSS WILSON: Along the lines--

CHAIRPERSON ARROYO: [interposing] Right?

ROSS WILSON: we've basically taken Elmhurst in Queens, and it has all the capacities that are required, and in fact has--delivers a very large number of babies and the same Kings County in Brooklyn.

CHAIRPERSON ARROYO: So it's not because there's a lower level of care being provided. It's the state's discretion, how many they're going to award.

ROSS WILSON: The states made the designation. We have made a choice that we have in each borough, the same level of care that would be provided as if there was an IPC, but what we've done is to centralize the data

collection and education part of the process so that we don't have to duplicate that unnecessarily.

CHAIRPERSON ARROYO: So the level two and level three perinatal centers, is that also a state designation?

ROSS WILSON: It is, but it's also based on volume and complexity. So that at a level two level they have everything that they need to deliver safely uncomplicated patients and babies. They don't have what's required for the most complex 10 percent, but we have level three nurseries, obviously, in Brooklyn, in Queens, in the Bronx, and in Manhattan.

CHAIRPERSON ARROYO: Okay. So on preconception planning, are we using this term in the same way, meaning women of childbearing ages between the ages of 15 and now I find 44, seems to be the bracket of women. So is that what we're--what you're referencing in your testimony, preconception planning?

ROSS WILSON: Yes.

CHAIRPERSON ARROYO: And so it is recommended that women of childbearing ages,

those 15 through 44, I'm going to use the Department of Health's guideline there or what's found in this--are you familiar with this document?

ROSS WILSON: I am not.

CHAIRPERSON ARROYO: Okay. I'd like your opinion on it, since Doctor Kaplan is not an MD, she's a physician assistant, although I find mid-level providers are more effective at doing care than others, but that's my personal experience. And I mean no offense to any of the doctors in the audience.

ROSS WILSON: We value highly mid-level providers in our system.

CHAIRPERSON ARROYO: I, you know, mid-wives, nurse practitioners, and physician assistants, I think are--assistants are, I think, the heart of our health care system, and are the ones that are doing the hands on work with patients. And if we're going to change how we're going to deal with women and childbearing ages, I think they are the ones that should give us some recommendations. So, it's

recommended that folic acid is simply vitamin C, is that what we're talking about here?

ROSS WILSON: No, it's not vitamin C. It's a different vitamin.

CHAIRPERSON ARROYO: And so that we should take folic acid in childbearing ages regardless of whether we plan a pregnancy or not?

ROSS WILSON: Yes, it is recommended that if it's possible that you're going to have a pregnancy, it's a good idea. If you're not planning a pregnancy or you're not likely to become pregnant. It offers no additional benefit unless you have a particular illness called folic acid deficiency.

CHAIRPERSON ARROYO: Okay. And hazards in the work place, toxic substances, chemicals, rat and rodent feces, this is just bad for health generally, particularly for women planning to have a child?

ROSS WILSON: It's bad for health generally. Mostly, that's the answer. There are a couple of fungal and bacterial infections

that are found in feces that can be at risk for women in the early stage of pregnancy.

CHAIRPERSON ARROYO: I remember my midwife when I was pregnant from my son told me not to change the cat litter. Still holds true?

ROSS WILSON: Holds true.

CHAIRPERSON ARROYO: My baby's 30 years old. And the family concerns, domestic violence, lack of support, I don't know that the Department of Health report ties that in as a contributing factor to mortality rates among women, child birth?

ROSS WILSON: We're looking at them from more than mortality rates. We're looking for the best outcome for the mother and the baby.

CHAIRPERSON ARROYO: Okay, I see.

ROSS WILSON: And if the mother is in an unsupported environment, particularly young teenage mothers who are already in a hostile or abusive environment, then both mother and baby are really at risk.

CHAIRPERSON ARROYO: So what health problems that run in the mother's and father's family, for example? Besides the ones that we've already mentioned, diabetes, hypertension.

ROSS WILSON: Well we've mentioned the major ones here. But in addition, there are things like blood clotting disease, hemophilia, etcetera. Some of the other blood things that are mentioned in the testimony that can run in families. Also there can be history of still births that can be related to both an anti-body or a genetic background. There are a number of rare illnesses. They're not common, but they're rare and if--it doesn't matter if it's a rare illness or not. If you have it, it's not rare. You know, it sort of matters to you, and so we need to unpack that and work out what's going on.

CHAIRPERSON ARROYO: And the--what's your sense about why women are showing up, fewer than 70 percent of your patients commence in their first trimester. What are the contributing factors? Are we talking about

insurance, lack of information, because we as a city have access, our patients or our women have access to the prenatal insurance program?

ROSS WILSON: We do, but I'm--

CHAIRPERSON ARROYO: [interposing] Why are they starting at seven--30 percent of them come in. Do you have the break down? What's the 30 percent?

ROSS WILSON: The 30 percent come in after the first trimester.

CHAIRPERSON ARROYO: Right. So that could be the second?

ROSS WILSON: The majority of that 30 percent come in the second trimester.

CHAIRPERSON ARROYO: Which is at four months of pregnancy?

ROSS WILSON: The first trimester is three months.

CHAIRPERSON ARROYO: Right.

ROSS WILSON: Second trimester is three, four, five, six--six months, and then the last three months. So half of that come in in the middle and the rest come in later. Now, some of these patients have just arrived in the

country, you know, at that stage of pregnancy, but I might ask Doctor Allen, because she has more insights into why people who actually live in our community who aren't in touch with the clinical system in our community choose not to enter anti-natal care at the time we like.

CHAIRPERSON ARROYO: Immigrant status, do you believe has a--

MACHELLE ALLEN: [interposing] So we actually--

CHAIRPERSON ARROYO: [interposing] Doctor, if you can identify yourself for the record.

MACHELLE ALLEN: Doctor Machelle Allen.

CHAIRPERSON ARROYO: And it's Machelle, right, M a?

MACHELLE ALLEN: But I answer to Michelle, Machelle.

CHAIRPERSON ARROYO: No, no, I just wanted to make sure I wasn't--

MACHELLE ALLEN: [interposing] But it's M a.

CHAIRPERSON ARROYO: mis--

MACHELLE ALLEN: [interposing] It is M a.

CHAIRPERSON ARROYO: Okay. Go ahead.

MACHELLE ALLEN: So doing a survey of women enrolling in prenatal care and asking those who are enrolling in the second and third trimester if there were any barriers. The responses we got where many women had just arrived from another country, they were just recent immigrants arriving late to deliver here. An interesting proportion of women actually were ambivalent about their pregnancies. The pregnancy wasn't planned and they really hadn't made a decision to keep or not keep and waited a while to decide to keep, and then another segment of women actually because of irregular menses were not really sure that they were pregnant. Those are three major categories that the patients fell into. It was not an access issue. It was not an insurance issue. A couple of women had insurance, noted insurance, but as you know PCAP covers even if you're not documented and they--the financial eligibility is easier.

CHAIRPERSON ARROYO: And I would imagine, and you know, I ask the questions of the panels, and then I look at the public so that we can hear your comments or your opinion about. While of these 30 percent, those that are showing up because they are just recently arrived, are they coming here to have their child or what? Do we understand the nuances of that population at all?

MACHELLE ALLEN: I can’t give you an in depth response. Many of them may have family members already here or family--with the Asian community, they actually may have grandparents and they come here to work and prove their status, offer better opportunity for their children. Most of the time--so I don’t have an in depth well thought out answer, but usually for better opportunities, they want to raise their children here.

CHAIRPERSON ARROYO: Okay. So insurance should not be the underlying factor.

MACHELLE ALLEN: No.

CHAIRPERSON ARROYO: For them coming in, 30 percent of them coming in later than

their first trimester. So are we--so we can--so 30 percent of those women are not insured. What's your break down in terms of the population of women who come in for care, prenatal care at HHC facilities, the percentage that are insured or how successful are you in getting them enrolled in PCAP?

MACHELLE ALLEN: I would say 98 percent of our patients are insured. The ones who come from out of state don't qualify for PCAP. So if anyone's coming from New Jersey or Connecticut, they won't qualify.

CHAIRPERSON ARROYO: Okay. And the--Okay. So Dan's question is how long before conception did their coverage start and how long after birth does the coverage extend? PCAP, you must be pregnant, right?

MACHELLE ALLEN: So as soon as you appear pregnant you're eligible, and the coverage for the mother extends through the post-partum period and for the child to the first year of life.

CHAIRPERSON ARROYO: And do you have a sense of or do you know how--is PCAP

transitions to another type of coverage at some point after pregnancy? Do you keep track of once they're no longer pregnant, and I guess through post-partum they're covered for PCAP. What happens to them after PCAP expires and do we have any sense of whether we're successful in transitioning them to some other type of insurance?

ROSS WILSON: So we don't have precise information about that. What we know is that we try very hard to transition those patients into Medicaid as eligible. For those people who are not eligible, particularly those who are undocumented, there's not much. There's no other real option for them in terms of insurance in the ambulatory [phonetic] sector. Under the health care reform agenda, they'll be a small group who will be eligible to get subsidized entries through exchange, but there will still be a significant group of undocumented patients who after delivery will not have insurance. And going back to your earlier question, PCAP commences at the time of pregnancy, which clearly means that

preconception care is not covered by PCAP, and what we know generally across HHC, I don't have the figures just for the OB population, but what we know generally is approximately 30 percent of our ambulatory patients are uninsured.

CHAIRPERSON ARROYO: Thirty percent?

ROSS WILSON: Thirty percent. So I don't think it would be any reason to be dramatically different from that for this population.

CHAIRPERSON ARROYO: So your opinion about why pregnant women are not screened for lupus?

MACHELLE ALLEN: I'll start.

CHAIRPERSON ARROYO: I gave you head start. I told you to be prepared to answer the question. Yes, Doc--

MACHELLE ALLEN: So there really is no screening test for lupus. So the diagnosis is made for a combination of presenting symptoms, any signs you pick up on a physical exam, and then what you get with your laboratory testing. So it would be the

history, so everyone--are you having any headaches, any nausea/vomiting, or any complaints that are occurring now that didn't occur before you were pregnant? Or perhaps, were present before you became pregnant and you didn't have an opportunity to see a provider. And then the physical exam, the rash that you spoke of often doesn't exist. Often there's nothing that you see on physical exam with lupus. And your blood pressure would be--so lupus will present with some vague symptoms. It's a hard diagnosis to make. When you do the physical exam, the blood pressure may be elevated, and when you look at the urinalysis they'll be an excessive amount of protein. And then it takes some clinical skill to put those pieces of the puzzle together. So the short answer is there's no screening test, but through the entire intake process between the history, the physical exam, the laboratory data you pick up the symptoms, the signs, and then the laboratory confirmation and be able to put it together.

CHAIRPERSON ARROYO: And how do you know that your primary care provider has got the clinical skills necessary to put it together.

MACHELLE ALLEN: So the clinical competence and proficiency.

CHAIRPERSON ARROYO: Yeah.

MACHELLE ALLEN: So the providers in HHC must be board certified within a certain period of time of getting their privilege. So hopefully, the board certification is a proxy for competence. In addition to that, the Joint Commission has put in place where your proficiency is evaluated when you first come on staff and then ongoing on an annual basis, where if you're doing procedures, you're being proctored and observed. If you're an internist and you don't do procedures, that someone is reading your medical records. So it's the certification by the academic board and then ongoing evaluations by the facility within which you're working.

CHAIRPERSON ARROYO: So, we have to rely simply on the certification to believe the competency of the provider?

MACHELLE ALLEN: And it required ongoing certification. So all the boards require maintenance of your certification. So it's not--

CHAIRPERSON ARROYO: I know, but not all carpenters are good carpenters. I mean, I--

ROSS WILSON: So this is a very complicated question for all of us at every level in every organization, because this is--

CHAIRPERSON ARROYO: [interposing] That's fair. I'll give you that.

ROSS WILSON: There's a distribution, you know, from one end to the other, and it's a question about whether at the lower end of the distribution, whether that's actually safe or unsafe or adequate or inadequate. So there's a distribution of performance in all areas. And I say to some of my surgical colleagues who don't like to be anything else other than

excellent, that 50 percent are below average at any one time.

CHAIRPERSON ARROYO: I think I'm an excellent Council Member.

ROSS WILSON: But by definition, because in any population, 50 percent have to below average, but I just want to come back to the--if I could. There's ongoing oversight. It depends on if you're a primary care doctor how well you treat high blood pressure, and so we have systems in place that shows one doctor whether his level of blood pressure control is as good or not as good as his colleagues. So this is--there are ongoing things that we're steadily building in. We're at early stages in this process. We're not where we would like to be, which is to be able to give people feedback about the things that they do in a way that allows them to improve, where alternatively allows us to know whether they're in fact unsafe.

CHAIRPERSON ARROYO: Okay. So let me bring it back to things that you boasted about in your testimony. So how do--what processes

are in place in a HHC to understand that the providers in the system are following these best practices, from a quality review or assurance perspective?

MACHELLE ALLEN: So, they're ongoing reviews of mortalities as well as morbidities that Dr. Kaplan spoke about. So within each department there's probably a weekly meeting reviewing the week's previous cases. In addition to that, there are audits that go on with reviewing adverse events, those that don't reach the level of a morbidity or a mortality. So the chart reviews of minor things that happen, and the risk department in each hospital keeps a profile of each provider of adverse events for those providers.

CHAIRPERSON ARROYO: But only the adverse events, not the ongoing care that they're providing individually?

MACHELLE ALLEN: Other than--no.

CHAIRPERSON ARROYO: Well--

MACHELLE ALLEN: [interposing] In terms of the quality review, the reviews are of incidents.

CHAIRPERSON ARROYO: Only incidents, not I am provider x, and I have a panel of patients that are compose of, I don't know, 12 patients. How am I doing as an individual provider within the system? So that's an analysis of individual providers outcomes or how well they're following the best practices for making sure that--and then we'll put it in different buckets, right? The women of childbearing ages that are not nes--they're not pregnant. Pregnant patients in a different bucket, but, and the discussion here today is about how do we best handle the care of a woman between the ages of 15 and 44 in the event that they plan a pregnancy or become pregnant unplanned that their health has been managed in such a way that whether planned or unplanned, we've been able to capture as much opportunity, to quote Doctor Wilson, or lose less opportunity to provide a better outcome.

MACHELLE ALLEN: So I'll start. So that's an excellent question that we're actually grappling with. What we're working with in other departments is a score card or a

dashboard, that there's certain metrics that get followed, blood pressure, for women, pap smears, specific tests, and the metric is followed by provider with the hope of giving the provider specific feedback on how they're doing with these particular items that are being measured. I don't know if you want to expand on that.

ROSS WILSON: So I want to go to the more complicated part of this, which is that as much as we talk about an individual provider or an individual nurse or a midwife, ultimately, the care in this environment is provided by the team working together. And sometimes, it's just as important as how well the lab worked in getting the test result back or the clerical system work as to how an individual component. So we're really looking at the patient outcomes and events, and then try to track back to how well the team and its components worked, and that's one of the reasons we've been investing significantly in the simulation center, because we've been doing team training, not just the physician or the nurse or the midwife or the

internist, but everybody. And in a couple of areas relevant to this conversation, both in terms of maternal hemorrhage and in also in terms of shoulder dystocia where the baby gets stuck halfway through delivery. We've been doing, developed standardized protocols and then system wide team training where everybody who's involved comes together and trains in a simulation environment. And I think our focus is very much on how does the team work and how do we make it and help it work better, because if the team works, the patient outcomes are better.

CHAIRPERSON ARROYO: And when you use the term team, that's generally for any level of care, any type of care. So it's preconception or prenatal care or post-partum care. Are you doing simulations in all of those different areas?

ROSS WILSON: We're doing it in labor and delivery at the moment. There's a focus on that because of its urgency and because of the very high cost of not getting it right.

CHAIRPERSON ARROYO: So for the purposes of this conversation, it's the care prior to that that I think we need to spend some energy on so that if the corporation is not planning to, that it begin thinking about how care to women of childbearing ages is being coordinated so that whether a pregnancy is planned or unplanned, we have a better outcome, and I reference my daughter's case because it's the only one I really--that's how I was able to try to get my hands around this larger issue. By the time they're pregnant, it may already be too late, and at that point, you can only hope to manage the condition in a way that can give you the best outcome possible. The question is, what do we do prior to pregnancy and I'm not sure that we're doing a really well coordinated job around the services we provide to women that we have in Care, because the ones that are not in Care that don't have the relationship, we can deal with another conversation about how we can connect more women to Care.

ROSS WILSON: So as--

CHAIRPERSON ARROYO: [interposing] But then once we connect them to Care, what care are they getting?

ROSS WILSON: So I think we can do better here. We've identified a couple of areas, one of them is teen health where we are actually have active in our developing teen health programs, particularly around women's health and that includes preconception care as well contraception advice. And the whole notion of educating at that age that preconception care is even thought about and valued. The second thing that we're really focusing on it and we have to get better at is to make sure these patients are connected to a primary care provider who is the person who really ought to be navigating the patient rather than having the patient having to navigate themselves around the health system, particularly around the need for preconception care. And I think in many systems and I think in ours, these parts are not connected up as well as they could be.

CHAIRPERSON ARROYO: Okay. Doctor Wilson, I can't let you leave here without asking you why it's going to take so long to bring North Central back, North Central Bronx hospital back on line with labor and delivery?

ROSS WILSON: So we had to suspend labor and delivery at North Central Bronx because we did not believe we had a safe level of staffing, and that was particularly around physician staffing, and that occurred in August. We'd had staffing issues and leadership issues that had been leading up to that, but we had felt that it was safe to continue up until August. At that point, we really didn't feel it was safe. We had to make a difficult decision. We had to make it quite quickly, because we had some abrupt staffing changes, and so we made that decision. We made it in the context that there was already one department in the North Bronx network. It was one department at two locations, so part of the department was at Jacobi, and part of it was at NCV [phonetic] with a single chair and leader. We're now in a situation where we've successfully recruited a

new chair for the Department who will start in the second week of December, and one of the early things that he's charged with is the development of a plan to reopen labor and delivery services at NCV, and it will take time because of the need to identify and recruit appropriately senior staff. We have to increase particularly physician staff in order to do that. So we'll get a plan. We will start recruiting and as soon as the staff is in place and the systems are safe we will open. We know that how long it's taking us to recruit staff in our other locations. It's taking a long time. It takes from when we seek, advertise, etcetera, to when someone starts is somewhere between four and six months. And our ability to recruit more senior and experienced staff rather than relatively junior staff is a key part of what we want for safety, a mix of both of those. So we don't know how long it will take. We're not going to waste a single day, but we also--

CHAIRPERSON ARROYO: [interposing] The announcement was August of 2014. Is that incorrect?

ROSS WILSON: We said we don’t know when we can open. We are hoping that we can open by the middle of 2014, but we will open as soon as we have the right level of staff on board, and the first step in that process is that we’re expecting from the new chair a plan in January after he’s been in place for a few weeks to develop a plan. We will look at that plan with view to commencing and implementing it. So there’s no delay other than the delay that it would take us to recruit and resource what’s required to happen.

CHAIRPERSON ARROYO: Is it a--pay them better, you might recruit faster.

ROSS WILSON: There’s a small budget issue, but we clearly--we want to be competitive in the market place, and HHC is often not competitive in the market place in salaries and that includes physician salaries, but we will do--

CHAIRPERSON ARROYO: [interposing] And nursing.

ROSS WILSON: And nursing and others generally.

CHAIRPERSON ARROYO: Okay.

ROSS WILSON: But that’s the plan.

CHAIRPERSON ARROYO: So, please keep us posted, because I think there is a great deal of frustration and concern at the community level and there’s been a couple of events that were the energy around making sure that that service gets reinstated as quickly as possible. None of us want an unsafe environment for a patients, but not having information adds to the frustration. When we understand the nuances, we’re better able to cope with reality that that’s happening, and there are those that believe that we’re just not paying attention and I’d like to believe that that’s not the case, but we need to be able to have that information out in the public in the advocacy community, our unions, all those that have a question about why you did this and why it’s taking so long or why would

it take so long to reinstate it. So my glass if half full most of the time. In this case, you know, receiving a call the day before an announcement was going to be made, it's just unacceptable, and I think just adds to the frustration that you're hearing in the public discourse.

ROSS WILSON: And I totally understand that. We were--we had to make a precipitous decision. It wasn't something we planned to do, but circumstances around staffing and patient events caused us to have to do something in a matter of a few days that normally you would want to take six months to do, and so this was done because of our concerns for patient safety first. It doesn't in any way mean that we're not committed to providing a full range of women's health services in the Bronx and also it doesn't mean in any way that we're not committed to the longevity of North Central Bronx hospital as an important provider of health care services in the North Bronx.

CHAIRPERSON ARROYO: Okay. Well, thank you Doctor Wilson, Doctor Allen for your testimony, and this is just open up for more work into the future, and I look forward to that work, excited. Unfortunately, we have to broaden the conversation, but I think, you know, we experience things in order for us to broaden the horizon of how well we can do what we do. Care to women in our city is important. The care that they receive at the hands of their primary care providers is critical in how those providers are doing the work that they do for women who could potentially become pregnant and whose pregnancy outcome can be an incredible experience or a really stressful and costly experience and I'd prefer the later.

ROSS WILSON: Thank you very much, and I hope that your granddaughter continues to make progress.

CHAIRPERSON ARROYO: Thank you. Elisa's two in four months, and she's absolutely gorgeous and has got attitude for her and for little girls. So thank you.

ROSS WILSON: Thank you.

CHAIRPERSON ARROYO: Okay. So I have--how many folks do we have to testify? Okay. We have a number of you guys that came to join us, and I thank you so much for being here. I don't like to use the clock. I think it's just--makes me feel kind of icky. So I'm going to call the first panel, and I'm going to urge you not to read your testimony verbatim. Please summarize it. Give us the sailing [phonetic] points and give us a copy for the record so that we can enter the full testimony so that we can hear from everyone comfortably and without a sense of please sum up. I hate to say that to folks. Rita Jensen? Where are you? There you go, hi. Marci Rosa and--are these two people? Karina Lozer [phonetic]--I think you guys have to--do we have--do we need a slip for each one? Sergeant? No? Okay. And Beverly Fetman [phonetic] come on up. [off mic] Give me one second. Now is this going to go to all the Council Members or just--to the whole committee, and how many are on the committee? And I have a sheet. So I just messed up the card stand. I'm sorry. So we have Jaqueline

Gilbert from NYSNA and I--okay. Jacqueline, you're going to be up there by yourself. And then we all have the perinatal consortium folks. There's four of you here. We have a patient, Danielle Sullivan. She had to leave, okay. Oh, dear. Ortu Ali? [phonetic] Okay, that's the next panel, so don't rush. Robert and Nan [phonetic] Strauss. Okay. So you guys are up next. I mean, Jacqueline and then the panel, okay. Alright, ladies, now that I got my act together we can get you started. Thank you for being here. I think you've done this before. Speak into the mic, identify yourself for the record. Begin when you're ready.

RITA JENSEN: Am I on the mic?

CHAIRPERSON ARROYO: And we have for the record, testimony from the New York Academy of Medicine. Thank you for that. Go ahead.

RITA JENSEN: Good afternoon, Chairperson Maria del Carmen Arroyo and all the members of the committee. Thank you so much for an opportunity to share with this committee what Women's eNews Team of Investigative Journalist has determined about the crucial

issue of African-American maternal mortality and maternity care overall for women in this City. I am Rita Henley Jensen, Editor in Chief at Women's eNews, which is a New York daily non-profit news service. The life and death of all pregnant women and all new mothers is an issue close to our hearts and the major focus of our journalism, and by the way, I'm a grandmother of four grandchildren who were born in New York City and to compare our experience with your experience, it's a privilege to work with you to connect so that every grandmother has the happy outcome that I had, and I think that that's the mission of this committee. So congratulations. Women's eNews reporters and editors have worked on this issue for five years and we wish to thank the Kellogg corporation--I'm sorry, the Kellogg Foundation for support of this work and its commitment and leadership on maternal and infant health and racial equity. The maternal mortality rate in the United States is climbing, while around the globe it's dropping. US now has higher rates of mothers dying than any other industrialized

nation and is ranked 49th worldwide. Rather than be an example for the rest of the nation, New York City has both high maternal mortality rates and extraordinarily high rates of African-American mothers losing their lives during pregnancy and childbirths. I wanted to adopt another daughter, at least a granddaughter. Akira [phonetic] Edys [phonetic] death is one of the many that signals deep problems in New York's care of new mothers and the tragic results. An African-American, Akira died shortly after giving birth at Mount Sinai Medical Center in 2007. Akira's aunt, Carol Edy recounted to Women's eNews that her niece employed and with private medical insurance bled heavily after receiving an epidural. She complained of headaches to the hospital staff. Never the less, they released her. She was brain dead four days after giving birth. Less than a year after she died, Akira's older son, age two, was savagely beaten to death while with his father. Carol Edy is now raising Akira's older daughter in her Harlem home, and the infant born to Akira on

that day is now being raised by that child's father also in Harlem. Clearly, New York City has an overall maternal mortality rate of 24 per 100,000 births, and I think you'll see the numbers shifted. It depends on how you account, but it's a problem. It's significantly above the national rate of 21 per 100,000. In 2011, as we've established, the maternal mortality rate of African-American women in New York City was 46.5 out of 100,000 births, three times the rate for this City's white mothers, and as Doctor Kaplan testified, they counted it differently the year before. So the year before is registered as nine times the white, the mortality of white mothers. The president of--and I have her picture here. The president of New York's Academy of Medicine, Doctor Jo Ivey Boufford, told Women's eNews that with proper care, the numbers could be cut nearly in half. Maternal health experts have told Women's eNews that nationwide for every maternal death there are 50 near misses or what they were calling extreme or severe complications, and now New York City has 100.

These numbers understate, moreover, the extent of New York's maternal health problem. The City's vital statistics, that varies apparently, include only maternal deaths within 42 days of the end of pregnancy. Nationally, the Centers for Disease Control and Prevention tracks maternal deaths over a one year period to record those who die slowly as a result of their pregnancy, and you see the results in the numbers that Doctor Kaplan provided. Women's eNews has asked again and again, why are so many black women and other non-white mothers dying or suffering extreme complications. Our reporters found that the reasons for these high rates cannot be explained by the answers most commonly assumed, genetics, teen pregnancy, obesity, lack of prenatal care, poverty, pre-existing conditions, or low education. The existing data refute these guesses. In 2010, New York City Health Department revealed, and that's the report we all have, that 54 percent of the women whose deaths were related to their pregnancies underwent C-sections, and only four percent of those who died gave birth vaginally.

The Women's eNews team was unable to determine if African-American women underwent a disproportionate number of C-sections. However, Women's eNews has found again in that report that deaths from embolisms often related to C-sections are dramatically higher for African-American, and that's this chart you see behind me and that's included in your packet. Based on data from 2001 and 2005, 82 percent of the mothers who died from embolisms were black non-Hispanic, 82 percent. Fourteen percent were Hispanic. Four percent were Asian-Pacific Islanders, and zero percent were white. It's that statistic that haunts me. In other major categories for the most common causes and we have them up here, racial and ethnic disparities were also pronounced. Women's eNews believe--we're journalists--that New York must record and make public more data to understand how these disparities could exist in a city with public hospitals and outstanding network of private hospitals and generous Medicaid and PCAP. To begin to save the lives of mothers, the City must begin with transparency, hospital

by hospital data of maternal deaths with the explanations that they were high risk, including break downs by race and ethnicity as well as methods of delivery and causes of death must be made available to the public and the maternal mortality review committees, they should be encouraged, at a minimum permitted to make their findings public. Only then with an informed medical community, journalists and citizens, can the City begin to make its hospitals mother friendly. And Women's eNews stands by ready to report on the transition, and I'm happy to answer any questions, and I didn't do very well on the summary, but I hope I didn't take too much time.

CHAIRPERSON ARROYO: Thank you. Go, flip a coin.

BEVERLY FETMAN: Okay. So I'm not a doctor or physician, and I'm not working for an organization, but I'm interested in women's health issues, and I know that anything worth doing is worth planning and preparing for, and I know that 50 percent of births or pregnancies are unplanned. Now, that's a tremendous

statistic. For those who plan it, they have a chance at an appropriate examination, but those who are unplanned don't come for examinations as we heard. The rate of people who come in the first trimester, second trimester; some don't come at all until they're ready to give birth. I think that a very big problem has to center around the education of women of what they need to do for--what they need to pre--in case they become pregnant, and I think that part of the solution should be education within the schools, that there should be classes in high school, junior high school even of women's health issues. I think that a curriculum should be developed and literature should be given out to students, and they should be prepared for what might be if they have an unplanned pregnancy. I think that there should be a program of having posters in ladies' rooms all over, wherever women will congregate. I think there ought to be posters like that, not on both sides of a page, but one long page. If you are pregnant, if there is a possibility that you may become pregnant, consider these

and take the list to your provider, because I think the providers are operating on--they have ten minutes per patient and they'll slip a few. They, you know, they overlook a few issues, but I think if women have to become their own advocates. They have to ask the questions and say, "You didn't ask me about my history or the family history." You need to--I think women have to learn to be strong and advocate for themselves and they have to be educated first so that they can do it. That's one thing. I think as far as lupus, before you ask me the question, I want to say that--

CHAIRPERSON ARROYO: [interposing] I don't--there are no clinicians on this panel, right? None of you are a doctor, I won't ask you that question.

BEVERLY FETMAN: Okay.

CHAIRPERSON ARROYO: Only those who come with an MD after their--or their--

BEVERLY FETMAN: [interposing] Well, I'll tell you--

CHAIRPERSON ARROYO: They're nurses or RN's, or whatever.

BEVERLY FETMAN: I was diagnosed--

CHAIRPERSON ARROYO: [interposing] The professionals.

BEVERLY FETMAN: with lupus as a result of a blood test. Now, a simple blood test can give you that. I didn't have any other signs, but my physician, my primary care doctor sent me to a rheumatologist who then took subsequent and more sophisticated blood tests and checked my joints and so on, and apparently I did not have it, but it was only after months of checking whatever happened on the blood test, it was off and they said I had lupus. Following that, no medicine, no treatment. That part of the blood test went down and it was okay. But of course it was no related to a pregnancy. There are a few things that I really wanted to say since most everybody covered all the--I spent a lot of time on preconception care and I distributed information on where preconception care could be--where preconception care could be information with regard, and I found that the best information I could get was from the

American College of Obstetricians and Gynecologists, ACOG. They have a very comprehensive analysis of all the areas that need to be checked, not just one or two, not just drug abuse or substance abuse or not just one or two things, but a whole roster of things that should be discussed with a doctor. Some might be embarrassing domestic violence and so on, but women should know that they are at risk if they don't do--if they don't check everything. And it's up to them to say, "Could I have a few more minutes to talk to you about whatever it is." I think that the direct education of women needs to be in all areas, but in all areas that affect women, but I think particularly since pregnancy is a woman's issue exclusively, I think that it's incumbent upon the city and the state to provide funding specifically for women on this issue, and the inside door of a ladies room in the bathroom so that while they're there they could read the information, the chart or whatever. "Are you considering pregnancy? Have you--do you have reason to believe you're pregnant?" and so on.

Something that will draw the attention as well as hygiene classes or whatever they call them now in the high schools and public schools. I think that that's what they called them then. I think that not enough information has gone out about genetic testing, and I want to say I have another agenda when I'm here. I want to say that because of the City Council and because of the efforts of the City Council to support, the Fordham Laboratory for a Familial Disorder Noumea [phonetic] research. My daughter has a Jewish genetic disease. There was not, of course, the--43 years ago when I became pregnant, there was not a test for her disease. There was on Tay Sachs. Now, there are 18 or 19 Jewish genetic diseases that can be tested for by a swab from the cheek and people don't know that they could do that, but it's a very restricted population, so it's not so hard to get to most everyone in that. It's much more difficult to educate on the possibility of cystic fibrosis which effects very race and every population, but the Jewish population has concentrated in Hebrew schools

and wherever they could, in synagogues and so on to educate people on genetic testing, specific Jewish testing for Jewish genetic diseases. And I must say that the disease that my daughter has Familial Disorder Noumea, 43 years ago I was given the prediction that she had a 50 percent chance to live. That was the story. I said I don't believe it. I'm not going to believe it, and we proceeded to think that she might live a normal life, and we worked in that direction, and so I'm proud to say that last year she got married at 42, and here's the evidence. So it's never, never give up, and it could have never happened without the support of the City Council and Council Member Oliver Koppell's initiative to support the laboratory that was doing the--found the gene and then did extensive and intensive research on how to better the lives of those with this this disorder, disease, whatever you want to call it. And by doing that, I think it not only gives hope to people who get terrible predictions for awful things, but that the City Council could really impact in such a way, and

I am absolutely grateful to you and to all the members of the council that voted for the last ten years to give what's actually a small grant to the Fordham Lab for Familial Disorder Noumea, which made possible for her to live. And so I'm grateful to all of you, and that's really what I'm here to say. I think it happens and it was a question of advocating for myself because nobody was doing it for me. So, I went to you and I went to others. Council Member Rivera is not here now and the Council Members, but I am grateful to them as well. For all those who supported Council Member Koppell because he did not give up. And although he didn't think he was going to get vast funds from me or huge voting, he did the statesman like thing to do. He did what was right, and he's a real example of what the city agency could do. So, as I say, I'm here to-- I'm not an authority, although I could see I'm not an authority although I spent a lot of time doing the research. I could--

CHAIRPERSON ARROYO: [interposing] Beverly,

BEVERLY FETMAN: What?

CHAIRPERSON ARROYO: [interposing] You're being modest. We all become an authority in way or another.

BEVERLY FETMAN: What we have to do.

CHAIRPERSON ARROYO: [cross-talk]

BEVERLY FETMAN: What we have to do. What we have to do we just do it. If we have the strength, if we believe in it, we just get the strength to do what we have to. So, I thank you again, and I'm grateful for this opportunity to say thank you, and I'm just sorry that the rest of the board is not here for me to thank them, but if they look at the film or video or whatever it is--

CHAIRPERSON ARROYO: [interposing] Yeah, it'll be online.

BEVERLY FETMAN: It'll be online.

CHAIRPERSON ARROYO: Yes.

BEVERLY FETMAN: As a matter of fact, I met Council Member Koppell in the street crossing. Ten million people and I met him on the street, and he said he's sorry he can't be here.

CHAIRPERSON ARROYO: [cross-talk] He's one of the examples of what a great leader in his community can do.

BEVERLY FETMAN: Absolutely.

CHAIRPERSON ARROYO: So thank you, Beverly, for your testimony.

BEVERLY FETMAN: Thank you and thank you for your support all these years, and if there's any way that I could help you--

CHAIRPERSON ARROYO: [interposing] We're going to call you, of course.

BEVERLY FETMAN: Call me. Call me.

CHAIRPERSON ARROYO: Go ahead.

KARINA LOZER: Thank you. Good afternoon Chairperson Arroyo and members of the Health Committee. I'm actually--[laughter] I'm giving this testimony on behalf of Marci Rosa, who is the Senior Director of Maternal Child Health and Public Health Solutions. My name is Karina Lozer, and I am the Deputy Director of Development and Special Projects there at Public Health Solutions, which is one of the largest non-profits in New York City and also nationally recognized public health institute.

We do a great deal of work in collaboration and partnership with the Department of Health and Mental Hygiene and our mission is to implement innovative cost effective and population based public health and community health programs, conduct research that provides insight on public health issues and provide services to other non-profit organizations to address public health challenges. Our direct service programs serve close to 80,000 individuals and families annually, and the vast majority of those we serve are low income women, infants, and children of color, many of whom are born in a country outside of the US, residing in some of the highest need neighborhoods in Queens, Brooklyn and the Bronx, and I think actually, you know, in sort of, you know, developing this testimony, what was most interesting to us and the reason why we wanted the opportunity to speak here today is because of our sort of, you know, our definition and I think more and more the common definition of preconception and preconception health is something that, you know, begins long before someone is even, you

know, necessarily considering pregnancy. But because as you were saying, you know, such a large number of pregnancies in the United States are unplanned and because they are very often, you know, maternal mortality and other poor birth outcomes come as a result very often of preventable chronic diseases and existing health conditions that can be worked on that were existing prior to pregnancy and can be worked on prior to pregnancy. This is something that we need to be thinking about, you know, long before someone's even, as I said, you know, planning a pregnancy. So, as I said, we have a number of different direct service programs where we work with women and families. We have a nurse home visiting programs, a Healthy Families New York program. We work to get folks enrolled in, you know, food and health benefits. We have our MIC Women's Health Centers where we provide family planning and contraceptive care, and just recently because of, you know, our expertise in these areas, and because of our, you know, reputations in the low income communities that

we serve, we've been awarded a grant by the New York State Department of Health to implement a five year maternal infant community health collaborative in Corona, Queens with a number of partners there. And so what I'm just going to--what we really wanted to do today and which I'm going to try to do really quickly, I promise, is just to talk a little bit about what some of those sort of basic, you know, risk factors are for maternal mortality and other, you know, poor birth outcomes and what we feel are the strategies that are, you know, sort of recognized nationally, and you know, being implemented by us and by others within the field in a preconception context to try to, you know, mitigate some of these--this morbidity and mortality that we've been talking about today. So, I promise I'm making this shorter than it actually is. Okay. So the first is access to comprehensive family planning services. So Public Health Solutions has--our MIC Health Centers, we have health centers in Bushwick and in Fort Greene, and we've been providing comprehensive family planning and

prenatal care to some of the most medically underserved neighborhoods for over 40 years and serve close to 4,500 women annually at these two sites. Now for the project in Corona, we're going to be working closely with Plaza del Sol Family Health Center to provide these critical services to women with a particular focus on, you know, working to ensure access to the most effective contraception methods, including IUD's and other long acting reversible contraceptives, its access to high quality family planning services, especially with an emphasis on LARCs, or the Long-Acting Reversible Contraceptives, that's linked to reduction in unintended pregnancy and also very closely space births which are intern associated with adverse maternal and child health outcomes such as delayed prenatal care, premature birth, and negative physical and mental affects for children. Also, nurse home visiting and community health worker programs. Public Health Solution's Nurse Family Partnership program which is actually also based in our home community of Corona, Queens,

is a nationally recognized evidence based nurse home visiting program for low income first time moms, and we've reached over 800 families in Corona in 2008. Now, while this particular, the nurse home visitor program is typically associated with improving maternal and infant health outcomes for expectant and new mothers. So that's not really the preconception life phase that we're talking about. It can also really have a pos8itive effect in a preconception context because home visitors can connect new moms with services and resources that will help reduce their risk factors for future pregnancies, including helping them to access health benefits, preventive healthcare, family planning, contraception, nutrition, healthy lifestyle supports, etcetera. Sorry. This new project that we're going to be launching in Corona, it's also going to be using community health workers who are trusted peer advocates and educators from the community. They provide outreach, education, referral and follow up, case management, advocacy, home visiting to those women who are

at highest risk for poor birth outcomes. The idea behind the community health worker program or that model for those of you who might not know, is to create a bridge between providers of health, social, and community services, and the underserved and often hard to reach populations within the community. Now, this piece of the project that we're implementing in Corona, in particularly the cultural and linguistic competency that it provides for is especially critical in this particular community, where you've got, you know, one a very, very high rate of individuals who do not speak English as a second language, who were born in a country outside of the United States and where you have a teen birth rate that's twice that of Queens. It's these particularly vulnerable teens and women that experience the greatest disparities when it comes to poor maternal and infant health outcomes and who will benefit most from this project. Lastly, health insurance coverage, just want to talk about that really quickly. Our health insurance enrollment program currently helps

over 15,000 individuals and families obtain public health insurance coverage and apply for food stamps benefits every year. For the project in Corona, we're going to be leveraging existing health and food benefits enrollment expertise and capacity and working closely with our partners to enroll Corona teens especially with a special emphasis on family planning-- sorry, I got all--the family planning benefits program which is a New York State program that's available for teenagers and women who-- I'm not looking at my notes, so don't kill me if I'm wrong about this, but who don't have-- who either don't have Medicaid or Family Health Plus or for whatever reason choose not to use it because of perhaps confidentiality reasons, something like that, but they can get access to, again, family planning coverage and contraception. Again, which is incredibly important for that preconception life phase in order to prevent unplanned pregnancy and then all of the--the poor, some of the poor outcomes that come along with that. And again, incredibly important insurance coverage and the

access to care and particularly preventive health care, family planning, that sort of thing that comes along with coverage. When we, you know, are talking about poor maternal and infant outcomes. I think in the report, the New York City Department of Health and Mental Hygiene report that everyone has been referencing, I think that folks that--women who did not have health insurance coverage, private third party or Medicaid, were four times more likely to die during birth than those who did have Medicaid or private insurance. So, again, a key piece. And I can't find my piece of paper with my closing, but that's my closing. Thank you very much.

CHAIRPERSON ARROYO: Thank you. Thank you for your testimony and I warn you that we'll circle around and we'll continue the conversation because my hope is that we in due time would be able to come up with our recommendations and/or policy decisions that can help address some of the concerns that we all seem to agree on need some work. So thank

you all for your testimony and Beverly, thank you for sharing your story.

BEVERLY FETMAN: Thank you.

CHAIRPERSON ARROYO: Okay. Jackie? Where are you? Okay. And then did we find the young lady? Did she leave? The patient left? She did, oh, I'm sorry. Nan Joyce [phonetic], Heork Heohotu [phonetic], Pamela and Robert, you guys are up next. I'm putting you all together since you get along so well. I have one slip, so somebody owes me a slip. I have Jacqueline. [off mic] Okay, yes. Okay. She's there for support.

JAQUELINE GILBERT: And Eileen is here. She would actually answer your question on Lupus.

CHAIRPERSON ARROYO: Okay, but we need to have a slip. Anyone that speaks into the record will get one. So, only because the Sergeant won't have it any other way. Okay. Please. And be--I'm sorry, we have for the record testimony from The Doctor's Council, SEIU, provided by Frank Proscea [phonetic], Doctor Proscea.

JAQUELINE GILBERT: Chairperson Arroyo, I'm Jackie Gilbert.

CHAIRPERSON ARROYO: Pull the mic closer to you. You speak very softly.

JAQUELNE GILBERT: Oh, okay. I'm Jackie Gilbert, a registered nurse who works at Harlem Hospital in the Woman's Health Department. I have been working there for the past 19 years. I'm also a member of MI, it's an executive team, HHC, and I'm the President of New York State Congress of Bargaining Unit Leaders. I'm here today to raise our concerns regarding serious short comings in the availability of quality pre-natal and perinatal services in New York City and in the low income communities in general. This lack of available health care services combined with economic and environmental factors is a major contributor to excessively high maternal and infant mortality rates in New York City. These mortality rates are particularly acute among black women and infants. The infant mortality rate in New York City in 2011 was 4.7 in 1,000 live births. For black babies, the mortality rate was 8.1 in

1,000 live births, compared to 3.1 in white babies. In Central Harlem, the total infant mortality rate was 8.5. The rate for the Bronx as a whole was 5.9, well above the city average. In **[inaudible 02:29:24]** mortality rates reach 7.7 and in Hunts Point 7.6. Similar disparities exist in the rates of maternal death. Maternal mortality rates have increased by 30 percent in the last decade. The impact has been most pronounced among black women who have a rate of maternity death of 79 per 100,000 live births, compared to 10 per 1,000 live births for white women. The high rates of infant and maternal mortality in New York City and the ratio and socioeconomic disparities in these rates are subject to numerous contributing factors. We join in supporting the proposals that have been put forward today to attempt to address these problems, and we at NYSA [phonetic] feel that it must be noted that the solution to this problem requires that existing healthcare services available to women in the city be maintained. In this context we feel that the

sudden closure of perinatal services at NCB hospital by HHC and the New York State Department of Health in August of this year will only serve to make a bad situation worse, and we are to address the problems of infant and maternal mortality, if we are to address it, it is imperative that we maintain the existing network of health services available to low income mothers and babies. We thank you for actually asking Doctor Wilson about the, you know, about requesting the reinstating of--and restoring the vital services at North Central Bronx, which you did earlier, and we're sincerely thankful for you for doing that. I thank you for your time and attention to this matter, and here is Eileen who would share a little on lupus.

EILEEN SCHNEIDER: Hello, I'm Eileen Schneider. I've been a registered nurse for 42 years, and I have a special interest in autoimmune diseases and lupus in particular. And I did not do any research before I came here, but what I can tell you is the national average for diagnosing a person with lupus is

seven years, and it's a huge gap in our ability to identify a disease. Autoimmune diseases affect a huge number of people, and many people don't understand that diabetes is a autoimmune disease, but lupus in particular, if we wanted to do a project that identified mothers that had lupus in the prenatal time, you could screen them for A&A. I don't know how much that cost is, but a positive A&A would require more screening, but the vast majority would be negative. And on that A&A test, if the red blood cells show a peripheral pattern, it doesn't say you have lupus, but it indicates that you have to look further. So it's one test that could be done as a screening. When they do their histories on patients that present, they don't ask a lupus friendly question, which is you have to widen the scope of who you're asking about in the family. You have to go-- has anyone in your family ever had an autoimmune disease? Because they're usually not directly related, but they can be familial. And it would give you another clue further testing. That's all.

CHAIRPERSON ARROYO: Thank you for the insight. I think as we pursue this conversation, the question about well what are we screening women of childbearing ages for, and I think the question that was penned to me by Dan, what are the things that we should be screening for consistently, vaccinating against and, you know, separate and apart what's already part of the Congress of Obstetrics and Obstetrician and Gynecologists, because to--you know, they set the framework for how prenatal care is being provided. And I remember when they implemented this incredibly complicated chart for pregnant women that was about seven different pages to try to guide the provider to do the appropriate kind of screening. But at that point, what do we do with a woman that has an autoimmune condition, and why aren't we doing this screening prior to the pregnancy?

EILEEN SCHNEIDER: I know of no prenatal screening that includes an A&A. I do know that they do a history, but it's not a broad history, and I don't have the specifics, but rated second in nationally, the Hospital

for Special Surgery is rated second in rheumatology, and I do know that they have a specific program for helping people with lupus become pregnant and seeing them through the pregnancies.

CHAIRPERSON ARROYO: And, you know, in my daughter's case the first question is why weren't pregnant women screened and then that's the question she posed to me, but in, you know, as the conversation involved with some of you in the audience, I realized that by then, you know, what could my daughter have done differently in planning for Elisa. And she didn't have a clue. So was there something that she could have been looking out for that could have brought Elisa into this world in a whole different way than how she was, at barely 27 weeks and an emergency C-section, and the, you know after birth care that she still kind of-- she's coming along. She's here. She's a little miracle princess, but could that have been prevented had my daughter known in advance what this pre-existing condition and how to better prepare herself. So I don't want to take

the time of our conversation to focus on the prenatal care. The conversation is about what should we be doing differently to help our women prepare for pregnancy and childbirth and a better outcome. So I value your input and I thank you so much for taking the time to come and answer the question for me. I really do appreciate it. Thank you ladies very much. And be ready for a phone call on more work to be done. Nan Joyce? Ihotu? I'm sorry. Pamela? And Robert? Okay, and oh, I'm sorry, I didn't realize we had--Chanel? Standby. Where are you? Chanel? Okay. Thank you. Okay. So, thank you all for being here. Do we need another chair at the table? We have one in the background there. Pull up. Robert's the only guy in the group, why don't you put him in the middle so he can behave. Hello? Come on guys. You do important work in the community, this can't be that difficult. Robert, sit up to the table. Thank you. Okay. Hi. Go.

JOYCE HALL: Good afternoon Council Member Arroyo. My name is Joyce Hall. I'm the

former Executive Director of the Federation of County Networks and currently Director of Practicum and Career Development at Long Island University Brooklyn, the MPH program. Thank you for inviting me to attend this hearing to testify. Women's preconception health and health care outcomes for moms has been an issue that I've worked on, as you know, for the past few years. My testimony today will focus on the need for comprehensive preconception care, but setting up for the rest of my colleagues here and looking at it from the issue of infant mortality is closely related to pre-term births, low birth weight, infants maternal mortality and health and health care of women before, during and after pregnancy. As we know, as infant mortality is defined as the number of deaths, total number of deaths of infant under the age of one per 1,000 live births, and it's considered to be a key indicator of the health of the community, a nation and city. In New York City, the leading causes of infant mortality include birth defects, congenital malformations, pre-term

birth, low birth weight, accidents, unintentional injuries and sudden infant death syndrome. Pre-term births, low birth weight are the second leading cause of death of infants. And for those who may not know, pre-term birth is defined as birth of an infant less than 37 weeks of gestation. Normal births usually occur between 38 and 40 weeks of gestation. Ratio ethnic disparities as we heard today in birth outcomes is here in New York City and the United States, and with most of them happening because of pre-term births and infant mortality. And that has been well documented. African-American women--An African-American woman is three times more likely to give birth to a pre-term baby, and a baby born to African-American women is twice as likely to die within the first year of life than a non-Hispanic white woman. In New York City, these birth outcomes are particularly prevalent in communities of color among African-American in the five boroughs, in which the majority percent of the population is non-black Hispanic, non-Hispanic black, rather. There's

several factors that are associated with pre-term birth which include three major areas, medical and pregnancy conditions, social, personal and economic characteristics and behavioral. The medical and pregnancy conditions include infection prior pre-term birth, carrying more than one baby, overweight and obesity, diabetes and hypertension during pregnancy. The social, personal, economic characteristics include low or high maternal age, black race, a low maternal income, and socioeconomic status. And the behavioral factors include tobacco, alcohol use, substance abuse, late prenatal care and stress. In 2012, the New York City Department of Health had a brief, data brief, which looked at pre-pregnancy weight and infant mortality, and it reported that infant mortality was highest in those community districts, the highest among infants born to obese mothers, followed by those born to overweight mothers, and lowest among those to healthy weight mothers. Among infants born to obese mothers, the highest infant mortality rate was among non-Hispanic

blacks at 9.2 per 1,000 live births, followed by Puerto Ricans and Asian-Pacific Islanders both at 6.4 infant deaths per 1,000 live births. And infants born to other Hispanic and white mothers who are obese had a infant mortality rate of 5.1 and 4.1 per 1,000 live births. As we know, infants born prematurely have higher rates of cerebral palsy, sensory deficits, learning disabilities, and respiratory illnesses compared to infants born at term. The morbidity associated with pre-term births that sends into later life resulting in great physical, psychological, social economic costs. In addition, infants born with congenital malformations are usually pre-term. The ultimate consequence of the pre-term birth is death of an infant. In addition there are also consequences for the mother which can include Cesarean delivery, maternal mortality and morbidity, pre-eclampsia and eclampsia. Overall, in New York City, the infant mortality rate declined 23 percent between 2009 to 2011 from 6.1 to 4.7 infant deaths per 1,000 live births. Despite these

city-wide gains, the areas with persistently high rates are generally those with the most poverty and the highest percentages of people of color. For example, for 2009 to 2011 the three year average infant mortality rates in select community districts were Brownsville 9.2, Bed-Stuy 7.0, East New York 8.4, East Harlem 6.9, Central Harlem 8.5, The Rockaway 7.2, Jamaica 8.4 As you can see from this, all of these districts are in our communities of color and the rates are much higher than the city-wide rate. In 2011, 9.3 of all births in New York City were pre-term births with 13.1 non-Hispanic black births being pre-term, which is disproportionate than any other racial ethnic group, but they also range from 7.6 to 9.1

CHAIRPERSON ARROYO: Okay, Joyce, you're going to make me do it.

JOYCE HALL: I'm included--So, I'm going to skip over these charts, but why preconception care when we need access to early prenatal--Access to prenatal care has increased over the past 20 years, and it has improved the

health of women. However, access to care before and after pregnancy is limited for low income and economically challenged women, primarily because they do not have health insurance. The studies show that women develop conditions, chronic conditions, health conditions, in between pregnancies which then go untreated, which then contribute to the adverse birth outcomes that we see today. My colleagues will go through some of their issues with preconception care, and I'll hand it over to Ihotu.

IHOTU ALI: Good afternoon, Chairperson Arroyo and distinguished guests. My name is Ihotu Ali and I am the Coordinator for the Pre and Inter-conceptional Health Program at the Northern Manhattan Perinatal Partnership in Central Harlem. I also previously worked on our school based preconception peer education program as well as being a birth and post-partum doula. So I'm going to give a brief overview of kind of what preconceptional health care looks like in concrete terms with some real specifics,

including the way that our program works and some of the data and outcomes that we've seen in our program. Particularly looking around education, health education, and social media. So preconception care refers to, we've talked about this a lot, refers to a woman's health. I'll define it as at least three months prior to pregnancy. This is first a particular nutritional issues that impacts the health of the fetus and overall pregnancy, so three months before pregnancy, before conception. This is different from pre-natal care. As the fetal neurological development that occurs in the first few weeks of a pregnancy happen often before women miss their first period. They don't know that they're pregnant. They can't. And before pregnancy tests were composited, and obviously well before prenatal care is established. You'll see in the chart that's provided to you in blue and around the edges and red and yellow in the middle, you'll see the weekly development of a fetus. The red denotes the most highly sensitive periods where a woman's nutritional status and stores are the

key to a healthy development of especially the central nervous system and the heart, even before a missed period. So this early care is especially critical to give women who struggle with multiple health issues such as poor nutrition, obesity, and hypertension and maybe using alcohol or substances, you know, be the support that they need to actually work on their own first health first before kind of the medication restrictions and their own stress of being pregnant. So interconceptional care, then, is similarly the health of a woman between pregnancies, including losing excess weight gained in the last pregnancy, breast feeding, having adequate 18 month spacing in between their pregnancies, and looking at past poor birth outcomes as a possible predictors for the future. So as we, this panel, has talked about there's kind of two main sides of the equation. There's the provider side and there's the side of the woman. I will be able to speak more to the side of the woman and community and education, but I will have a few things to say about the clinician side as well.

The health care provider needs to give the utmost care to especially high risk, but all non-pregnant women such as recommending blood pressure medications or giving the rubella vaccination. That cannot be done during pregnancy. Also looking for hidden underlying health conditions which could be lupus, could be thyroid disease, could be rheumatoid issues or other autoimmune issues. So the other side is of a woman who needs to have the knowledge, the plan, and the time and support to support to adjust her lifestyle to achieve healthier pregnancies. She needs to, as was mentioned before, advocate for herself to make sure that the appropriate screens are done. Health care providers can incorporate the preconception model in counseling both female and male patients during reproductive health visits and conversations about family planning, and here's a key one, on preconception visits that the March of Dimes has recommended that all women go for before even beginning the process of getting pregnant, going for a specific visit where they get tested and screened for a

variety of issues. I'm not sure how frequently that is happening, but that is advocated by the March of Dimes. So interconceptional care then should begin actually earlier than it currently is to be more effective. It should be happening during the third trimester of prenatal care for pregnant women rather than-- so it's before they exit the prenatal care rather than at the follow-up six week visit. A lot of women don't come for that follow up visit. It's quite a long time after their birth, and it may be the last visit that they see with their provider before they lose public health insurance, PCAP, two weeks later at eight weeks. So it really needs to begin in the third trimester of prenatal care. Sexually active patients and pregnant women in their last trimester can also be referred from health care providers to community based programs for reproductive health education, nutrition and weight loss support and for case management. Community programs such as MNPP [phonetic] and many others employ home visit methods, have birth doulas, and also do social marketing

around preconception and interconceptional care that raises a kind of public awareness out in water and brings in women who don't have medical, current medical homes or insurance, and encourages and facilitates that relationship with a medical provider who can do the appropriate screenings. So there are handful of community programs around the country that offer this health education and case management and they do have documented results, one being the Strong Healthy Women Intervention of the Central Pennsylvania Women's Health Study and the Northeast Florida Magnolia Project were successful in reducing the rates of STDs, binge drinking, and increase self-efficacy, intent to eat healthy, and intent to be physically active, and encouraging women to take a daily multivitamin. At the Northern Manhattan Perinatal Partnership, at NMPP, I run one of three programs nationwide under the Healthy Behaviors in Women and Families three year funding stream from the Maternal and Child Health Bureau. So it's a very innovative program. There aren't a lot of

programs like this exist, and they're trying to see if it works and if it could be expanded. So we call our program Thrive, and over the past two years, and now into our third and final year of funding, we've run continuous cycles of a 10 week nutrition and fitness education program. So the last cycle was our seventh and gathered 28 women weekly for live cooking demonstrations of healthy snacks and dessert alternatives, fitness classes, and one on one reproductive health counseling and life planning. We use--I'll show you a couple different tools that we use. This is from the Delaware Department of Public Health. It says "Set your mind. Set your goals." It's a reproductive life planning tool booklet that women can take home with them, and it ask them to really consider what is your biggest dream, how does having children fit in with that, and also looking through their family health history as well as any existing conditions that are here and it does have thyroid conditions, seizures, asthma. It does not have lupus or any other concerns that I can tell, but if

you're interested, I can leave a copy of this. We also have a copy in Spanish, and we also go through this small card with them which is from the March of Dimes which is called, "Nine things to do before becoming pregnant." One of them is having a medical check-up, and on the other side it has your preconception check-up, a list. You're supposed to talk to your doctor about family history, any medicine you take, making sure your vaccinations are up to date, any medical conditions you have and how long you should wait between pregnancies. This is also a part of--you know, we give these to all of our women, and it's a part of our campaign to get them talking to their doctor so that they know where their own health is, and also as consumers, as patients coming into the medical establishment, you know, alerting doctors that this is an issue that women care about and they should as well. Let's see. So in the group that just completed last week, we have African-American, African-Immigrant, Latino women. About half of the group were obese, a quarter with very high depression

scores based on the screen that we gave them and virtually all had very high levels of stress, many of them being moms with young children and poor eating habits and infrequent exercise. We also had two women with lupus. Also one woman who was anemic, and others that I suspect may have thyroid issues. So we screen participants for a lack of medical home or insurance, chronic health conditions and depression, and then we offer them short-term case management including things like escorting them to the local clinic and Medicaid offices, referring them to free weight loss and blood pressure counseling and to drug treatment programs. We also make internal referrals to other programs at our agencies such as to mom support group, community health worker program where we have a lot of Spanish-speaking counselors, parenting classes, the doula program, and we keep the graduates of the program in touch through reunions and our Facebook page. So a little bit about the results of the program before I close up. Over the last 10 weeks over 80 percent of our

participants are now taking daily multivitamins which before virtually none of them were and didn't even know that that was beneficial for women's health. Our weight loss superstar lost 22 pounds. Eight additional women lost eight pounds each and the woman with the highest drop in her blood pressure went from 146/96, which is hypertensive, to 102/83 which is a healthy blood pressure. One woman was overweight and she said that her biggest dream was to become a mommy, and now she's already lost eight pounds, is taking daily multivitamins, eating five servings a day of fruits and vegetables and using condoms regularly, which we also provide before next year when she plans to attempt a pregnancy. One woman in her last pregnancy smoked all the way through and was still smoking when she came to us, and now she has already begun a series of smoking cessation and acupuncture sessions that are free at a local acupuncture school that we found and she's exercising daily. One other example here. Another woman said that her biggest dream is to earn her PHD and stay healthy for herself and

her family as she has a child with autism, and that's quite a lot of work, and she wants to just focus on her family for now. So across all of our seven cycles we've seen marked increases in daily nutritional label reading, physical exercise, stress management, self-care and preconceptional control, the sense that I can do something to make sure that my babies are born healthy, and these results were sustained or increased even after eight months after completing the program.

CHAIRPERSON ARROYO: Okay. You're going to make me ask you to wrap up.

IHOTU ALI: Okay, that's fine.

CHAIRPERSON ARROYO: And the three of you, take a page from that book. Okay. Thank you.

IHOTU ALI: So I'll just say that there's one quote where someone says, "I wish I could share this program with everyone who's interested in changing something important in their life." It's a well-loved program. It's just one program. It's quite small. I think it really takes a steady stream of funding to

make programs like this more common knowledge. So we do particular things like provide child care. We give a five dollar metro card for women who come. We offer discounts and incentives so that they can do things like go to the farmer's market and buy vegetables and kind of just do general things that are good for your health. When you're poor and you have a kid, you just can't do it. So, I will say to wrap up, all women deserve access to a healthy lifestyle. Some of us have more access than others, and prenatal care in particular simply comes too late per the visual I showed earlier. Hopefully, you've seen in your packet. It comes too late for the types of problems that we're seeing now like autism, like cognitive delays, and especially some of these problems cannot be addressed during pregnancy because you cannot take vaccinations and medications. So I really urge on behalf of panel and my agency for the City Council to take a stand for New York City as a model for the country in putting two million dollars into city-wide preconception and interconceptional education

and social media programs and also looking at the clinical side of things, but I can speak particularly to the education side, which is very powerful for these women on a very deep level to have time for themselves and have someone to tell them that you're worth it to take care of your health. And also 500,000 dollars for doula care expansion to ensure that this information is not kind of a piece meal sharing of information that it really is, as the woman was saying on the stalls of bathrooms. It becomes common knowledge. So the idea is that most women know to see a doctor when they're pregnant, to avoid alcohol when they're pregnant. Let's make it common knowledge to take a multivitamin with folic acid and get screened at a preconception visit. So let's make it a common adage to say we need the soil to be nutrient rich before we plant the seed. Thank you.

PAMELA DAVIS: Good afternoon Council Member Arroyo. My name is Pamela Davis. I'm the Deputy Director of the Queens Comprehensive Perinatal Council. I'm here

today as a representative of one of the regional perinatal coordinating bodies of the city-wide coalition to end infant mortality, and I appreciate the opportunity that the City Council Health Committee is providing in order that we might advocate for preconception and interconception care programs throughout New York City. The preconception and interconceptional models of care place a more direct focus on addressing those health and social determining factors which can negatively impact on birth outcomes. I would like to highlight the importance of establishing models of care with an emphasis on teens as this is a critical period during a woman's life course relative to reproductive health. We know that in New York City 88 percent of teen births are paid for by Medicaid and 90 percent of teens are not married. Teen births also pose a greater risk for pre-term birth, low birth weight, and infant mortality, and in 2010 statistics show that the overall New York City infant mortality rate was 4.9 deaths per 1,000 births. However, the infant mortality rate for

teens under the age of 18 was 9.2 deaths and teens between the ages of 18 and 19 was 7.6 deaths during that same time frame. Teens also have the highest rates of unintended pregnancy and spontaneous or induce terminations. Addressing these issues during the early preconception teen years is critical to effectively addressing the alarming rates of teen pregnancy, poor birth outcomes and health disparities. The weathering hypothesis refers to early health deterioration and is constructed as being a physical consequence of social inequality. When we examine the high rates of teen pregnancy and poor birth outcomes, the higher rates are found throughout New York City in communities of color, especially for African-American and Hispanic women. Studies have shown that women of color and particularly those who reside in low socioeconomic communities experience worsening health profiles between their teen years and young adulthood, indicating a need for targeted interventions during this phase of the life course. Health behaviors and practices

initiated during adolescence can greatly impact not only on current health status but future reproductive outcomes such as increase risk of low birth weight and very low birth weight with advancing maternal age. How do we effectively address these alarming disparities? We're proposing comprehensive and culturally relevant models of care that must effectively address chronic disease screening and prevention, sexual risk behaviors, use of contraception methods, sexual reproductive health screening, and evidence based health education interventions prior to pregnancy. The models will also address strategies aimed at reducing social inequalities that contribute to the widening gap of health disparities. We hope to have the continued support of the New York City Council in order for an impact to be made in those high need communities which exist in each borough despite the overall city-wide decline and vital statistics. Thank you for your time and the opportunity to speak with you today.

NAN STRAUSS: Good afternoon, Chair Arroyo, City Council Members. My name's Nan

Strauss. I'm the Director of Policy and Research for Choices in Childbirth. We're pleased to submit this testimony jointly with Childbirth Connection. As organizations focused on improving the quality of care during the childbearing year, we feel our role here today is to connect the dots between maternal health outcomes and the preconception, and particularly the interconception period and the childbearing year. We can particularly talk about preparing women to be in good health for their next birth and their next pregnancy. And I'm going to skip over all of this material that's been covered so well by other people today. I do want to focus on ways that care during childbirth can affect women's health in the future in the post-partum period, in the interconception period, and in future pregnancies. Medical interventions that are beneficial in particular circumstances, even life saving, are being used routinely in situations where the risks may out weigh their benefits, and where no risk low-tech solutions are being underutilized. The high Cesarean

rate widely recognized as well beyond what's needed and appropriate is associated with excess mortality and morbidity including the rise of near miss conditions such as placenta accreta, placenta previa, and Cesaran scars that can affect subsequent pregnancies as well, and the more Cesarean sections that a woman undergoes, the greater their risk for future complications. Post-partum support and interconception care as we've heard are woefully lacking and result often in needless deaths or complications that arise in the post-partum period and in missed opportunities to foster healthy birth spacing and ensure women's health for the future. Many women have no access to support in those critical first days following their return home from the hospital, despite the fact that complications frequently develop during this period, and this also leaves many women without breastfeeding support or information about family planning options. I want to quickly mention that the data collection and maternal mortality and morbidity review really has to be strengthened to better

identify at risk populations in a more granular way. New York City is a particularly diverse city, and right now the broad categories of data that we collect aren't capturing some of the specific differences. For instance, there are different risk factors for Puerto Rican women as opposed to other Hispanic groups such as Mexican-American women, Cuban women, and Councilwoman you raised earlier the issue of providing benchmarking so that facilities and physicians can see how they're doing in looking at processes of care that are offered and provided so that they can ensure that the facilities are providing the best evidence based practices possible. After talking about the problems, I want to propose some effective strategies for addressing them, and again, linking the intra-partum period of childbirth to what happens subsequently. The most direct approach to improving outcomes to ensure that all women have access to high quality evidence based maternity care practices to reduce the risks of unnecessary harm and increase the likelihood of positive outcomes. And we have

to ensure women are getting the support they need during the critical post-partum period. As a means to achieving both of these goals, we recommend expanding funding for doula care, including obtaining Medicaid funding for doulas so that all women have access to doula care. Doulas are trained support persons in providing emotional, physical, and informational support to women before, during, and after labor and childbirth. Doulas can offer a continuous presence at birth, share information about labor and comfort measures, and facilitate communication by helping women to articulate their questions, preferences and values with clinicians and hospital staff. This care has well-documented benefits including reducing Cesarean rates significantly by about 28 percent, shorter labors, fewer instrument assisted births, less need for epidurals, and increased breastfeeding. Doulas can reduce unnecessary medical interventions and increase the use of safe beneficial evidence-based measures that are currently under-utilized such as comfort measures like using birthing balls,

massages, tubs, supporting the women's wish for freedom of movement in labor and facilitating potions for giving birth other than lying flat on their backs. Doula care can be particularly beneficial for women from low income medically underserved in at risk communities and can help reduce disparities. Community based doula programs offer low or no cost services tailored to meeting the specific needs of the community they serve. These programs expand access to doulas by eliminating cost barriers and often offer a comprehensive approach to meeting their client's needs. Some community based doula programs use a peer to peer approach, pairing pregnant women and teens in underserved areas with trained doulas from their own community. This can make the doulas particularly well suited to address issues related to discrimination and disparities by bridging language and cultural gaps, and serving as a health navigator or liaison between the client and service providers. In community based doula programs, the doulas often go beyond the traditional role of providing childbirth

support to ensure that women's needs are being met in a comprehensive manner. Medicaid insured women have a greater need for basis services in pregnancy than women with private insurance report needing help more frequently with food, nutritional counseling, treatment for depression, and help with smoking cessation. And community based doulas are well positioned to connect women with healthcare as early as possible, assist with health navigation, offer pregnancy and childbirth education, coach women through labor with relaxation techniques, etcetera, and then provide this bridge to the post-partum and interconceptional period by providing breastfeeding support, assisting families in accessing services in the months following and then providing counseling and information about access to family planning to help with birth spacing. The great news is that while doing this, expanding doula care has the potential to bring down the cost of care by reducing very costly unnecessary medical interventions. Medicaid costs for Cesarean delivery in New

York State are about 6,300 dollars greater than for vaginal births. So reducing a unneeded Cesareans when those C-section rates are now at over a third of all births in the state can result in significant cost savings, as much as 70 million dollars statewide and because New York City has such a high percentage of births and an even higher percentage of Medicaid births than the state could be as much as 40 million dollars saved for Medicaid in this city alone. Several states are currently investigating the potential for simultaneously reducing costs and providing doula care funded by Medicaid. Doulas can positively impact the post-partum and interconception health by connecting women to services, providing information. These first days at home are a critical period and home visits provide essential information and support for women to remain healthy. One thing we haven't talked about is that medical complications very frequently manifest themselves in that first week after returning home. As we know, a six week post-partum visit is not going to be a

great time to address that, and so having community doulas who can check in on women, provide additional information starting in those very first days can be a huge help at addressing developing complications and starting those conversations about family planning and then also assisting in breastfeeding. In the long term, doula support can help women develop their capacity to navigate the health care system and become educated in how to stay healthy in the long term, can have positive impact through the rest of that woman's life and throughout the time that she's managing healthcare decisions for her child. Pregnancy and childbirth is a unique time to engage and empower women as active participants in their own care and that of their children. For many women, child birth is their first meaningful experience and interaction with the health care system as an adult. Women are highly motivated during pregnancy and birth to become more engaged and educated health consumers, and this is why it has such a strong potential to improve health-

comes around the period of birth, but also in through the interconception period, because doulas can really facilitate that process. Choices in Childbirth has been working with The Doulas for All campaign, a state-wide initiative spearheaded by the New York Coalition for Doula Access to advocate for equitable access to doula care by petitioning the state for Medicaid reimbursement. The coalition's efforts are endorsed by dozens of community-based health and women's organizations, many of whom are testifying today, some at the table with me here right now. We know that change is possible. Examples of effective programs and studies demonstrate that we can achieve significantly improved outcomes. We're proposing that the City pass a resolution in support of the New York Coalition for Doula Access for the New York State Medicaid program to make doula care a reimbursable service, and designate 500,000 dollars to fund the development and expansion of community-based doula services in low income medically underserved communities in New York

City. We support the dedication of two million dollars to fund pilot programs in preconception and interconception care for low income New York women, and in addition we suggest enhancing data collection in order to reduce the alarming racial, ethnic, and geographic maternal health disparities. Thank you very much for your time and attention.

ROBERT LEDERER: Good afternoon, Chair Arroyo. It's always great to see you again. And before I give my testimony, would it be possible for one of our late arriving speakers to speak before me, because I'm kind of giving the wrap up for our panel?

CHAIRPERSON ARROYO: Let me see. We've been here since what, 1:00? Yeah. No, we're--we'll put him in the last panel.

ROBERT LEDERER: Okay.

CHAIRPERSON ARROYO: There's one more panel.

ROBERT LEDERER: That's fine.

CHAIRPERSON ARROYO: Okay. Thank you.

ROBERT LEDERER: Thank you. Okay. So I'm Robert Lederer, Director of Research Policy and Advocacy for Bronx Health Link, which is a education research and advocacy organization, and we're part of the city-wide coalition to end infant mortality which there are representatives here on this panel as well allied groups that are working together on the set of proposals that you've heard from in the last few minutes. And I'm going to skip through all the issues about the diagnosis of the problem which has been so excellently done by yourself and speakers we've heard earlier, the issues of the extreme racial disparities and the shocking rates of maternal mortality and the chronic women's health issues. Those are very clear. The question is how can we have an impact, and so let me outline and sort of sum up what our package of recommendations are. The first, as you heard, Ihotu Ali talk about the program that they have at Northern Manhattan Perinatal Partnership, which is based on a national model that comes out of the federal Department of Health and Human Services

and it's the evolution of a lot of thinking and research over the past decade or so towards what's called the Life Course Model, which views the periods of health challenges such as pregnancy and childbirth as only evolving and only being as severe as they are because of conditions much earlier in life, and so therefore, the interventions have to start really in childhood and go through each period, adolescence and the childbearing ages, and of course, afterwards as well, middle-age and old age. And so the models that are being developed for preconception and interconception care are based on that principle and so they are very holistic and very multileveled, and they include everything from physical assessment, medical and social screening, health education and counseling, treatment, social psychological services, and of course, referrals to other agencies and services that can provide what the woman will need and by the way it's not only for women, it's also looking at the role of men in that whole dynamic of the infant's health, and so the programming is

aimed at both genders. So, as this thinking has evolved, the infant mortality reduction initiative which you, Chair Arroyo, have been such a champion of, has also evolved its programming, and the model there is primarily and educational model, although there is some case management. And so over the past year there's been a re-design of that program which is being implemented this year and is still under development to try to reach women and to a lesser extent young men at an earlier stage to really try to intervene in the preconception period, and also to target geographically those neighborhoods that are the hardest hit with the poorest birth outcomes. Of course, in a climate of static funding, that creates a difficulty because that means that pregnant women who are more targeted at a higher level before, there's just not enough funds to do both, so there's going to be a shortfall there. But we're not here today to talk mainly about the funding needs for the infant mortality reduction initiative. We're here to make the case for a new initiative focused exclusively

on preconception care. Now care, of course, includes and educational and an outreach component and it has to be done to be most effective by community based agencies that are really skilled in reaching the hardest to reach communities that are culturally competent that are multilingual and so forth, but we're talking again, as I said before, about actual medical care, assessment, screening, screening for the conditions that you asked some very good pointed questions about. That has to be beefed up because there's not funding screens to really allow those services to go to women who are uninsured in the communities, because as was mentioned earlier, the Medicaid services for pregnant women does not cover--that whole program does not extend before pregnancy. And so that's where the City Council could play a role in stepping into that gap to create a model program that would have a series of pilots around the City. We're proposing the level of two million dollars a year. That would be tightly coordinated both internally, but also with the infant mortality reduction

initiative to avoid any duplication and with existing model programs that do exist in some hospitals and some clinics, they're sporadic, but there are some and we need to have a kind of coordinated picture of all this. So that's our main recommendation. And the second one, which you just heard from Nan Strauss in some detail is about the doula model which we think is extremely powerful and valuable and actually fairly inexpensive to begin through a 500,000 dollar annual model program to look at where than can supplement the other models of care and be integrated in there to especially focus on the post-partum and the inter conception period to increase women's access to services. So that's pretty much our recommendations. We think that based on all the research that's been done and all the experience around the country and right here in New York City is very some programs that this committee stands at the precipice of setting a tremendous precedent for the whole nation to set up some model programs that could really kind of blaze a trail for showing how powerful results could be achieved

with not only birth outcomes, but also with women's healthy throughout their life course, and we look forward to working with your committee directly on crafting legislation. And thank you again very much for this important hearing.

CHAIRPERSON ARROYO: Thank you all for your testimony. So let me ask first, recommend that whatever conversation you're having around shaping a pilot or the components of the recommendation that I'm hearing will cost about 2.5 million dollars, in addition to the infant mortality funding that you I would imagine are asking be restored to previous year funding levels, right?

ROBERT LEDERER: Right, correct.

CHAIRPERSON ARROYO: Okay. That you quickly include conversations with the committee staff.

ROBERT LEDERER: We would love to.

CHAIRPERSON ARROYO: Dan and Crillian [phonetic], because they're the ones that are going to help me move stuff around in here, and if they get it, you can be sure that

I'm going to get it, because they'll make sure that I--I'm well-educated around the issues. So please as soon as you have whatever the template is, it sounds like you're pretty much done, but time is--this clock moves really quickly between now and the beginning of the year. There's a transition that we're going to experience both here at the City Council and in the City administration, so we have to be ready to engage in a conversation at both sides of City Hall around this issue, and maybe with the Department of Health supporting conceptually this process that it would make it easier. So in addition to making sure that the committee infrastructure support is on board and understands the nuances, but that you also have these conversations at the City Department of Health level, because you know, 2.5 doesn't sound like a lot of money, but it could be a challenge. So if the City can come up with some, the City Council can come with the other, but we need to start those conversations quickly so that we can be ready to put something on the Mayor's desk and the new

Speaker's desk as early in the year as possible.

ROBERT LEDERER: Clearly understand that and we appreciate that and we're happy to do that.

CHAIRPERSON ARROYO: You got to be careful what you ask for, right? And as you know, that with me, it just means more work for you.

ROBERT LEDERER: Right.

CHAIRPERSON ARROYO: More work for them too, but--

ROBERT LEDERER: [interposing] Right.

CHAIRPERSON ARROYO: It's important that we don't wait until the usual come around and make your case for, you know, the budget priorities for the City. That usually happens around March or--I'm not sure. I give you to the end of the year.

ROBERT LEDERER: Okay.

CHAIRPERSON ARROYO: Okay?

ROBERT LEDERER: I'll take that as a challenged.

CHAIRPERSON ARROYO: So that we all have a sense of what it is that we're looking at, so that we can then begin to make the case both at the administration level, at the agency level, the Department of Health, but also here with the new Speaker and the new leadership here in the City Council.

ROBERT LEDERER: Okay.

CHAIRPERSON ARROYO: Thank you all so much.

ROBERT LEDERER: Thank you very much for your--

CHAIRPERSON ARROYO: [interposing] and thank you for listening to my stories and trying to answer my questions.

ROBERT LEDERER: It's important.

CHAIRPERSON ARROYO: Okay. And we have Chanel Prochia [phonetic]? Porchet? Porchia. And Georgianna Glose. That should have been in the other panel, but she's here now, so we're happy to have you. And that is the last panel. Please if you're here to testify and you haven't filled out a form like this, I don't know that you're here so I won't

call you. So I urge you to fill it out. Okay, ladies, you're closing up the show here so make it good.

CHANEL PORCHIA: No pressure. No pressure.

CHAIRPERSON ARROYO: No pressure. Okay, Chanel?

CHANEL PORCHIA: Greetings Chairwoman. Thank you. Greetings and thank you for allowing us to speak this afternoon. My name is Chanel Porchia and I'm the founder of Ancient Song Doula Services. We are a community based organization, doula organization. We're located in Brooklyn in Bed-Stuy in particular, and we service all four boroughs, but our concentration has been East New York in Brownsville because of the high infant and maternal mortality rate. Our colleagues who are doing this work have already stressed some of the reason as to why this needs to be addressed, and I'm just going to highlight some of the ways in which we are addressing it and how we see doula care as being something that could possibly assist with

preconception care, care throughout pregnancy and post-partum. Currently, we offer doula training through labor and post-partum, and our doula training encompasses the cultural aspect of care, looking at women as a whole and not just our parts, and realizing that care begins or the life cycle of a woman begins at the wee ages that we are born. Currently to date we have trained over 100 women within the community to offer doula care to the women that are in the community with them. In some of the hospitals that you were concerned about in terms of the high infant--the high C-section rates, which is Brookdale Hospital, Kings County, Suni [phonetic] down state, and really bringing care that is talking about domestic violence and how that plays a role, talking about economics, but also helping women to advocate for themselves throughout their care. So traditionally, a doula is seeing a woman maybe three visits there with them throughout their labor and delivery and then they do two post-partum visits. Our organization, in particular, we usually try to see women within

the first or second trimester, all throughout their pregnancy, and then post-partum is extending for about a year. Reason being is that--myself, personally, I'm a mother of four. I've had two home births and one hospital birth in which it was an emergency C-section due to pre-eclampsia, and I realized the need for quality care for women just in terms of us being able to advocate for ourselves and what that looks like. We--in that component, through--we have some of our doulas here. We have been able to see because our program is evidence based a lower C-section rates, women being able to advocate for themselves in terms of the care, instead of making their visit only ten minutes, it being 20 minutes. Asking the questions that are necessary that they sometimes feel not in power to ask. Our primary focus, the population that we serve is women of color, low income families, undocumented women, and the uninsured. We are in favor--we work along preconception health organizations such as Northern Manhattan Perinatal Partnership, Diaspora Community

Services, and other organizations within NYC on a referral basis to be able to reach women. We do some of the work that is not being done, so going to where the women are, going to nail salons, going to the health clinics and sitting in the health clinics, going with them to their prenatal visits. We've noticed how once a doctor realizes that there is a doula how care is totally shifted, and how they're taken a little bit more seriously in terms of the situation that is presented to them. So, you know, I just wanted to bring to light our situation and what we're doing to address that, and we are also a part of the Doulas for All campaign, the coalition to get doulas covered by Medicaid, because the majority of the women that we serve are Medicaid, women who are on Medicaid. And doulas, currently, we do not accept insurance. So our services at our organization and how--we are a social profit. We're not a non-profit which means that all the people that work for us, we are all volunteers. We don't get a salary. The fundage that comes in through us goes right back to the people

that we are serving. So us being able to have additional resources so that we can do more outreach in more communities and offer more trainings, free doula trainings to the women in the community so that they can serve the women that they see every day would be great. So thank you for your time, and if you have any questions I'm willing to answer.

GEORGIANNA GLOSE: Thank you. Council Member Arroyo, thank you so much for this opportunity. I'm Georgianna Glose. I'm the Executive Director of a very small community based agency in Fort Greene. We focus on the three public housing developments very close to us, Ingersoll, Whitman, and Farragut and I just want to point out that in that community we have the second poorest census tract in the City, 185.01, and it has of course, all of the statistics that tell us that there are risk factors for high infant mortality and low birth weight, and my purpose today as a member of the Brooklyn Infant Mortality Task Force and CCEIM for the last 12 years is to tell you about how our experience

and research has led us to support those two pilot requests made earlier in the last panel, to provide care to--hospital based care and provide referrals in ways that help the participants in our community, because we realize that having a healthy baby is the product of being a healthy woman, and so we want to see people healthy over the life course and also to support the pilot project for doula care. I've written more, but that's--

CHAIRPERSON ARROYO: Okay. Well, you both heard me provide some direction to the group, the panel before you. I think it's really interesting and important that we advance this conversation quickly given, you know, what's on the horizon for our city. It's--my questions I'll leave to the staff in the process of preparing. It covered by Medicaid, why is not covered, and what would get it to qualify as a Medicaid covered service, is one of the things that has to be examined. Obviously, outside of the purview of the City Council, but our advocacy along those lines are useful, most of the time, and also on

the issue of funding. So that request for the 2.5 is City money, not that the State put up the 2.5 to begin to kick start the Doula for All Program, correct?

CHANEL PORCHIA: Yes.

GEORGIANNA GLOSE: Yes.

CHAIRPERSON ARROYO: Come back. You have to speak into the mic.

ROBERT LEDERER: The advantage of changing Medicaid policy to cover doulas is that then they--the 500,000 of the City or the City to approve that would be supplemented by reimbursable expenses and it would stretch the dollars.

CHAIRPERSON ARROYO: Okay. So if this work requires for us to engage the State in a conversation about it, that’s a little bit more complicated, and I’m not sure that the right individuals have been identified at the State who need to be part of the conversation. Obviously, my counterpart at the State Senate and Assembly Committees to at least engage the administration at the State level in consideration, and I’m not sure how

complicated, although I have a sense, how complicated it is to change Medicaid eligible services at the State level. And I'm good at some things, but I'm not good at that, but and I'm sure that the committee staff will do their due diligence to research the what and how and more importantly come to a place where we can say that is a much longer process and it will-- you know, we would have to engage in years of the advocacy that then begins today, right, as you have these conversations. So because that's not within the purview of this committee, we can certainly begin to understand what's required to get it as part of a Medicaid eligible service. And I know that you have your folks at the Albany level that can also help you figure that out. So I thank you all for coming to the hearing. Thank you so much for hanging out for those of you who stayed to the end. I look forward to this conversation moving forward. It's got different layers. We're going to peel them back a little bit at a time, at least whatever time I have left in the four years in the next term. So, I'm looking

forward to that work, and some of what we do takes a little time. The most meaningful stuff that we do takes a little time, but it is possible. So thank you all for being here. Thank the staff for preparation for the hearing. I didn't do that at the beginning. Thank you Dan and Krystal [phonetic], and with that, I recess the hear--adjourn? We're going to adjourn because we're not voting tomorrow? Okay.

[gavel]

C E R T I F I C A T E

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

Date 11/27/2013