CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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Start: 10:15 a.m.
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HELD AT: Committee Room – City Hall

B E F O R E: Carlina Rivera,
Chairperson

COUNCIL MEMBERS:
Diana Ayala
Mathieu Eugene
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A P P E A R A N C E S

Dr. Machelle Allen
Senior Vice President and Chief Medical Officer at New York City Health and Hospitals

Dr. Wendy Wilcox
Chairperson of OBGYN at Health and Hospitals Kings County

Cynthia Lynch
New York Association of Licensed Midwives

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Every Mother Counts

Shawnee Benton Gibson
Mother of Shamony Makeba Gibson

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Dr. Tara Shirazian
Founder and President of Saving Mothers

Helena Grant
Director of Midwifery at Woodhull Health and Hospitals

Dr. Mimi Niles
Midwife

Denise Bolds
Bold Doula

A P P E A R A N C E S (CONT.)

Chanel Porchia-Albert
Founder and President of Ancient Song Doula Services

Alesdair Ittelson
InterACT

Becki Pine
InterACT

Zama Neff
Human Rights Watch

Eugenia Montesinos
Midwife at Metropolitan Hospital

Sharon McDowall
Metropolitan Hospital

Katy McFadden
midwife, a registered nurse certified in neonatal intensive care

CHAIRPERSON RIVERA: [GAVEL] Good morning everyone. I am Council Member Carlina Rivera; Chair of the Committee on Hospitals.

Today, we'll hear from representatives of Health and Hospitals H+H, voluntary hospitals, advocates and other stakeholder about prenatal care in New York City hospitals. The ability to protect the health of mothers and babies in childbirth is a basic measure of a society's development and having a healthy pregnancy is one of the best ways to promote a healthy birth. Preconception and prenatal care, can prevent complications during pregnancy by helping educate pregnant people about the importance of following a healthy and safe diet, getting exercise, controlling existing medical conditions, avoiding smoking and alcohol and ensuring they are taking safe medications.

We are fortunate to live in New York City where there is a saturation of healthcare providers where all people who are pregnant and low income can obtain health insurance and where we have hospitals such as H+H who provide prenatal care to individuals regardless of health insurance status and immigration status.

However, our healthcare system still provides inequitable healthcare. Statistics show that while about 30 women in New York City die each year of a pregnancy-related cause, approximately 3,000 women almost die or experience morbidity during childbirth. This is simply unacceptable. Any pregnancy related death is a tragedy.

In 2016, 15 people died because of pregnancy related reasons and of those who died, six were African American, and six were Hispanic. In other words, women of color accounted for 80 percent of pregnancy related deaths. That same year, there were 2,875 cases of severe maternal morbidity, a rate of nearly 260 per 10,000 live births. Black people were 2.5 times more likely to experience severe maternal morbidity than their White counterparts.

Meanwhile, Latino people were about 1.8 times more likely to experience a near death experience during pregnancy than White people and Asian/Pacific Islanders were nearly 1.3 times more likely. Additionally, only 23 percent of Black patients gave birth in the safest hospitals compared 63 percent of White patients.

Infant health is also impacted by inequities. Government data suggests that Black infants are more than twice as likely to die as White infants. Research to points to race, rather than educational attainment or income level of the patient as the cost of such discrepancies. In fact, a Black woman with an advanced degree is more likely to lose her baby than a White woman with less than an eighth grade education.

Frankly, we're failing our city's infants and pregnant people. No one should fear death when bringing life into this world. What more can we do to better protect people and furthermore ensure that they are receiving safe and quality healthcare.

Today, I look forward to examining the importance of access to quality, meaningful and early prenatal care and its impact on the health of the parent as well as the child.

Is prenatal care accessible enough in our city? What are the barriers to prenatal care and how can we take those barriers down?

For example, are hospitals engaging enough with the city's doula in midwife communities? What more can we do? We can no longer accept the health

outcomes we have been seeing for years. Currently, approximately 1 out of every 23 Black people who give birth will endure potential life threatening complications. The rate for White people is about 1 out of every 63 births. It also bears repeating that women of color count for nearly every pregnancy related death in the city.

Today, I am asking if these statistics were reversed, if more White people were dying and nearly dying due to pregnancy, would these health outcomes be tolerated? Absolutely not. It's time for a change.

Thank you to everyone who has taken the time to be here today and I look forward to your discussion and the testimonies. With that I'm going to call up the first panel. Deb Kaplan from DOHMH, Dr. Wilcox from Health and Hospitals and Dr. Allen from New York City Health and Hospitals.

COUNCIL CLERK: Could you raise your right hands please. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this Committee and to respond honestly to Council Member questions?

PANEL: I do.

COUNCIL CLERK: Thank you.

DR. MACHELLE ALLEN: Good morning Chairperson Rivera. Can you hear me? Good morning Chairperson Rivera and Members of the Committee on Hospitals. I am Dr. Machelle Allen; Senior Vice President and Chief Medical Officer at New York City Health and Hospitals.

I am an obstetrician/gynecologist by training, substance use disorder and HIV in pregnancy has been my area of focus. I have worked in New York City Health and Hospitals for 38 years. I trained at Jacobi Hospital and have worked as an attending at both Harlem Hospital and Bellevue Hospital and have served as the consultant for the New York City Department of Health providing reviews of the city's pregnancy related deaths in my past.

I am joined by Dr. Wendy Wilcox, Chairperson of OBGYN at Health and Hospitals Kings County. In addition, Dr. Wilcox is the New York City Health and Hospitals Clinical Service Line Lead for Women's Health, a maternal mortality reduction initiative as well as the Co-Chair of the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes.

Dr. Wilcox has worked for Health and Hospitals for over ten years.

On behalf of Health and Hospitals, Chief Executive Officer, Dr. Mitchell Katz, I thank you for the opportunity to testify before you to discuss prenatal care at Health and Hospitals.

As the largest public healthcare system in the United States, Health and Hospitals mission is to deliver high quality healthcare services to all New Yorkers with compassion, dignity, respect, and without exception. We serve over 1.1 million New Yorkers every year across the five boroughs and empower them to live their healthiest lives.

The Health and Hospital system is an anchor institution for the ever changing communities it serves providing hospital and trauma care, neighborhood healthcare, skilled nursing care and community care, including care coordination and home care.

New York City Health and Hospitals has a very long history of focus on improving the healthcare of the women and children in this city. As our patients often represent the uninsured, the underinsured, the

underserved, and thus have a more urgent need for attention.

For over ten years, Bellevue Hospital has served as a New York State Department of Health Regional Perinatal Center for health and hospitals. As a regional perinatal center, the responsibilities include improving the quality of perinatal care provided not only at the RPC site but at the affiliated sites. Through outreach services, which include 24 hour specialty and subspecialty consultation services, patient transport coordination and services, outreach and education, onsite quality of care visits at each affiliated perinatal hospital and participation in the statewide perinatal quality improvement and activities.

In 2013, we joined the American College of Obstetrics and Gynecology, knows as ACOOG's, a safe motherhood initiative which included specific interventions for reducing the occurrence of an impact of severe hypertension, deep vein thrombosis and maternal hemorrhage which are the leading causes of maternal mortality. In fact, New York City Health and Hospitals was recognized by ACOOG as the only health system in New York State which had every

hospital in its system participate in the safe motherhood initiative.

In 2014, New York City Health and Hospitals established the medical stimulation lab, where we "prepare for real life". We shamelessly borrowed from the airline industry to develop simulated scenarios and obstetrics in other areas so that our provider teams could practice and hone the skills necessary for those rare events in which a quick response makes the difference between life and death.

We now have simulations and shoulder dystocia and maternal hemorrhage and cardiac arrest in pregnancy. Subsequence in implementing obstetric simulations we have seen an improved response in these occurrences. In 2015, while some of our facilities had implemented prenatal depression screening, at the time of the primary care implemented depression collaborative, the New York City Health and Hospitals as a system, joined the Greater New York Hospital Association to the depression collaborative as part of New York City Thrive Initiative and implemented prenatal and postpartum depression screening and intervention at all of our sites.

We currently screen 95.5 percent of all prenatal patients. 95.7 percent of all postpartum patients and 91.7 percent of moms who were seen at the well-baby visit. The Yield Rate during pregnancy, that's a positive screen, is 5.1 percent and 96 percent of all prenatal patients with a positive screen are referred for further treatment.

In 2018, in an effort to increase the clinical knowledge and judgment of our providers teams and to engage in best practices, to improve teamwork and communication and decreased variation among clinicians, as well as reducing clinical errors and reducing the number of OB adverse events, New York City Health and Hospitals invested in Relias, which is an online educational course which provides assessment based personalized learning and it is accepted by the American Board of Obstetrics and Gynecology for maintenance of certification.

This is also the only online comprehensive training course endorsed for obstetrical and neonatal nurses. This is now required for attaining and maintaining privileges in our perinatal services.

Improving maternal and infant health has been a central focus of the de Blasio Administration and

Health and Hospitals. In Fiscal Year '19, we had approximately 160,000 prenatal visits and over 15,000 babies were born in our facilities. We are committed to providing and protecting the full spectrum of women's healthcare. Our doors remain open to all and we will continue to support our patients in providing state of the art and culturally competent care.

The Health and Hospitals 2019 community health needs assessment identified reducing the burden of life cycle driven illness and health equity challenges is a priority health need. As such, we have implemented several initiatives to improve pregnancy and birth outcomes within Health and Hospitals. In 2018, in partnership with the Mayor's Office and the New York City Department of Health and Mental Hygiene, they began implementing a comprehensive maternal program with a focus of identifying and responding to pregnancy related morbidity and mortality in women of color. And I'll walk you through each one of the initiatives.

Number one, in our maternal medical home, care coordinators and social workers will provide care management and screening for depression. Screening for clinical conditions, screening for trauma and

social determinants of health and psychosocial conditions to patients who are predisposed to or high risk for poor adverse pregnancy outcomes. Our care coordinators will help patients navigate their appointments and receive supported services.

Number two, our simulation based program currently trains doctors, nurses and other members of the delivery team to respond to the highest risk emergency situation, such as shoulder dystocia, hypertensive disorders in pregnancy, maternal hemorrhage and cardiac arrest, which may occur in the labor and birthing suites. The simulation trainings are being brought directly to the facilities as many labs are being constructed at our facilities with the most complex patients. This is just the latest contribution of the public health system to address maternal health.

Number three, the interval pregnancy optimization program, helps to improve maternal health by training primary care providers to ask patients specifically about their pregnancy intention. The question which is asked of the patient is whether or not they plan to become pregnant in the next year. If yes, she is referred for preconceptual counseling. If not, she

is referred for the effective contraceptive of her choice. In this way, the health of the woman may be optimized before she becomes pregnant. Her diabetes controlled, her chronic hypertension controlled, counseling abouts, alcohol consumptions and cigarette smoking.

Number Four, our mother, baby coordinated visit program aims to increase the maternal adherence to the postpartum visit by having the postpartum visit scheduled with and possibly collocated with the babies pediatric visit.

Number Five, addressing implicit bias, which is the unconscious attitudes or stereotypes that can affect behaviors, decisions and actions in the treatment of women of color who are pregnant, is a priority of Health and Hospitals. H+H has conducted an implicit bias training for our entire board of directors and our facility CEO's with the assistance of Perceptions Institute. We have 22 additional facility based training scheduled throughout the next upcoming year. In addition, and collaboration with DOHMH, we have provided training to our obstetric leaders and other trainees from across the system on implicit bias through the Rebirth Equity Alliance.

These trainings were launched in October and focused on improving equity in childbirth. To date, we have trained 99 members of our staff.

Number Six, quality improvement; we are working hand and hand with DOHMH to provide training sessions in all of the acute care facilities within H+H, as well as some voluntary not-for-profit hospitals participating in the DOHMH Maternal Hospital Quality Improvement Network, which is a comprehensive strategy with 14 New York City maternity hospitals to address the root causes of persistent racial and ethnic disparities, maternal mortality and severe maternal morbidity with emphasis on the importance of the "how to" of setting up a quality improvement process in the department. With the DOHMH support, the H+H hospitals which are participating in the Quality Improvement Network are integrating reviews of all cases of pregnant and postpartum patients with severe hemorrhages and ICU admissions into our quality assurance and improvement processes and providing data to DOHMH to inform population based strategies to address these conditions.

The Quality Improvement Network Hospitals are also partnering with DOHMH to implement the New York

City Standards for Respectful Care at Birth. Per the training on implicit bias by Perception Institute and training and practice changes to promote respectful patient provider interactions.

Number Seven, our Health and Hospitals Community Care program ensures that pregnant women access the highest quality of care in a home setting, which includes anti-partum assessment and instruction, breastfeeding teaching and support and high risk infant care, among others. From January 2018 through December 2019, Community Care has provided 445 prenatal home visits, 9,700 newborn visits and over 10,000 postpartum visits.

And finally, Number Eight, additionally, ten of our acute care facilities have earned the prestigious baby friendly designation from the World Health Organization. In collaboration with DOHMH, New York City Breastfeeding Hospital Collaborative for promoting the highest level of care for infants through breastfeeding and promoting bonding between mother and baby.

As part of New York City's Birth Equity Initiative, Health and Hospitals partnered with DOHMH and the Centering Health Institute to launch pregnant

centering pregnancy. An evidence based group, prenatal program at New York City Health and Hospitals Elmhurst. Centering pregnancy has been shown to improve maternal and infant health outcomes, including reducing preterm birth which is the leading cause of infant death and encourages greater patient engagement during the prenatal experience.

The program features group pregnancy visits with a provider, networking with other pregnant women, group discussions and prenatal wellness and educational classes on nutrition, stress management and breastfeeding. All pregnant women are eligible to participate in the group care sessions and are asked to join the group during their initial prenatal visit, unless their pregnancy shows signs of becoming very high risk. The sessions begin between 16 and 20 weeks gestation and occur with the same frequency and routine prenatal care visits.

I'd like to spend a minute talking about our midwifery services in Health and Hospitals. Midwifery services are offered throughout Health and Hospitals to improve patients experiences. New York City Health and Hospital employs over 80 midwives

across the system and thus is the largest employer of midwives in New York City.

Last year, Health and Hospitals North Central Bronx opened its renovated and expanded maternity unit with an investment of $50,000. The units clinical space has doubled from 2,300 square feet to 4,800 square feet. With all clinical services available on one floor, expected patients can easily access obstetric and gynecologic services and the labor and birthing suite. Patients will also be able to access the maternal fetal diagnostic unit for specialized ultrasounds.

We are currently collaborating with DOHMH to access our midwifery services to highlight what's working well and where we have opportunities to improve and the doula services at H+H. Health and Hospital assesses doula services through our relationship with community based organizations. Health and Hospitals refers patients who request doula services to one of several community doula providers. The Brooklyn Perinatal Network by my side and Ancient Song. Over the past three years, physician midwives and nurses have held multiple meetings with doula organizations to learn more about

the services that doula's provide and to bond and form relationships with one another. Over the last three years we have made many referrals for doula support for patients and are looking to expand these services. Both Harlem Hospital and Metropolitan Hospital are in the process of formalizing agreements for doula services.

In conclusion, we would like to thank the Council for its support of Health and Hospitals and providing funding for state of the art equipment to improve the care and outcomes for the women we serve, including Councilwoman Rivera and Council Member Mark Treyger.

Recent fiscal year '20 appropriation of $400,000 in capital funding for upgrades to critical OBGYN ultrasound equipment at Health and Hospitals Coney Island.

Thank you for the opportunity to testify today and we are happy to answer any questions.

CHAIRPERSON RIVERA: Thank you and thank you for your 38 years you said, right, of service. Thank you very much.

DR. MACHELLE ALLEN: Your welcome.

CHAIRPERSON RIVERA: I appreciate you coming in to testify today. I just have you know, quite a few

questions on some of the services. Thank you for going through the initiatives. I guess I want to ask, you have listed all the prenatal services that H+H provides to pregnant people and you spoke a little bit in the beginning of if someone came in and whether they were pregnant or weren't and you mentioned contraception, very, very briefly. So, I guess my question to you is, if I entered an H+H facility and I thought I was pregnant, what would happen? How would I be approached? What services and information would I be offered?

DR. WENDY WILCOX: Good morning, thank you for that question. So, if you entered a Health and Hospitals facility for a pregnancy test, you would be offered a test and depending on what that test showed, it would depend on what kind of counseling you wanted or needed. Certainly, for someone who is pregnant and wanted to continue through the pregnancy, they would be offered obstetrical care and prenatal care.

For someone who had a negative test but wanted contraception, they would be offered contraception through our either gynecologic services or family planning services that all of our facilities offer.

We offer the full line of contraceptive options including reversible long acting reversible contraception, so LARCS, which is IUD's and implants as well.

And if someone is pregnant and did not wish to continue the pregnancy, they would also be able to access abortion services at Health and Hospitals.

CHAIRPERSON RIVERA: So, you would sit down, there's contraception, there's abortion care information and if they were pregnant and wanted to continue with their pregnancy, you would give them information on doula services, on the midwifery programs. Does it depend on where the patient and the pregnant person is geographically? Does that come into account or do you provide the full expansive view of what you can provide to that person?

DR. WENDY WILCOX: So, you know, a lot of that comes in counseling a patient. So, the first step would be the intake and actually getting that person into care and certainly, every facility has a different compliment of what type of care in terms of provider is offered. And for doula services, we do not employ doula's at any of our facilities, so we

offer referrals to community based organizations for care that would involve doula support.

CHAIRPERSON RIVERA: I ask because in your testimony, you mention making referrals for doula support for patients especially at Kings County and we've been joined by my colleague Diana Ayala, who represents East Harlem and South Bronx and these three, East Harlem, South Bronx, Central Brooklyn, these are some of the neighborhoods, some of the communities in our city with the highest risk when it comes to pregnant people. And so, I ask in terms of some of your referral services, some of our networks and coalitions are doing tremendous work. They are doing very much with very little. How is the relationship between H+H and the community based organizations in terms of a referral system?

DR. MACHELLE ALLEN: So, Wendy will take that. We've been working as I said in my testimony with several doula groups. There's a fourth one that we look at, the Doula Project. We are actually working very closely over the past three years.

CHAIRPERSON RIVERA: Can you just talk into the microphone.

DR. MACHELLE ALLEN: Over the past three years with Wendy's leadership actually doing significant outreach to the community based organizations. For East Harlem and the South Bronx, as I said Harlem and Metropolitan are in the process of actually developing memorandums of understanding the agreement for doula services. We have a ways to go. It's the patients choice, we like to provide the appropriate referrals since we don't have them on our staff. I think that's in the process of changing. Do you want to add to that?

DR. WENDY WILCOX: No, I would just say that we're trying to encourage tight linkages through the departments of OBGYN and the hospitals and the community based organizations and we look forward to encouraging those relationships and actually expanding them.

CHAIRPERSON RIVERA: Is access better at some H+H hospitals compared to others?

DR. MACHELLE ALLEN: I don't have in front of me the distribution but it's not 100 percent across all of the H+H hospitals. The majority of our hospitals do but not 100 percent.

CHAIRPERSON RIVERA: Is there a wait list for some of these services at the hospitals.

DR. MACHELLE ALLEN: There's no wait list. We have access for prenatal services for virtually same day access definitely within the week.

CHAIRPERSON RIVERA: I ask because I know that some of the programs haven't necessarily been expanding and please feel free to give me some information, especially when it comes to midwifery programs. I know some of them have I guess closed at certain hospitals and expanded in others. How do you make that determination in terms of the availability and access to those sorts of programs and services at each acute care facility?

DR. MACHELLE ALLEN: So, of our 11 facilities there are 3 facilities that actually don't have midwives on staff and our commitment is if the need is there, the demand is there from a systems perspective, we will definitely provide the opportunity and the means to recruit and hire.

CHAIRPERSON RIVERA: So, is it the 3 facilities, is it because there is just not the same demand at the other facilities?

DR. MACHELLE ALLEN: I don't know the specifics for those three facilities. I'd have to get back to you on that Councilwoman.

CHAIRPERSON RIVERA: So, you partner with CBO's to give out educational materials on all of these programs and services?

DR. WENDY WILCOX: Usually that's done through our health educators but yes, they're aware of the neighborhood, the services available in the neighborhood of the surrounding hospital and those are offered to the patients.

CHAIRPERSON RIVERA: I ask because in Elmer's Hospital there are a hundred languages spoken in that facility alone and I don't imagine there is materials in one hundred languages, but I know that there are community based organizations like who will have those trusted conversations who are credible messengers.

DR. MACHELLE ALLEN: Actually, in Central Brooklyn we've been doing work with the community based organizations in Central Brooklyn, coming up with a concept piece on how to improve the health outcomes of the residents of Central Brooklyn. We've worked with One Brooklyn as well as the community

based organizations with Brooklyn and we realize that we have a lot more work to do but we are definitely committed to engaging our community partners.

CHAIRPERSON RIVERA: Which facilities do not have midwifery programs?

DR. WENDY WILCOX: That's Harlem Hospital, Queens Hospital and Lincoln.

CHAIRPERSON RIVERA: So, Harlem and Lincoln Hospital and Queens.

UNIDENTIFIED: And Lincoln.

DR. WENDY WILCOX: We said Lincoln.

CHAIRPERSON RIVERA: And Lincoln, yes. Harlem, Queens and Lincoln, understood. Has NYC Care had an impact on the provision of prenatal care?

DR. MACHELLE ALLEN: We have, through NYC Care, we've actually expanded the number of patients who are getting primary care and anticipate those numbers will translate into a prenatal care. We're not expecting to run out of capacity. We are committed to providing capacity as the number of participants grow. We have not heard any complaints of a problem with impacting access to date.

CHAIRPERSON RIVERA: It could be a positive impact.

DR. MACHELLE ALLEN: It would be wonderful.

CHAIRPERSON RIVERA: Okay, because I know you are expanding in other boroughs. In some of these boroughs as I mentioned have neighborhoods with alarming statistics and data, which is why we're here today and I realize that Health and Hospitals opens their door to anyone in the city who walks in but we want to make sure that the healthcare is equitable and I think that we have found that it is unfortunate in terms of — as I mentioned in my opening statement, it has nothing to do with education. A lot of it is implicit bias. A lot of it is how we have cared historically for our communities of color.

So, what are the most important factors and risks prenatal care address and you mentioned preterm births, how do you access a pregnant persons healthcare risks and how do you educate them as to maybe if they have hypertension or diabetes?

DR. WENDY WILCOX: So, that's all part of the assessment that's done for prenatal care. It usually follows a standardized format where we ask the past history, not only past medical history but past surgical history, past obstetrical history, past gynecologic history. We're also doing multiple

screenings through our Maternal Medical Home project on many of social factors to access for things like depression. Dr. Allen mentioned that in her opening statement. We're also starting to access women for trauma as well.

So, we're really trying to do a full assessment and provide the care that every individual needs.

CHAIRPERSON RIVERA: Which conditions are associated with preterm births?

DR. WENDY WILCOX: So, the number one factor that would predict a preterm birth is having had a prior preterm birth.

CHAIRPERSON RIVERA: I'm sorry?

DR. WENDY WILCOX: Having had a prior preterm birth is one of the number one predictors for having a subsequent preterm birth.

CHAIRPERSON RIVERA: And I'm going to turn to my colleagues in a second who have a question. Last year we had a hearing on screening, specifically for drugs and alcohol. Do prenatal care services at H+H screen for drugs and alcohol and what is the process for obtaining consent?

DR. MACHELLE ALLEN: So, thank you for that question. It's a very important question. We had a

hearing last April after which we had the opportunity to work closely with ACS to coordinate their processes and to inform them of our processes. We have informed our CEO's or CNO's, our CEO's as well as our Chiefs of OBGYN, that substance abuse disorder is not a moral problem, it's a medical problem. To avoid bias, we're implementing universal screening, verbal screening following the protocol and recommendations of the American Colleges of Obstetricians and Gynecologists.

We will be implementing a four question screening questionnaire which will be universal and the only reason to get a urine toxicology test is for medical conditions. If a patient self-disclosed, you really don't need to verify whether they are telling the truth or not with a urine toxicology. And any urine toxicology that will be done will only be done with informed written consent and documentation. There are of course exceptions to that. If a patient present with altered mental status, is the differential diagnosis meningitis, cerebral vascular accident or drug intoxication. That's an indication for a urine toxicology. The two main points I want to make here that we've shared with our leadership,

is that screening for drug and alcohol is universal to avoid the bias of screening just based on race, ethnicity or appearance and written informed consent, it will be required and documented in the chart. That's the expectation.

CHAIRPERSON RIVERA: Thank you for that. I just want to, I'm going to go back to implicit bias in one second because last April, you testified that it's the policy to only drug test with the mothers informed consent and that a mother has the right to refuse; however, you said that the testing is universal and that it's not necessarily always obtained in writing and in April it was verbally between the doctor and the mother and that the patient is not provided anything in writing about the test or its potential consequences.

Also, the policy is not available publicly. Has that changed since the last time you and I met here in City Hall?

DR. MACHELLE ALLEN: That has changed. I have to share with you that our legal team is reviewing all the documents. There is a written informed consent, written information to be shared with the patient and a policy. What needs to be done is education of all

of our staff, making sure the documents are actually at the appropriate literacy level and translated into our most appropriate languages. There are approximately 13 languages that we translate all of our legal documents into.

So, currently, our legal department, our lawyers are vetting all of that material, getting it at the appropriate literacy level and getting it translated. That's why currently it's not publicly available, but through the clinical guidance, we've been very clear as a system what the expectations are.

CHAIRPERSON RIVERA: When will it be available?

DR. MACHELLE ALLEN: I'd have to get back to you with a date on that.

CHAIRPERSON RIVERA: I ask because you know, our statistics show that Black and Brown pregnant people are more likely to be tested. We heard some incredible stories and people who were kind enough to share their experiences and by the way, I know we would have a lot more parents here sharing their experiences but until we get universal childcare and afterschool programming, unfortunately many of them cannot join us today.

So, you also mentioned that since October, 99 staff members have received implicit bias training. Could you clarify how the implicit bias curriculum is developed and if the community has the opportunity to provide input and by the community, I mean some of our local experts. And can you share some of these plans in writing with us in terms of what you expect to deliver in terms of training and when it will be fully implemented?

DR. WENDY WILCOX: So, I'm not aware about sharing in writing but I'll let you know what we as Health and Hospitals are doing. So, there are multilayers of what we're doing. We are partnering first and foremost with New York City Department of Health for a few different trainings. One is trauma resilience informed systems and that is looking at racism, communication and making systems changes across the issue. And this is involving the hospitals in the Maternal Hospital Quality Improvement Network. And so, to date, the Department of Health and Mental Hygiene has trained over 250 staff across the 14 hospitals. Of this, 171 of the staff are H+H staff.

In addition, Health and Hospitals is engaging Perceptions Institute, which helps engage larger groups of people and get them to think about implicit bias and explicit bias and how it might be effecting decisions that are made in the hospital. So far, we started with leadership, it started with the board and also the hospital CEO's and there are 22 dates scheduled to go to the facilities and train more people.

In addition, kind of on top of this, we engaged an entity called Rebirth Equity and they actually trained 99 participants on multiple levels. It was mainly targeted at maternal and child health staff and really engaged again, smaller groups of people to look at implicit bias and perceptions of others. So, it's a very multilayered approach.

CHAIRPERSON RIVERA: I saw these were launched in October. Well, I want to give my colleagues an opportunity to ask questions. They've been very patient; I'm going to ask first Council Member Diana Ayala.

COUNCIL MEMBER AYALA: Good afternoon. Thank you, Madam Chair. So, my question is really relating to the Maternal Care program and I wonder how much of

that is guided by the patients experience in the hospital? Is that considered at all when you're training and retraining staff and the reason I ask the question is because I recently became, in the last few years I've become a grandmother four times over and I've had the pleasure of being invited to be in the room when my daughter had her children. So, I was there for each and every one of them and I find that the experience and this wasn't even in a public hospital, it was actually a private hospital was horrendous and I hadn't realized it had I not you know, been looking from the outside in, how horrible of an experience childbirth — the childbirth experience can be for a young mother. Specifically, for a young mother who is very inexperienced and very, my daughter's a very nervous person as it is, so she's I think a little bit of a hypochondriac and she you know, calls the doctor like every three minutes, which I found was very annoying to her doctor.

I found that you know, she was ridiculed for her weight. She was pretty much embarrassed in front of you know, her spouse and the rest of us that were in the room at a very inopportune time and I you know, I

wonder in my district, obesity, hypertension, diabetes, you know, the numbers are astronomical and I would imagine that that's the same for individuals that are pregnant and I wonder how much of that education really is yielded from the experiences of the patient and not so much you know, from what we've learned in science and through books. But who speaks to the patient is really important to me because I think that you know, I just, I'll tell you the last experience that she had, she decided because she has hypertension because she is overweight that she was not going to have any more children and her baby was, because she had hypertension had to come out immediately, emergency C-section and her doctor was not there. So, the doctor that was attending continued to ask, are you sure you want to tie your tubes? Are you sure that you want to do this? You know, your baby might not make it. Who says that to a pregnant mom? Like, who says that. Like, I couldn't believe that this was said to her three times in the course of you know, the duration of the time that she was there.

The baby came out purple, not breathing and he looks at her and he says are you sure? The baby is

having complications. What the hell? What is that? And I don't think that her experience was unique. I don't think that she was exception, I think that she's the rule and that really, really pisses me off. It pisses me off because that was not my experience and I don't understand what is happening and how much you know; education is being geared towards the doctors.

I mean, it's great to have doula's, it's great to have midwives. I had midwives for my first two children. They were great but how much education is going towards these doctors that are interacting with these patients on a daily basis?

DR. MACHELLE ALLEN: So, the patients feedback and the patients experience and the patients voice is very important. And I share with you that same experience as my daughter had her first child and my first grandchild recently and the perspective as a grandmother as opposed to the obstetrician was enlightening.

I'll have Wendy share with you perhaps another experience from another patient but we do have patient advocates. We do have a community advisory board and we do depend on the feedback. Our efforts,

when we get that feedback and do speak with the providers one on one for those providers who lack a sensitivity, lack the respect to provide them specific training starting with implicit bias because many people don't realize how they come across and they need to be told. And they need to be educated, that what I think is inoffensive maybe completely offensive.

I just want to say I share experience and Health and Hospitals as a system is totally focused on the patient experience and the patient should be front and center. I'm going to have Wendy speak about the things that we're actually doing to improve that.

DR. WENDY WILCOX: So, as Dr. Allen just stated, we definitely pay attention to our Press Ganey scores which gives us an indication of the patient experience and that they score us and often give us actual quotes that are shared with the Department leadership that we then go ahead and give back to our patients.

With your liberty, I'd just like to share one from my own hospital that was recently shared with me. When I already gave up on the natural birth to go for a C-section, the doctors encouraged me to try

for the last time that I can do it and I am so happy that I did it and gave birth to my baby on my own without C-section. Love you doctors.

Now, that obviously is something that I will probably carrying around with me for the rest of my life because it made me feel good but as leadership, we've been working at this a long time. Sharing day to day feedback with the staff, going to individual staff members. Having people go to the trainings. Part of the goal of the Maternal Medical home is to have yet another person in our practices that patients can reach out to for questions like, can I reschedule my appointment? Can I just talk to you about this? I had a question about whatever and they have cell phones and give their numbers out readily to patients, so that patients have yet another person to contact.

Obviously, in terms of the birth experience, we feel like the entire team is there to keep the patient in the center. Nurses play a role, physicians play a role, our midwives when they are available play a role when they are there. Doula's can even play a role in terms of keeping the patient in the center of her care and everyone engaging with

here, communicating with her, you know, discussing the care plan and really trying to keep the patient center and focus.

You know, this is not something that necessarily is taught in medical school. We're trying to change that and trying to get people further down in the pipeline for our learners but it's definitely something that's front and center today and pretty much all of the different trainings we're going through we're trying to address that. How do you best reach the patient?

COUNCIL MEMBER AYALA: I agree and if there's anything that we can do, I have a bunch of hospitals in my district. I am literally across the street from Lincoln, because I think that you know, more education needs to occur in communities like mine and educating new parents on the detrimental effects right of not treating hypertension and diabetes appropriately when one is expecting a child and what the consequences can lead to, I think are really important because that was also something that because a young parent who has hypertension, who has you know, borderline diabetes who would be considered you know, to be obese. Not having that level of

education and understand the correlation between you know, infant mortality and you know, good health is important.

So, thank you so much for being here today and thank you so much for this important subject matter.

CHAIRPERSON RIVERA: Thank you and we've been joined by Council Member Levine and Moya and Council Member Levine; you had a question?

COUNCIL MEMBER LEVINE: Thank you so much Chair Rivera for convening this hearing to focus on a really urgent challenge and my goodness, Council Member Ayala, that was very powerful. Thank you for making this real and emotionally impactful. We have to tackle this. We need to tackle illicit bias, we have expand doula services, we have to confront a broader heath inequities which are underlying. The disparate outcomes and maternal mortality. We need resources to that and you know that Albany is facing a $6 billion budget deficit this year, which maybe balanced on the backs of low-income patients in New York State and New York City by cuts to Medicaid and one of the things we love about Health and Hospitals is you disproportionately serve patients with Medicaid and uninsured as well.

That means that cuts to this funding stream would also disproportionately hurt you and your patients and I fear also hurt your OBGYN services at a moment when we need to be expanding resources and I wonder if you could speak to what's on the line as we face these very frightening cuts coming from Albany.

DR. MACHELLE ALLEN: So, my answer is brief. We have the commitment of our senior leadership that we will not cut back on any services.

Our intention is to continue to provide the services that we provide today.

COUNCIL MEMBER LEVINE: You don't mean just for obstetrics but for all the services throughout the system?

DR. MACHELLE ALLEN: All the services, pediatric services, primary care services, we are committed to the services that we provide today. You ask what is the plan and that's the plan that I'm aware of. If it changes, we're happy to follow up with you.

COUNCIL MEMBER LEVINE: That's a reassuring commitment and I certainly applaud you and Dr. Katz for doubling down on that. You could potentially face hundreds of millions in funding cuts. Just to be sober about this, it's a pretty substantial piece

of your budget and I'm wondering how you maintain services in the face of cuts like that? Is it closing facilities? Is it reducing head count on the administrative side?

DR. MACHELLE ALLEN: Any cuts to Medicaid, threaten the financial wellbeing of H+H and our mission to quality healthcare will be fought. We will fight the cuts that threaten our healthcare and the safety of New Yorkers. We are prepared to work with the state on changes to their Medicaid program and reforms and savings that are critical solutions, not cuts and I think for further detail, I would have to defer to Dr. Katz and our CFO John Ulberg for more specifics.

COUNCIL MEMBER LEVINE: Understood. We are going to be fighting really hard to protect you, to protect everyone in the city from these cuts with our allies in Albany. I think it's going to be a tough fight. I think the stakes are really high, especially for low-income New Yorkers who rely on Medicaid to stay healthy.

If I may just very quickly, I know that you talked about NYC Care and the roll out in the Bronx. I think it's true to tackle disparities and maternal

mortality, we also have to tackle disparities in broader healthcare including primary care and NYC Care is a really important component of that strategy. You are now fully rolled out in the Bronx, correct? Brooklyn is next, what's the timeline going forward?

DR. MACHELLE ALLEN: I don't have the timeline with me right now. I'm happy to get back to you on that with a specific timeline, Council Member.

COUNCIL MEMBER LEVINE: Okay, I think to state the obvious, if an individual who doesn't have insurance has the benefit of an annual physical and getting the vaccinations and catching medical problems early, so that preventative action can be taken for conditions like hypertension or diabetes. When you can have that baseline of primary care, at the moment in which someone becomes pregnant, they are just going to face much better odds and so, NYC Care is actually in my opinion also a critical component to reducing disparities in maternal mortality and improving neonatal outcomes.

DR. MACHELLE ALLEN: Agree with you 100 percent. We've been working closely with our primary care partners, recognizing that improving the baseline

health of the woman makes all the difference in the world with her pregnancy experience.

So, we've implemented the pregnancy intention question within the primary care visit. So that every women of reproductive age has a conversation, are you planning to become pregnant within the next year? If she indeed is, than she's sent to OBGYN for preconceptual counseling and in the meantime with a primary care physician, because our guidelines and our thresholds during pregnancy are much tighter than when you are not pregnant. So, they are different targets for blood pressure and sugar.

In addition to that, if the woman states that she is not desirous of a pregnancy in that year, we actually refer her to GYN, so she can have the appropriate contraception of her choice. And realizing how important primary care is, the postpartum visit is really important as well. At the postpartum visit, you get to have your blood pressure rechecked. If you had gestational diabetes or further complications, medical complications to the pregnancy, that postpartum visit is where you get to see if they've resolved or not and if they've not been resolved. And even if they have been, if

there's an underlying condition, that's the opportunity to refer the patient back to primary care. We realize about 40 percent of our pregnant women do not keep their post-partum visit, whereas 98 percent of them keep their well-baby visit.

So, we're working with our facilities so that the post-partum care is co-scheduled and maximally collocated with the well-baby visit.

Now, some of our facilities have been able to co-schedule, but because of space constraints, not collate, collocate. Others have been, we've been using Saturday hours and nighttime hours, evening hours realizing that many of our moms work and can't come to the hospital between nine and five. May not have the ability to take a day off, sick leave, etc.

So, we're working very closely with our pediatric partners to ensure that our patients get their postpartum care completed and refer them back to primary care because you are absolutely 100 percent correct. The primary care, our primary care partners are the ones who engage us in preventive healthcare, work with our weight, work with our nutrition, work with our exercise, education. I just can't agree with you more.

COUNCIL MEMBER LEVINE: Okay, well, we appreciate that. Thank you, Dr. Allen and Dr. Wilcox, and thank you very much Madam Chair.

CHAIRPERSON RIVERA: Thank you for mentioning the co-scheduling. What about the emphasis on a family medicine doctor and perhaps having those visits happen at the same time to increase the percentages? So, the doctor can check out the baby and they can check out and talk to the parent. So, it was 40 percent for the postpartum visit.

DR. MACHELLE ALLEN: They have to keep their visit with the obstetrician, but they'll bring their child to the pediatrician. So, when they come to the pediatrician, we're actually doing the postpartum visit at the same time and the same place.

CHAIRPERSON RIVERA: I just think you know, in terms of our time and our resources, we just want to make sure because I know the family medicine practices is so, so important and we're all very fearful of the cuts. But just know that we will be there fighting for you and I will be asking Greater New York as well because they do a lot of lobbying in Albany and that's going to be incredibly important.

So, just a few more questions because we have a lot of people here to testify and I want to make sure that we can keep them in here with us. So, in terms of maternal morbidity, there's DOHMH support, there are eight H+H hospitals integrating reviews of all cases that include severe maternal morbidity. What are you doing with the review of these cases and the data that is informing what you called in your testimony, population based strategies to address these conditions.

Dr. WENDY WILCOX: So, the hospitals and the MHQUIN are submitting their data to the Department of Health and they in turn can give us our own data back to us. However, before that, as Dr. Allen mentioned in her testimony, we have a regional perinatal center at Bellevue, so we were collecting a lot of the same data and using it as we plan our care.

CHAIRPERSON RIVERA: When I asked about preterm births and you mentioned one of the highest kind of indicators was having a previous preterm birth but what are the other indicators and conditions and is there something structural about these conditions? For example, if it's diabetes or it's hypertension, are we looking at maybe that pregnant person lives in

a community without access to healthy food for example?

DR. WENDY WILCOX: So, that is what one of the main reasons why we implemented the maternal medical home. So, in addition to the routine screenings and history that we would take during the clinical exam that we would be able to screen patients for some of the social determinants of health, as well as I mentioned, you know, depression and trauma and things like that to figure out who our most high risk patients are and then with the help of a maternal care coordinator and/or social worker, the patient is guided to additional support, however that support is needed.

CHAIRPERSON RIVERA: What are the actual conditions though? Can you give me a few examples?

DR. WENDY WILCOX: Sure, you mentioned some of them yourself. Hypertension is very prominent in our communities, even higher than some of the New York City averages. Diabetes is also high. Patients who have had a prior preterm birth. Obesity is also an independent risk factor for some adverse pregnancy outcomes. So, all of those things would qualify a patient as being at higher risk.

DR. MACHELLE ALLEN: And I would just add structural anomalies as well, fibroid uterus is notable for causing preterm labor. There's a broad spectrum of etiologies.

CHAIRPERSON RIVERA: And just to clarify, do all of the H+H facilities have prenatal programs available?

DR. WENDY WILCOX: Yes.

CHAIRPERSON RIVERA: And would you be able to share the budget for these programs by facility?

DR. MACHELLE ALLEN: Unfortunately, I don't have those numbers but we can follow up with finance people.

CHAIRPERSON RIVERA: That would be great. I just want to make sure that we have these numbers on hand, so we can have a Finance hearing that really gets to the heart of what we can do to best help your facilities. And I guess, I'll ask just a couple more questions and then we'll move on to our lovely panelists.

So, how are you ensuring that all pregnant people receive proper and meaningful postpartum services? I know you mentioned the co-scheduling and what you're doing to keep the mother or the pregnant person

taking care of themselves. Do you partner with Thrive at all?

DR. MACHELLE ALLEN: Say that again.

CHAIRPERSON RIVERA: Thrive, Thrive NYC.

DR. MACHELLE ALLEN: Yes, we do.

CHAIRPERSON RIVERA: In terms of services. Just trying to get an idea.

DR. MACHELLE ALLEN: Yes, that's one of the functions of the maternal care coordinators and the maternal care social workers and the maternal medical home is to help to ensure that women are also reminded and coming back for their postpartum visits.

In addition, Health and Hospitals Community Care provides care in the community. Nursing care and care through our community liaison workers and that can certainly be for patients who are discharged with hypertension and/or other medical conditions. There are also referrals for the babies and just to give you a few numbers, Health and Hospitals Community Care over the course of two years, so from January 2018 to December 2019, provided 445 antepartum visits, 9,704 newborn visits and 10,122 visits in the postpartum period.

CHAIRPERSON RIVERA: Thank you for those numbers. We're going to hear from a number of people that provide services prebirth and throughout and I hope that you'll stay and listen to their testimony. Some of their stories and their experiences and I just want to thank the both of you for giving us so much time today and I look forward to working with you in the future.

Thank you very much.

DR. MACHELLE ALLEN: Thank you for the opportunity.

CHAIRPERSON RIVERA: We're going to call up Cynthia Lynch from the New York Association of Licensed Midwives, Shawnee B Gibson Spirit of a Woman, Melissa Gardilla and Patricia Loftman.

And just to make sure that we get to all the panelists here and that we hear from Greater New York, we're going to put a clock on the timing and we're going to put a clock for two minutes if that's okay.

CYNTHIA LYNCH: Good morning, thank you for having this meeting today. My name is Cynthia Lynch; I'm a licensed midwife. I've been practicing in New York City and primarily in the H+H system for the

last 20 years. I'm here today representing as the Vice President of New York Midwives which is the New York State affiliate of the American College of Nurse Midwives, which is the professional organization that represents licensed midwives nationally.

I just wanted to let you all know that midwives are independent providers. We attend approximately ten percent of all deliveries in New York State. We are masters or doctorate educated and obtain licensure in New York after passing and national credential exam.

The midwife model of care promotes pregnancy as a normal physiologic event in a woman's life and prioritizes a woman's psychological, physical and cultural needs.

I want to thank the Council for taking the time to discuss midwifery care its role in serving the women of New York City. Some of you may or may not know but 2020 has been declared the year of the midwife by the World Health Organization because of our role in protecting and promoting maternal health worldwide.

In sake for time, because I know you've talked a lot about statistics, I'm going to sort of skip

through that and jump to Governor Cuomo's task force on maternal mortality and morbidity which showed some really stark racial disparities in maternal care and outcome.

Black women in New York are eight times more likely to die of pregnancy related causes than White women are. Severe maternal mortalities estimated to result in additional costs exceeding $17 million each year for New York City alone.

One of the driving forces behind maternal mortality morbidity is cesarean section and the complications that come from that. According to the DOH statistics, as of 2016, am I over my two minutes.

CHAIRPERSON RIVERA: You can finish your thought of course.

CYNTHIA LYNCH: Okay. New York State had a cesarean rate of 33.9 percent and when broken down by race, Black women were six times more likely to die of complications from cesarean section than White women.

When the Midwifery Model of Care is integrated into medical establishment it has been shown to improve maternal outcomes. It is the standard of care in many European countries, such as England,

France and Sweden which all of which have better mortality rates than we do here in the U.S.

A Cochran Review of Literature shows that midwife lead care decreases preterm birth. Decreases the use of pain medication and cesarean section and can help to reduce New York's maternal mortality rates.

In addition, midwives promote maternal autonomy, share decision making, provide maternal respect and are crusaders for reproductive justice. We invest time and resources into our healthcare relationships and we increase client satisfaction.

Midwifery care improves maternal outcomes and lowers costs by avoiding the overuse of interventions and eliminates unnecessary and nonbeneficial interventions including primary C-sections, avoids short term and long term complications and chronic conditions for women and newborns that can sometimes result.

And it also by definition —

CHAIRPERSON RIVERA: If you could just wrap up.

CYNTHIA LYNCH: Okay and repeat cesarean sections.

So, what I wanted to really say is that in short, midwives have been working in New York City for a

very long time. We have been a couple of the different H+H city hospital systems since the 70's. We have really great stats. You won't hear about them. Our services are underutilized. Woodhull is one shining star of the system. Their primary section rate is 12.6 and their repeat is 13.9.

The European model exists at Woodhull where midwives are fully integrated into low risk and high risk care. And I think there needs to be something spoken about sort of the power dynamics that occur within the HHC and in general in hospitals where midwives don't have the same ability to be heard, seen, paid, hired. And while H+H has midwives in several hospitals, they're not all utilized to the same extent which is why you don't see the same stats in the different hospitals and midwifery care is a solution to this maternal crisis that we have and we just have to start utilizing it. Like, it exists and we're doing it, we just need to use more of it.

CHAIRPERSON RIVERA: Thank you. Thank you so much.

CYNTHIA LYNCH: Thank you.

PATRICIA LOFTMAN: Good morning to the Council Members. Thank you for this opportunity to provide

testimony before the Hospitals Committee. My name is Patricia Loftman; I'm a Certified Nurse midwife, fellow of the American College of Nurse Midwives and former Harlem Hospital Center Director of Midwifery.

I graduated from Columbia University Graduate School of Nursing with a specialty in midwifery in 1981. I've been a midwife for 38 years.

I practiced full scope midwifery caring for women for three decades and was the Harlem Hospital Center Midwifery Director from 1984 to 1999. I retired from clinical midwifery in 2010.

A midwife is a licensed independent healthcare provider with prescriptive authority in all 50 states. While all midwives possess a master's degree, many possess a doctorate as well. Midwives practice full scope midwifery which provide the full range of women's reproductive healthcare through the life span. Midwifery care encompasses prenatal, labor and delivery, postpartum, gynecologic care which includes contraceptive management and post-menopausal care and primary care.

I would like to provide a historical context of midwives in Health and Hospitals Corporation now known as H+H. The Harlem Hospital Midwifery service

was the second oldest midwifery service in HHC. Second only to the midwifery service at Kings County Hospital. The Harlem Hospital Midwifery service was created as a clinical site for the Columbia University midwifery students in 1965.

Columbia University midwifery students were not permitted to use the Presbyterian hospital as a clinical site, as it was reserved as a domain for the Columbia University School of Medicine medical students.

I entered Harlem Hospital in April of 1982. I wanted women to understand that receiving healthcare in a public hospital did not mean having to accept second class care. I became a midwifery service director in 1984, shortly afterwards I joined the HHC Council of Midwifery Service Directors. The Council was composed of HHC midwifery service directors, all HHC hospitals had a midwifery service.

Between 1985 and 1999, when the Council was dissolved, HHC midwives attended the births of 25 percent of all HHC births. Midwives were a critical and integral part of all obstetrical departments.

I was a midwife at Harlem Hospital when the community was ravaged with the crack and HIV

epidemics beginning in 1984. For ten years between 1985 to 1995, I, together with another midwife cared for women whose pregnancies were complicated by drug use and/or HIV infection in a special prenatal clinic designed specifically for them.

These women should not have had a good outcome but they did and why was that? These women attended clinic weekly, which was a requirement and adhered to multiple and varied appointments. They were engaged in their health and healthcare because they were cared for by midwives who looked like them, who understood their cultural and norms, values and needs and who did not practice medical apartheid, which had been their experience and who used medical technology wisely and with whom they developed a relationship based on trust.

The women remained engaged in the health care system post-delivery, continuing to adhere to health maintenance activities. While the women had to the option to return to the regular GYN clinic, they chose to continue to receive their reproductive care in the special prenatal clinic.

Recently, an unprecedented amount of immediate attention has centered around the crisis of Black

maternal morbidity and mortality. Today, Black women are eight times more likely to experience a pregnancy related death than a White woman in New York City. Evidence has emerged to support racism as a direct cause of the medical conditions born by Black women that placed them at risk for maternal morbidity and mortality.

Midwives provide women centered individualized respectful, safe and satisfying maternal care. While emerging evidence reveals and documents that health systems that integrate midwives experience less cesarean section, premature birth and neonatal mortality. The number of H+H hospitals that don't have a midwifery service has never been higher.

My own hospital, Harlem Hospital Center, eliminated the second oldest midwifery service in New York that not only provided the template on how to care for pregnant drug using women, drug using and HIV infected women it was the first baby friendly HAC hospital in New York City. I was instrumental in both.

Midwives also provide primary care and empower women to maximize their health and emotional wellbeing once the maternity cycle has ended. Women

enter their subsequent pregnancy healthy, thereby improving their pregnancy outcomes and preventing pregnancy related near death and deaths. More and more women of color who are the consumers of women's reproductive healthcare in public hospital systems where most midwives work are asking for midwifery care and midwives who look like them.

At a time when access to abortion services is under threat, midwives were included in the New York State Reproductive Health Act, which codified role protections into New York State law.

In closing, substantial evidence exists that documents the benefits to all women of midwifery care. Midwives are experts in holistic healthcare and vast experience across all birth settings from home birth and birth center to large tertiary academic medical centers. They increase health equity to women and families, enabling them to address issues of reproductive justice, birth equity, health disparity, maternal and infant morbidity and mortality and primary care at a time when the availability of women's reproductive healthcare providers is decreasing.

All women deserve a midwife. The only way that will occur however, will be if every H+H hospital has a midwifery service that is fully integrated into the H+H hospital system.

CHAIRPERSON RIVERA: Thank you so much.

MELISSA GARDILLA: Alright, hello. Alright, thank you to the New York City Council Committee on Hospitals for organizing this hearing on the importance of prenatal care, disparities and midwifery and doula care.

My name is Melissa Gardilla and I'm with Every Mother Counts. A nonprofit organization in New York City whose mission is to make pregnancy and childbirth safe for every mother everywhere. We work towards achieving quality, respectful and equitable maternity care for all and we prioritize working with community partner organizations and bringing their voices to the forefront.

Delivering high value care requires that we place women and families at the center of the experience, while seeking out innovative and evidence-based strategies such as midwife lead clinical care and perinatal doula support which confer important

benefits to women, families, stakeholders, communities and insurers.

We urge the New York City Committee on Hospitals to scale up and further integrate these proven high value models into the health system, as we've already heard reliable and consistent evidence shows that both midwifery and doula care reduce cesarean and preterm births, increase breastfeeding, improve care satisfaction and engagement, prioritize shared decision making and they are cost effective.

These solutions are documented to be effective in low and underserved populations but remain unavailable to many in the city based on where they live or their income. Expanding access to midwives and community based doula's would help enhance available support services, address racial bias and fill gaps in our maternity care system.

Midwives have served as an essential part of the city's maternity care workforce but midwife positions have been cut back and birth centers at Bellevue, Morris Heights, Mount Sinai West have been shuttered. In New York City and State, efforts to increase access to doula's are underway but small scale initiatives and limited implementation has meant that

only a small percentage of communities in need are being reached.

We urge the Committee on Hospitals to learn more about the work of community based organizations, such as Ancient Song doula services to explore ways in which additional collaboration and integration can be accomplished.

I'm going to wrap up because I know my times up but in closing, improving maternity care is just about more than just improving clinical care, it's also about improving women's experiences. A recent study called the Giving Voice to Mother study, recently revealed that one in three women of color, giving birth in their U.S. hospital reported mistreatment including being shouted at, scolded or ignored or having the request for help being refused or delayed. We need to ensure that people are engaged in care decisions and that their care reflects their right to be treated with respect and dignity. This goes beyond eliminating bias, racism and disrespectful treatment. It requires valuing a woman's right to make informed decisions about their own care, the right to be listened to, the right to

be heard, the right to have their needs met from the beginning.

Thank you.

CHAIRPERSON RIVERA: And thank you for all of your recommendations which are in line with many of the panelists before you. Thank you.

SHAWNEE GIBSON: Good morning. My name is Shawnee Benton Gibson. Let me begin by thanking and acknowledging the City Council for having this convening and creating a forum where these issues can be presented, discussed and explored.

I appreciate you, each of you who are sitting here still for your efforts and your time and attention. I sit before you today as a community member, a healer, an advocate an activist, a clinician, a spiritual leader, a disrupter and a mother of three. I am also unapologetically Black, a cisgender woman, African American, a New Yorker and a Queen from Queens.

And finally, I am your neighbor. I am a fellow citizen and mother in mourning over the loss of my eldest child whose death could have been prevented. Today, I act as a vessel and a conduit for the voice

of my daughter Shamony Makeba Gibson and the voices of so many young women of color just like her.

They are no longer here to physically speak for themselves however, their spirits are ever present and alive as I address this community of leaders, innovators and witnesses who are gathered here today. My daughter's story is loud, colorful, expansive and artful.

It is filled with the energy that she possessed when she was living, breathing and moving through this world. Her story is in the hearts of those who knew her and in the mouths of those who knew her as well. It is also in the air and the ethers now that she has transitioned. Shamony's transition was sudden and unexpected. However, as I look back over my work as a reproductive advocate and leader in the reproductive health community, I have to question why I thought that I would be spared.

I question why I was not expecting Shamony to succumb to the issue that so many Black and Brown women throughout this country and this city and throughout the world have. I never thought about her being in danger of losing her life as a result of her bringing her children into the world. I was actually

more concerned about her having postpartum depression or psychosis, which is something that runs in our family. I forgot about my own birth traumas and those of my mother, grandmothers, aunties and sisters. I forgot about it because I thought that we were smart enough, educated enough and connected enough to prevent that from happening to her.

I naively believe that my optimism about how knowledgeable we all were which shield her from this epidemic, wow. Shamony's death continues to reverberate across the city and nation because she doesn't fit the formula and yes, there is a formula. When I read the articles, reports and the research regarding maternal morbidity and mortality, I see information that speaks to physical health challenges and disease in the body.

I read about women who don't have access or who don't have adequate medical care. I read about women and families who don't know their rights. Shamony's experience did not align with that formula. She was vocal, loud, commanding and demanding. She had a degree in business and two active and lucrative businesses. She was a community leader, a performance artist and a visual artist. She was

trained and developed as an adolescent to speak up and serve our community in order to combat racism and White supremacy.

She had a midwife, midwives for both her pregnancies and her births. She had doula's for both her births. She did research so that she could breastfeed properly, nourish her babies. She danced while she was pregnant, walked, studied, talked about it, bragged about it and intuitive about it.

She was awake, aware and active about Black maternal health and the darker side of reproductive health. She was proactive and productive regarding her health and the health of her family and her friends. She wanted to know, she was a seeker and yet she still died.

So, clearly, knowing is not enough. Having resources is not enough. I am here to say that everyone that is present for this conversation isn't necessarily fully invested in doing all that it takes to stop this epidemic. Just because you are sitting at the table doesn't mean that you are invested, fully present or equipped to address what is being presented here. And just because you are not in the room doesn't mean that you aren't committed,

interested and equipped to provide guidance toward effective, generative and equitable solutions for the greater good of all.

Yesterday was M.L.K Day and what I got profoundly connected to as I contemplated what his life and legacy means for all of us, I got connected to the fact that your sense of purpose can sometimes be ignited by the darkest, most tragic and mentally, spiritually, physically and emotionally devastating things. Martins legacy was fertilized by the scourge of racism, White supremacy and hate. His purpose was inextricably tied to saving the unpopular, doing the unthinkable and going toward the unimaginable.

I'm here because I'm willing to go to the deepest, darkest places and spaces so that no more women have to die and no more children have to grow up without their mothers.

They say that if you know better, you do better. I don't agree. Knowing is not enough. To do better, is to do better. Wounds create worlds and as such, the women who house them must be treated like the world. This country has taught Black women to remain silent, keep working, multitask even when you have a baby in tow to figure it out on their own despite the

odds. To ignore their mental, spiritual and emotional pain and when we do all that, we are still judged for everything that these oppressive and racist systems have forced upon us.

There is an informal saying in my work as a clinician, the saying declares that if it's hysterical it's historical. Our bodies are processing trauma daily as Black women. It's compounded trauma, it's the trauma of our mothers, mothers, mothers and it's killing us. There was never a time for a Black woman to address their traumas, especially when we're released from enslavement. Especially those that are associated with the for mothers and for fathers who went through enslavement or enslavement like, experiences and those unaddressed and unspoken traumas live in our bodies and they breed disease. Stress and trauma are silent killers and also, they are mobile, transferable and contagious. We have been taught that trauma is vicarious but trauma is contagious. It spreads, it compounds, it's binds and it alters. It impacts the body on a cellular level and it can open you up and shut you down.

Every case where a Black or Brown woman who dies or has a near death experience will not have a smoking gun or a direct line to negligence connected to it. However, we as leaders, politicians, clinicians, medical practitioners, we have been willfully and woefully negligent by not doing the work to address how racism, oppression and White supremacy has diminished the quality of life and quality of healthcare in our communities across this nation and the planet.

This morning, I'm not requesting a universal protocol for all women. Universal means one way of doing it. A universal protocol that applies to all women will not say Black and Brown women. This morning I am asking for a set of specific protocols, actions, policies and procedures that are uniquely tied to the women and babies who are Black and Brown. It is our sisters who are dying or having near death experiences while doing the most natural thing that a woman can do which is to bring life into the world.

Today, I am asking for a comprehensive solution that addresses the needs of Black and Brown women across their life spans. What I am seeking are systems, protocols, programs and people who will

speak to the reproductive needs and wants of Black and Brown girls and women. Education that is specific to the skin that you are in. Systems and institutions that are committed to making sure that we address racism and anti-Black racism specifically. Formal and informal leaders across all disciplines that are committed to principles over power and politics.

Screenings pre, during and post birth, physical and mental health screenings and including the extended support person that know what's going on with the women. That what she talks about and that what she does not. Bundles to address medical crisis, such as hemorrhage, blood clots, high blood pressure that applied universally for Black and Brown women. Full spectrum doula's on deck for all women of color. Compensation that aligns with the rich, generous and multifaceted services that they provide. Community midwives of color and recruitment, scholarships and other financial support to ensure that those who wish to pursue this age or vocation can actually actualize that vision and purpose and I thank you for this Black midwife because Black midwives are like unicorns in this world.

Community health workers wrap around services, anti-Black racist training that speaks directly to White supremacy as a construct, not necessarily a person, a face or a position. Education that begins in medical school that is injected throughout a medical providers career. Mandatory continued education especially around anti-Black racist work.

I am here to declare that my work will not stop. I am here to hold myself accountable and to hold those responsible who knowingly and unknowingly keep this epidemic going. I am here to let you know that Shamony Makeba Gibson lived. She is alive in this work. She is alive in the faces and the DNA of her children, the two, my grandchildren that are still alive Omari and Cari [SP?]. She is alive in this movement and she is alive in this moment as I speak her name. Shamony Makeba Gibson, Shamony Makeba Gibson, Shamony Makeba Gibson.

Thank you for listening.

CHAIRPERSON RIVERA: I just want to thank you. Thank you for everything, for all that you have said. Not just the midwife. If I could just call, you're a pioneer in this field and what we're doing and to know that we're closing these services instead of

expanding them, the reason I just shut off the clock was, we've already lost so much time.

So, I just want to thank you all for sharing and taking all your recommendations very, very seriously. I wouldn't be having this hearing if you didn't have my full commitment that this is what we deserve.

We deserve more services, we deserve an expansion and we deserve to remove the barriers in becoming a midwife and continuing to serve this city and I just want to thank you all so, so much. Thank you.

Okay, I am going to call the next panel Lorraine Ryan, Dr. Tara Shirazian and Helena Grant.

LORRAINE RYAN: Chair Rivera and Members of the Hospitals Committee, my name is Lorraine Ryan; I represent the Greater New York Hospital Association and all of the hospitals in New York City and beyond that are part of the association.

I first want to acknowledge the prior panel and with all due respect, I appreciated all of the comments that they made today. I thank you for holding this hearing and for allowing Greater New York to speak on behalf of the prenatal care, postpartum care and perinatal care that is provided in our hospitals each and every day.

As a clinician myself, I've been actively involved in improvement efforts with our hospitals for more than two decades. I think with such limited time, I want to acknowledge that healthcare, we all believe, Greater New York strongly supported the ACA, that healthcare is a human right and our institutions which are nonprofits in public hospitals continue to care for the most vulnerable patients in our communities.

We view addressing racial disparities and maternal mortality and morbidity as part of that mission. However, there are many hospital challenges that we currently face. As you know, we're fighting major budget cuts to the Medicaid program and beyond at both the federal and state level. Despite that, our hospitals proudly provide maternity services throughout the city and beyond. In 2018, they delivered 103,000 babies; 57 percent were Medicaid, 40 percent private insurance, 2 percent uninsured.

However, despite these unprecedented threats to the survival of New York hospitals, our hospitals continue to keep their doors open each and every day, 365 days a year and committed to providing the best care possible, not the standing insurance status.

With regard to prenatal care, I will go very quickly. I think is fairly well understood. Prenatal care is provided by our hospitals primarily in clinics and in private practices. If a mother suffers complications during the pregnancy, she may be admitted to the hospital and cared for by specialists at that point and time. The goal of prenatal care is to keep the patient and the baby in the womb, the fetus healthy, to monitor progress and to intervene as necessary.

Monitoring weight, diet, exercise, mental status, and conducting ultrasounds and sonograms to ensure the growth and development of the fetus is normal and routine. More and more of our hospitals are supporting however, those nonclinical services. Such as centering pregnancy for expectant mothers, which combines individual prenatal physician visits with peer group support to discuss and understand what it takes to go through a healthy pregnancy, to deliver an infant and to take care of that newborn within the context of the family.

Centering pregnancy programs have been associated with reduced incidents of preterm birth, percentage of low birth weight infants and lower instances of

gestational diabetes and postnatal depression. Currently, the Department of Health is supporting two pilot programs around the state. The first cohort is underway in New York City, Suffolk County, Rockland and Westchester. Downstate are part of those pilots. These are covered services and where they are not covered, they are being provided by the institution. They are run by certified midwives who lead the group under the supervision of an obstetrician.

We also wholeheartedly support doula's and midwives. Midwives are present in many of our hospitals as you've heard today, but not all of our hospitals and we would love to see more of that taking place throughout the city.

Greater New York supported legislation at the state level to allow midwives to run their own midwifery birth centers and hopefully, that legislation will push more and more of those centers to open up. Despite all these efforts; however, there are stark racial disparities in maternal mortality and morbidity that you've heard about many times today, so I will not go through it again.

How are we responding to the problem? The 2018 task force at the state level on maternal mortality

and disparate racial outcomes was created by the Governor and out of that task force came ten specific recommendations. I will touch on a couple of them.

Along with the recommendations, came $8 million in support — are you telling me I can have a little bit more time?

CHAIRPERSON RIVERA: Yes, I'm going to give you a little more time, but we did not set the clock.

LORRAINE RYAN: Oh, good, okay, good for me. Okay, we talked briefly about the maternal mortality review boards that exist both at the state and city level. These are designed to examine cases to understand what the opportunities for improvement are so that we can avoid future mortalities and morbidity. These are subject matter experts in obstetrics as well as improvement science that will unearth these root causes to prevent recurrence in the future. These are essential at both the state and city level.

Last summer and I think one of the most effective things that we've seen in the last couple of years in New York State in terms of addressing the maternal mortality and morbidity crisis, are the listening sessions conducted by the State Commissioner of

Health, along with representatives from communities throughout the state. They were held in Brooklyn, Harlem, Queens, the Bronx and across upstate.

These sessions were intended to visit high risk areas and listen to local concerns. What came out of those sessions were identifying the need for more minority healthcare professionals, midwives, doula's, practicing obstetricians and non-licensed clinicians. Increase awareness of disparities among providers, implicit bias training, you've heard it mentioned many times today. Our providers need help and support to deliver equitable, culturally competent medical care. We all have to acknowledge that.

Increasing provider support during the postpartum period. The first meeting of the states postpartum work group just met very recently and they have two and three pages of recommendations for what we need to do in the postpartum period, which is commonly now called the fourth trimester. I agree wholeheartedly with the facts stated earlier that 40 percent of women do not even make that first postpartum visit because of the challenges of taking care of their families.

CHAIRPERSON RIVERA: Thank you.

LORRAINE RYAN: Currently, ongoing, if I could just very quickly wrap up.

CHAIRPERSON RIVERA: Just wrap up, I just want to make sure —

LORRAINE RYAN: The number of quality improvement programs that were mentioned earlier by Dr. Allen, the paternal depression screening program that took place in New York City that focused on these safe motherhood initiative bundles on venous thromboembolism, hemorrhage and hypertension are very actively engaging our providers collecting data, but more importantly implementing evidence-based practices.

CHAIRPERSON RIVERA: I'm going to ask you a question about some of the things that you've recommended. I just want to make sure that —

LORRAINE RYAN: Okay, just last final comment. While hospitals absolutely have a duty to do better and strive for optimal outcomes of care, they can ultimately only control what happens within their clinics and the four walls of their hospitals.

We need more support in the community. We need community based resources at a level that's meaningful. Not just something that we're throwing

you know, pennies at it, if you will. We need to address food and housing insecurity, inaccessible primary care, lack of access to education, poor transportation; one of the reasons mothers don't get to those postpartum visits. Language barriers, health literacy, lack of emotional support and many others.

With that, I will happily answer questions and leave you with our monitor that social justice should be our guiding principle. Thank you.

CHAIRPERSON RIVERA: Thank you.

DR. TARA SHIRAZIAN: Hi, I'm Dr. Tara Shirazian; I'm an OBGYN here in New York and I'm the Founder and President of Saving Mothers. I started Saving Mothers a decade ago. It's a New York City based organization. Our goal is to decrease preventable causes of death around the globe for women and improve access to health services.

We create models of care for women that combine health education, hospital based access and also community based sentiments and understanding in order to optimize care for women.

So, we're in many countries globally and this year we set out to create a New York City initiative

after learning so much about issues related to maternal mortality, disparity in health, racial disparities, all the things we've already spoken about today.

So, the way in which we started this program was actually looking at the data that exists, that's published data on maternal death over the last two decades. We did a thorough search of all the programs in New York State and what they've accomplished in the last two decades. And unfortunately, we've learned that they have accomplished very little in terms of changing the maternal mortality rate but many of the programs and of the 16 published programs that we identified, 15 were hospital based and 1 was community based.

So, the community based programs didn't have a lot of published data out there to really look at and evidence to sort of demonstrate its full impact and to be clear, we were looking at maternal deaths specifically, so we were not looking at like neonatal death or morbidity or preterm labor, any of those things. Maternal death was one of our key words.

So, we learned that of the programs that exists, both the hospitals and the community have great

elements but there is no one solution. So, we set out to kind of create a combined effort between sort of the hospital and the community if you will. We call it the Empower program, we just launched it in Harlem last month and it's a program that's geared towards the mothers themselves and the community health workers in Harlem that are currently taking care of them.

So, the program consists of education and I mean, specifically health education for practical health education that involves understanding your health risks and understanding your complications in pregnancy.

We know what women die of. They die of PE, they die of preeclampsia, high blood pressure, cardio myopathy. We know the causes, so educating around the symptoms and the causes is really our goal.

So, we set out to launch the program. We've just sort of started, we've had a lot of great feedback from the community and our goal is to expand this program but offer health education both for those community health workers and other community participants. We are very open to partnership and we hope that many groups will want to partner and we are

giving these kits to the women themselves and teaching them how to use it.

So, they will be kits that involve understanding your health risks, improving communication, improving you know, how you hurt in the hospital and so, that's were we started.

Thank you.

CHAIRPERSON RIVERA: Thank you very much.

HELENA GRANT: Greetings Council Members. I'm Helena Grant; I'm actually the Director.

CHAIRPERSON RIVERA: You just want to make sure your mic is on. Is there a red light?

HELENA GRANT: Greetings Council Members. My name is Helena Grant; I am the Director of Midwifery at Woodhull Health and Hospitals. I am the current New York City representative for the New York State Association of Licensed Midwives. I am the current Co-Chair of the New York City Maternal Mortality and Morbidity Review Committee. I am a member of the College of Nurse Midwives and I'm also Co-Author of the Midwifery Statement for the New York City Doula Report by City Council and I want to just thank you for this invitation.

I want to start off by stating that offering midwifery care to all women within a hospital space is not only safe but satisfying and sacred. I think we're hearing a lot about the safety measures but we're not hearing a lot about satisfaction and we're not hearing about calling in the sacred and that's really, really important to women's satisfaction and when we change language around what we do, we change outcomes.

I want to talk a little bit about what happens at Woodhull and how we create the statistics that we're really proud of. So, many patients who come to Woodhull are low risk and are cared for completely by midwives and they will actually never see a doctor. However, the hallmark of our obstetric service at Woodhull is an integrative team approach that emphasizes co-management with midwife and physician team and if the patient develop risks factors but is very attached to the midwife, we provide them with a return to normal philosophy for the labor and birth.

So, even if the client has mild to moderate complications during their prenatal course, that transferred and necessitates them to go to an MD during their care, or very high risk care with a

maternal fetal medicine doctor, the midwife will get back in on the woman's care and will be with her during her birth.

And Woodhull mirrors this European obstetric model that has been talked about a lot during today. Using this model has garnered us some really tremendous results. Year after year midwives attend the labors and catch the babies. Again, language matters, so we don't deliver babies, that's something that comes to your house. With the close work of our physician team, we yield a very low primary C-section rate of 12.6 percent, repeat C-section rate of 3.93 percent, episiotomy rate 1.4 percent, third and fourth degree laceration rate of 0.1 percent, our V-Back after cesarean rates 67 percent and these rates have been noted at exemplary around the nation. I mean these are the rates that women are talking about and these are the rates that lower maternal mortality and morbidity.

It's one thing to toot your horn and say what you're doing. We do refer many of our clients to doula services, most notably Ancient Song and Doula by my Side and we do at Woodhull have a very high

rate of home birth and birth transfer site where we welcome doula's.

And, I'm just going to read a testimony with permission from a doula who had to transfer a patient because it's again, one thing to talk about what you're doing but to have outside people talk about it is always more proof positive.

This is by Doula Erica Livingston who says, my client was originally expecting and home birth, but ended up with preeclampsia at 37 weeks and hence, needed an induction that took three whole days. The midwifery care at Woodhull is impeccable. Everyone including the doctors and nurses work consensually. This is not the way it is at most hospitals at all. The client had a really positive experience and actively loved her birth.

As a doula, I can say I have not transferred to any other hospital in the city that had the pleasure of coming upon so many people who were genuinely kind. My client felt like her choices were grounded, centered and honored. No one checked her without asking first and even when they were examining her, they asked her if their touch was okay.

As a doula, I had emoji heart eyes over Woodhull. It was so good that when it was time to leave, I had a hard time leaving. I live in Bushwick and I had two home births myself and this was the place I was going to come if I had to transfer. The midwives and doctors seemed to have a woven basket within their care and clearly there was no competition. The work integrated with one another and there is no birth hierarchy. Everyone from the nurses and the midwives and the doctors were circled around the client and centered on serving her. I wondered if part of this was because there were so many women of color working together as well.

As a doula, I felt integrated into the space and was respected for my role. It was easy to support my client at Woodhull and the team made me feel valuable. It's such a safe place for clients and doula's and my client is still on fire about the care she received and I would be honored again to doula in this space.

And I just want to say, this is because outside of all of the programs that you heard, we are having some really integrative conversations within our obstetric team about books like Medical Apartheid,

about books like Killing the Black Body and about what it means to really treat women from an epigenetic perspective because we do realize that both in midwifery and medical education, those things were not taught and so, people of color need to be at the forefront of this movement, teaching other people who want to care for the woman and families in these communities.

And so, these things need to be integrated because medical care sits outside of those other teachings.

CHAIRPERSON RIVERA: Thank you so much. And I did visit Woodhull Hospital to see this area of the hospital and it's beautiful and I think there's just an energy there that really speaks to how you are trying to approach this in a holistic way and I know that this is the European model, so what are some of the key elements of the European model that have led to some of the successful outcomes that you mentioned?

HELENA GRANT: Well, the European model is very similar to what I described. Midwives are the hallmark of care across Europe. It's only because of the United States history of both racism, patriarchy

and putting women of color out of business that we have obstetricians who basically own obstetrics.

Europeans have a shared model and philosophy of care where even when the woman is moderate to high risk. Unless she's extremely high risk, she's care for by a doctor. But if she's low risk, like we know in England, the Queens of England, they all had their babies with midwives. This is a United State phenomenon that we have medical patriarchal, technocratic, meaning that we use technology to monitor women and labor. And it's really about the history and knowing the history of women being removed as midwives from taking care of their own community ad bringing other persons who are not from their community in, to take care of them that don't speak the language and language could mean, like when I say to a patient, you know, I need you eat some vegetables. Auntie needs you to eat some vegetables, that's very different from a physician who's 25, who is just saying, miss, you have this high blood pressure and I need you. It's a different way, as you said, you use the word energy. It's a different energy and it's different connection that we share with the clients and even midwives who a lot of times

are not from the community, they learn some of that over the course because of the midwifery philosophy.

So, it's the philosophy of care that makes the difference in the space, because even when the woman becomes high risk, there is a different level of education and synergizing a thought and being one with the women, that can happen.

CHAIRPERSON RIVERA: Thank you so much for that because you know, my jurisdiction here as the Chair of the Committee on Hospitals is to discuss prenatal care in our hospitals but our whole intention is about birth justice and you know, I joked with my team and the amazing staff here that you know, the hashtag of this hearing was going to be called the midwife. But you know, these are serious, serious issues. When we have ten percent of our births in the presence of a midwife but almost everywhere else in a modern society, it's well over 50 percent. We are just dragging our feet on one of the most serious issues of our time.

So, I just want to thank you for what you are trying to do and I know that you know, it starts at home right. That's how we organize, that's how we

get things done and I want to ask a couple more questions.

Let me start with Greater New York, because you did have some information that you gave us and I wanted to ask, because you mentioned community based resources and I think everybody here is in agreement that we want more community based resources and for our colleagues at Saving Mothers, you mentioned that you only had a little bit of data from community based organizations.

DR. TARA SHIRAZIAN: That was published data, evidence, which is really what I look at to determine you know, how to construct a new program.

Like, what are the models that work? And actually, I should say, there are lots of models across the country that work. California has a — it's all in this paper, which I'll leave you, but California has a few very effective models that combine a lot of community organizations and hospital based organizations.

So, there are methods that will move us forward but it requires a lot of collaboration.

CHAIRPERSON RIVERA: Well, we have DSRIP and the question is whether or not DSRIP is actually working

and I wanted to ask, that we all agree that we need more community based resources. In fact, a lot of our community based organizations, they're doing a tremendous amount of work without receiving the funding at all or on time.

So, the goal of DSRIP, you know, where money flows from the state to the hospitals and then to the community based organization that the hospitals are partnering with. So, how has DSRIP improved the resources in communities regarding prenatal care? We've heard it isn't enough.

DR. TARA SHIRAZIAN: I think we need DSRIP focus on prenatal care. The next generation of DSRIP, which is currently in the workings through the federal and state system to be approved, will have a very specific perinatal focus. Governor Cuomo has already stated that and hospitals cannot provide, and the clinicians that you've heard from today, I think would agree, you can't provide the type of care that you need that is so holistic and comprehensive to a mother and baby without engaging the community. And the safety net that communities used to provide, immigrant communities and to some extent, and I'm obviously not an expert, even the African American

communities are no longer there. The toxic stress that you spoke of earlier, is engaging and distracting people from a way from being that provider or that support and that's where centering pregnancy, doula's and other neighborhood initiatives are becoming the village if you will. And I think we have a tremendous opportunity with DSRIP and as I said, there's already a targeted focus on maternity care. They have been called a prenatal care, a postpartum care, but we're looking at the comprehensive journey that a woman takes and really, we need to start before pregnancy.

The Department of Health is also focused on maternal wellness, preconception care. Does a woman even understand her underlying comorbidities prior to becoming pregnant and getting those under control, so that the pregnancy has a chance of being a healthy pregnancy.

So, I think this hearing is very well positioned to really have an impact on where the district targets are in the future of that funding, which is yet to be determined.

CHAIRPERSON RIVERA: I hope so. I mean many of us worried. We hear a lot about listening sessions

and task forces and I'm always led to the same question which is, what are we doing with the data? How are we actually translating that into work when we know what has been working for decades and centuries, actually centuries.

DR. TARA SHIRAZIAN: Yeah, I think those listening sessions are a bit of a game changer. There's no turning back, there's no putting the words that came out of those sessions back in the bottle. It was stated, women don't feel respected the way they need to be respected. They don't feel that they get the tailored care that we've all heard today. And so, important and vital to all communities actually.

So, I think the genie is out of the bottle on this one and we absolutely support greater funding, whether it's through a district like program or directly to CBO's who are aligned with inpatient providers in clinics. Whatever the recipe is, we are supportive of more.

CHAIRPERSON RIVERA: I understand about the funding, I just want us to just always remember, there are always going to be challenges in funding for our city to be threatened with eliminating what

is probably the most basic human right, which is healthcare. Is to me, inducing a level of anxiety and stress that our community based organization and our public hospitals have already had to deal with for a very, very long time.

So, I hope we can all work together on this one. I just want to thank you all for your testimony. For the work that you are doing and really appreciate all your work and your recommendations as well.

Thank you.

PANEL: Thank you.

CHAIRPERSON RIVERA: Mimi Niles, Debra Lesane, Denise Bolds and Chanel Porchia-Albert and I'm sorry if I mispronounced anyone's name. Please feel free to correct me.

MIMI NILES: Hi, good afternoon I should say now, it started with good morning. I'm so grateful that the Committee on Hospital had the vision to have this committee hearing. As is obvious, this is a topic that many of us are really passionate about. We probably could have used the bigger room.

My name is Dr. Mimi Niles; I'm a midwife and a midwife care researcher. I did all my training here in New York. I am an immigrant to New York. My

mother was a midwife in India before we immigrated to New York and I've been working at Woodhull for the past ten years as a midwife clinician.

I just wanted to, I think everything that I have written has already been shared, so I think I'm going to just focus on one part of my testimony which has been shared, but I do want to highlight.

It's essential that we understand that just including midwives does not do enough to change the systems of care and the institutions of care. So, it's not enough to have maybe one midwife or two midwives as some of the H+H facilities do. Really the change happens when there's full on integration of midwifery care into services.

So, services like Jacobi, Woodhull and NCB which were the focus of my research, have fully integrated midwifery care into all aspects of their women's healthcare trajectory for people and that's really when you see improvements of care. So, I see in briefing that was created by I'm not sure who, you mentioned the midwifery integration scoring system and we know that when there's higher integrative scores, that overall healthcare systems do better.

So, though New York is in the higher core, we only scored 54/100. That's not great, that's not a passing score. So, we can still do much, much better on how we're integrated. The H+H facilities integrate midwifes, but not consistently and not across the board.

So, you could take a 30 minute subway ride and have a very different maternity care experience in an H+H facility. So, I really want to make it clear to the Council that it's not enough just to say that you offer midwifery care. Really, it's the quality and the full on integration of midwifery care that really matters and it matters to women. It matters to family and it matters to providers as well.

My research shows that when midwives are allowed to fully function to their full capacity, to the full scope of their practice, they are also more satisfied in the care they give. And that increase satisfaction leads to increased engagement. It leads to increased commitment to the communities that they are working in.

So, it really is this very positive feedback, it's not just about what the providers are able to offer but how do we make relationships of care that

are beneficial to everyone because providers are burnt out. Something we don't talk about enough. Providers are fatigued and burnt out particularly in the public healthcare system where we are under resourced, we are understaffed and we are doing the work that many of the private hospitals have chosen not to take on. So, we really, the public system bears the burden of the people that the private hospitals do not and will not care for.

Thank you so much.

CHAIRPERSON RIVERA: Thank you.

DEBRA LESANE: Good day City Council. Thank you for this opportunity to speak today. My name is Debra Lesane and I am the Director of Programs at the Caribbean Women's Health Association. I'm going to kind of go off my written word because so much of it has already been said but I just want to say first of all that Caribbean Women's Health Association provides a range of services to support pregnant women and postpartum women throughout New York City.

We do receive funding for a doula initiative called Healthy Women, Healthy Futures and the City Council funding allows us to coordinate the provision of doula services. It is a citywide initiative by

Caribbean women. It's responsible for coordination of doula services in Manhattan, Bronx and Queens.

So, a lot has been said today on the importance of doula support and I just want to say that Caribbean Women has been a part of this effort. This is our sixth year of providing doula services in New York City.

Caribbean Women's Health Association was established 37 years ago to provide maternal and child health support services because immigrant women in East Flatbush predominantly from the Caribbean were not receiving adequate prenatal and postpartum healthcare support.

So, the pregnancy and birth outcomes for this population was very poor. Over the years, the Caribbean Women's Health Association programs have expanded to meet the needs of the community. At this time, CWHA still has a particular focus on meeting the needs of pregnant and postpartum women and we also provide HIV testing and prevention education and immigration legal services.

Although maternal and child health outcomes have been approved overall in New York City in the last 37 years, there are still glaring maternal and child

health disparities across the neighborhoods and communities of New York City. I live and work in East Flatbush where 37 years later, we are still working to improve maternal and child health outcomes for mothers and babies in New York City.

I'm just going to skip to the part of my testimony where I highlight the fact that severe maternal morbidity and severe maternal mortality are very high in the community of East Flatbush where our organization provides services and I've outlined the data. The severe maternal morbidity rates are measured per 10,000 deliveries. Immigrant women are particularly at risk for severe maternal morbidity.

For 2013 and 2014, the severe maternal morbidity rates for East Flatbush was 567.7 cases per 10,000 deliveries compared to a rate of 270 for New York City overall. That's more than twice the rates for East Flatbush.

Also, for East Flatbush, the rates of expected mothers receiving late or prenatal care is higher than the citywide rate. In addition, one in eight births to East Flatbush residents is preterm, which is higher than the citywide rate.

In addition, East Flatbush still has consistently high rates of infant mortality and neonatal mortality between 2013 and 2017. There are many factors that contribute to these striking disparities including preconception health status, poverty, racism and overall access to adequate healthcare.

However, the social determinants of health also play a major role in women's overall physical and emotional health including housing, access to food, etc. CWHA provides breastfeeding workshops, parenting classes and other supportive services to more than 300 pregnant women per year. Most of these women are referred to CWHA from local hospital prenatal care clinics.

And I just want to highlight that we do have a very good working relationship with Kings County Hospital which is located blocks away from our facility. So, we do receive many referrals for social services from Kings County.

In light of the maternal health issues that continue to exist in our communities, our hospitals need adequate and secure staffing and funding to be able to provide a high level of care and service coordination to all, regardless of insurance or

immigration status. This is especially important for pregnant and postpartum women who should be receiving care in a comfortable, culturally sensitive and stress free environment.

Our overall recommendation is to improve the effectiveness of hospital prenatal care services would be to identify resources for improved coordination between hospital based services and community based supportive services for pregnant women especially for communities like East Flatbush and Brooklyn where the health status indicators for pregnant women are still unacceptably high.

We are also recommending increased resources for the most high need areas in New York City for evidence based interventions that will improve the quality of prenatal care services for high risk women such as perinatal case management services, comprehensive doula support programs and centering pregnancy programs.

Thank you.

CHAIRPERSON RIVERA: Thank you.

DENISE BOLDS: Thank you and good afternoon. My name is Denise Bolds and I am known here as Bold Doula. I have my own private practice as a doula and

I'm just honored to be sitting at the table with these wonderful women who have also contributed to my practice. I have so far in five years, supported 144 births in my private practice. I have a master's degree as a medical social worker and before that, I was working as case management for high risk pregnancies for managed care organizations.

So, I am very much in tune with that. I also trained at Bellevue Hospital back in the 80's as a trauma technologist. I want to pull you back even further. 55 years ago, in 1964, I was born at Harlem Hospital. My mother gave birth to me by herself unassisted in the bed where she pushed me out and unwrapped the cord from around my neck and actually put me up to her chest because she had tuberculosis and the nurses did not want to assist this pregnant woman in delivering her baby.

Our system here has been flawed for a long time. This is not a recent thing. This is not new news. This has been happening for a long time and as gentrified as Harlem is today, Harlem Hospital is still one of the most underserved, underpaid, under resourced hospitals in New York and that in itself is an atrocity.

I'm working in volunteering at Harlem Hospital with their new upcoming doula program, why should I have to volunteer? My lights are not free, my education and the master's degree was over $100,000, I'm still paying that off but yet still, community doula's are asked to work for pittance. They are given the lowest of education and they are asked to come out and do the resources on their own and they're also asked to work close to free.

That is an equity that is not fair. Here in New York, we also have a situation where a lot of our moms are giving birth with doctors who are students themselves and that culture, that energy has to stop. It is a lack of congruence it's a lack of respect, it's a lack of diversity.

I also want to mention that Erica Garner also died from postpartum complications of pregnancy. This was one of the strongest voices in New York and when it came time for her to have that support and help postpartum, she didn't have it. Think about that. I also want to mention to you really quickly before my time is up to, is that historically ACOG has always not been supporting of Blacks since the emancipation of slavery and Blacks had to go out and

forge and get their own medical doctors and their own medical system of care. We cannot keep building on expectations of having a better medical system prenatally and postpartum on a system that was based on racism. We have to address the foundation if we want to address the house staying up.

I'm very, very passionate and compassionate about what's happening here and as a mentor of doula's, I mentor doula's here in New York and the doula's who are coming through are in front line and they are dealing with a lot of oppression and hostility from hospitals and hospitals don't understand. Every time a doula walks into their doors, there is customer satisfaction that improves their NCQI scores in order for them to keep their accreditations. We have to work hand and hand in order to understand that.

I have a podcast of ten years with over 100,000 listens and I've given voice to the voice list by letting those people, the birth workers of color have a platform to speak and share their information. I'm a little dismayed that with all the work that I'm doing this past panel that was up before me, the women who was talking about her Harlem based program, I've never heard of it. Why am I not hearing about

these type of resources? Because we're still in silo's. We have to think about this and we have to take a very close critical look and we have to have the right people. All people who are frontline doing the work at the table.

Thank you very much.

CHAIRPERSON RIVERA: Thank you.

CHANEL PORCHIA ALBERT: Good afternoon everyone. My name is Chanel Porchia-Albert; I am the Founder and President of Ancient Song Doula Services. I am also a commissioner on the NYC's Commission for Gender Equity. I thank you for hearing my testimony this morning.

So, I'm going to make mine very short and sweet because I'm actually coming from a 45 hour birth. Yeah, birth is long sometimes and doula's work hours that go above and beyond the extension of your physical and mental capacity to be able to provide equitable services to individuals throughout NYC and in this country.

I want to touch upon some of the things that were mentioned earlier in regards to H+H hospital systems and their implementation of doula services as well as

their lack of providing resources to midwifery care to individual within their catchment areas.

I've noticed that implicit bias has become a catch phrase or a comfortable language for individuals to make them feel good about not necessarily addressing the real problem within systems which is racism. What we actually need within our hospital care systems is one overall of systemic change that encompasses an anti-racist medical model of care that actually sees the individual as a whole person and understands that a one off training, a bundle and a couple of seminars and task force is not going to do the job in providing equitable services to individuals.

I also want to mention, although I am a doula, I don't think that it is diverting of the doula to carry a heavy load of trying to end racial disparities on their own. Doula's are overworked, overtaxed and completely overpaid, excuse me, underpaid. Underpaid, excuse me, for the services that they provide.

As the community based organizations that serves all of NYC and parts of northern New Jersey, we have been around since 2008 and we actually started in my

living room. Started with having conversations with individuals and really wanting to connect. Connect on a real human level to be able to provide services.

Since the media attention around the infant and maternal mortality because the infant and maternal mortality rates have been atrocious for years. But since the media attention, we have tripled the number of referrals that we get on a monthly basis. Hundreds of referrals from institutions and hospital based institutions and other community based organizations. We have 70 doula's who volunteer their time who are underpaid or are doing it at no pay. We are a small community based organization that is providing services to individuals where which we have a model that says, we don't turn anyone away.

How are we supposed to be able to provide culturally relevant, culturally humble care that centers the individual in an equitable way when we ourselves can't take care of ourselves and the families that we have in a way that feels good and equitable to every one throughout NYC.

We need to move away from cultural competency in a more culturally humble framework that understands that I don't understand and it's a learning model. A

true collaborative care framework that encompasses the midwife, the OB, the nurse and the doula that is truly informed, trauma informed and patient centered that really centers the needs of the individual on a case by case basis and not throughout the spectrum of their reproductive health, of course.

And I want to keep it very short and sweet and just leave a quote from Martin Luther King because I believe he's a radical visionary and sometimes people like dilute that vision. But a shallow understanding from people of good will is more frustrating than absolute misunderstanding from people of ill will.

And so, understanding that good intentions without backing means nothing. It is our human right and moral right to stand up for human rights and justice when we see something that is going on and when we continue to allow individuals to be treated in a way that disenfranchises them either through economic injustice, climate injustice or personal interaction within the healthcare system, we continue to morally degrade ourselves as human beings and as those who need to hold each other accountable for the work that we do.

Thank you.

CHAIRPERSON RIVERA: Thank you so much and thank you for mentioning — well, we talked about the history today and how deeply racist and intrenched it is and even how to this day we hold in high esteem, medical professionals who engaged in the sterilization of Black women, of the Puerto Rican community and it's hard for us to now think that we're going to trust the very people that tried to take away what is something beautiful. Something that should be cared for.

So, I just want to ask a question and then I want to turn it over to my colleague here who joined us today. So, there are discussions at the state level to incorporate doula services into Medicaid. For some reason this is controversial.

CHANEL PORCHIA ALBERT: Oh, yeah.

CHAIRPERSON RIVERA: For me, I mean, I think I know how we all feel about this legislation but I'd love to hear briefly how one or all of you feel and I think the barriers that people face and just trying to — the barriers to practicing as a doula. And also, the most significant barriers to accessing doula services. I guess those are my questions for you.

CHANEL PORCHIA ALBERT: So, in regards to the New York State Doula pilot program, I can say that currently as it stands it's inequitable. It's inequitable for the reimbursement rate that they are providing towards doula's. I mean, I just said, I came off of a 45 hour birth.

Having someone who is supporting you for 45 hours who is not really eating, who is not really sleeping, who is being attentive to the individual. Who is providing comprehensive care to support someone through their birthing experience and then only being reimbursed for services at a $600 rate in New York City is not a living wage. The average individual or doula realistically wise in a place where they don't you know, overexert themselves can maybe have about three births a month.

Right, and understanding how Medicaid reimburse, we also understand that Medicaid may or may not choose to bill or to reimburse that doula in a timely manner as well.

The individual then is also burdened with the fact that he now has to look towards billing. Something that they may not have done before. This is another expense that is now taking out of the

doula's own personal resources, on top of if they have children, they have to pay for childcare. On top of transportation. On top of all of the things that they need just for a daily living, right.

It also puts a burden on the individual who receives Medicaid in being able to access a doula who has culturally relevant care and has that understanding of that background. The ways in which it is set up, a doula can come and just say, I'm a doula and provide services and not necessarily understanding where did this person get training? Has this individual been trained to be able to serve communities of color, Black and Brown people. Have they been trained in trauma informed care to be able to provide services.

The other bill that was recently vetoed, which was a lot of people here sitting at this table fought against was the doula certification bill. Which would have put limitations on the doula being able to practice in a free will, right.

As we understand, doula services are a holistic service, much like acupuncture, right or acupressure or somebody going to get a Rikki session or a message therapist, right.

The doula thereby would have been under the constraints of institutions and not be able to practice independently and freely as they would want to. To be able to sustain themselves at a living rate. And so, the current legislation that has been brought forth has been something that has been inequitable, not only to the individual doula but also to an organization.

As someone who runs the doula organization, the burden of having me now, having to charge individual doula's in order to get reimbursement for the services that were rendered is an additional burden on the individual, which should not be had.

Having doula services from community based organizations that are provided for where there is funding for being able to administrative services, so that the burden is not on the doula to have to have that is something that needs to be put in place and more equitable services.

CHAIRPERSON RIVERA: And let me just, because I want to make sure that Council Member Rosenthal, who joined us has a question. I want to make sure she gets a chance to ask it.

So, what's a better way to increase the access to doula services?

DENISE BOLDS: Well, first of all, the Medicaid doula pilot project that's here in New York State. To me it's a punitive response to if we have doula's come through then this will increase and rectify our statistics, right. And it became a very punitive setup in what Chanel just said. I don't need to reiterate all of that. It is not equitable; it is not helpful. It is not pertaining to access. Medicaid is not the solution to doula access. It is a three legged stool.

Hospitals need to have a leg on that stool. Insurance companies need to have a leg on that stool as well as the state and if you have a budget line for a hospital put $100,000 on their budget for a doula program, even more than that but just as a pilot, you will see their NCQI scores are going up. Insurance companies, I did medical case management. Bed days for high risk pregnancies; it cost more money. It bleeds out more money of the system if you put in that preventative budget for doula, you're going to save money on bed days. But meanwhile, hospitals and insurance companies have been basically

excused from contributing to this resource and that's where there's a fallacy with that.

So, it's a punitive response to the call for having a doula, but it is not the solution because Medicaid alone is not enough. Insurance companies have to be on the line as well as the hospital.

CHAIRPERSON RIVERA: Thank you, thank you.

DR. MIMI NILES: I'd like to add also that Medicaid reimbursement for doula services is only adjusting part of a problem when it comes to maternal mortality and morbidity. We heard earlier that it's not just low-income women that are impacted by this issue. It's Black and Brown women who are being more impacted regardless of their income status or their education status. So, just to focus on Medicaid reimbursement for doula services is not, you know, it's a drop in the bucket, but it's not really addressing the whole issue.

I'd also like to speak to the funding of doula services here in New York City set aside from the Medicaid issue. We, as I mentioned, we are funded by our community based doula program is funded by the New York City Council. Because of the New York City Contracting process, it does not allow us to fully

operate our services year around. From year to year our contract with New York City is usually completed. The contract process is usually completed in May of a fiscal year that begins in July.

So, community based organizations are expected to operate, provide staff time and other resources. With regards to our doula program, often times our doula's have to work throughout the year without being paid, because our New York City contract has not been completed and finalized.

So, that is really something that needs to be addressed in order to improve support services for pregnant women in New York City. Specifically, doula program services.

CHANEL PORCHIA ALBERT: As well as HAC and their implementation of their doula services. The implementation, although they are working with doula's, just having doula's sitting at the table and hearing their voices and not necessarily taking their voices into consideration, doesn't mean anything.

Also, having a doula program and not putting aside funding to be able to support said doula's providing their time and their energy and their resource to patients is inequitable. You can't say

that you want to have a doula program within your systems and then not provide a way for doula's to support themselves and being able to do the work and serve the community in a way that not only serves the community in an equitable way but also serves the individual so that they feel valued within the work that they do on a consistent basis. Doula's give up hundreds and thousands of hours a month in services and most times for free, especially if it's a community based doula and that's not an equitable model. It's not a sustainable model and it's not a way for doula's to be able to continue to do this work in a way that feels good to them and serve the communities that they live in.

DENISE BOLDS: Can I add too that Medicaid is also an issue for midwives. So, we are not equitably reimbursed either. I can do a birth in room six and a physician can do a birth in room seven. They will get 100 percent Medicaid reimbursement. I will get 85 percent reimbursement. For better quality care, for more time, for more engagement, for more trust building, for more family involvement.

So, this is an example to me of structural racism and medical patriarchy. Because if those are the

decision makers here and in Albany and if all those health decision makers are physicians, this is the problem, right, is how do we dismantle historic power systems? Because they infiltrate every single part of the system and I stand here with my doula comrades in saying that this impacts all of us and that trickles down into the people we are really here for, which are the women. The childbearing people, the families, the communities that are the Bedrock of New York City.

DR. MIMI NILES: Yeah, so and I just want to add to for doula care, doula care 45 hours at a birth, that's about right. Also, don't forget, we are on call stating at about 36 weeks. Okay, I have to be by the phone, I have to be ready to go. I also have to provide two prenatal visit and any other crisis intervention and resource linkages that may come up until the birth. After the birth, I have to do breastfeeding support, postpartum visits to the home as well as the continuation of that resource linkages and providing support and services to make sure that that baby can stay alive through the first year.

Imagine that, that's what a doula does. It's not just the birth itself. We are encompassing a lot

more and delivering a lot more care and we are also asked now to do crisis intervention, social work. We're asked to do a lot more out of our scope of practice and that wears a doula thin. I'm one of the fortunate doula's. I'm walking in with a master's degree in social work but not all of my doula sisters have that same level and scope of practice like I do.

So, we have to keep in mind what we're asking for and what we're reimbursing doula's is completely inequitable.

CHAIRPERSON RIVERA: And thank you for mentioning, I know that earlier I said on how if your paid, you're paid late, it's just unsustainable and especially if you're a small organization, which I know many of you are doing a lot with so little. So, I just want to thank you.

I want to recognize Council Member Mathieu Eugene, whose joined us and I want to ask Council Member Rosenthal had a question who is joining us.

COUNCIL MEMBER ROSENTHAL: Yeah, thank you so much and thank you Chair Rivera for holding this incredibly important hearing. And thank you to everyone who has come to testify today, your work is so critical.

I'm wondering a couple of things. One, when you sat and heard the H+H testify and DOHMH testify, did you feel that they, and given the fact that we've now in terms of my personal involvement have been actively engaged in this for a couple of years, as I've been Chair of the Committee on Women and Gender Equity, pushing for more money in the budget for maternal care, doula services.

Do you feel over the last two years that their level of engagement, their commitment, their comprehension as we've codified the M3RC including doula's, midwives that their commitment has improved or changed?

CHANEL PORCHIA ALBERT: No, I think that there hand has, and I'm going to be very transparent. I think that their hand has been forced to address the situation that they are ill equipped and resistant to doing it in an equitable way.

I think that community based doula organizations and individuals who are advocates within this work, rather it be around reproductive justice or birth justice, their work has been coopted and manipulated into systemic, not even systemic change but silo change within particular areas that is inequitable

and does not — they don't understand what it means to be not just in a community but an extension of that community and the community based doula organizations and the midwives who are working within these particular areas are not just working in the community, they are extensions of those communities in which they serve.

And so, having personally sat at these tables and understanding what these individuals, what these things are doing, there's a great resistance to systemic change. There is a great resistance to accountability measure that would truly center the patient in a way that uplifts them and makes them feel empowered enough to say, oh, this is what I want or this is what I don't want.

Using ACS as an agent towards manipulation, fear based to get someone to comply with a medical procedure. Using manipulative task of — I'm sorry, my level of frustration is just.

COUNCIL MEMBER ROSENTHAL: High, rightfully high.

CHANEL PORCHIA ALBERT: It's very high and I'm also coming off of a birth.

COUNCIL MEMBER ROSENTHAL: Appreciate you, yeah 46 hours.

CHANEL PORCHIA ALBERT: But understanding that these individuals work in these systems on a day to day basis and are doing it highly frustrated but are still showing up at work every single day and giving their all.

Midwives are trying to provide care in a way that truly centers the patient and they are being restricted. Not by their patients, by institutional policies that will not allow them to practice in a way that is functional.

COUNCIL MEMBER ROSENTHAL: So, let me ask you specifically. Is it the way doctors are trained and doctors have so much power in the institution or is it that health and hospitals corporation and trickling down to each individual hospital, the presidents of the hospital are not messaging.

CHANEL PORCHIA ALBERT: Right, so that is a part of the problem. A part of the problem yes, is education but overall, there needs to be systemic change, right. Because you can't write a respectful care at birth documentation and hand it to a patient and tell the patient, oh, these are your right and then the patient goes into a center and says, yeah, you know, this is what it says, it says that I have

these rights and then the providers like, that's cute but that doesn't mean anything to me.

COUNCIL MEMBER ROSENTHAL: And it that resources?

CHANEL PORCHIA ALBERT: Yeah, that's resources. Those are resources that we all, that we worked on.

COUNCIL MEMBER ROSENTHAL: What I mean is, does the doctor say, great, it doesn't mean anything to me because I don't have the resources.

CHANEL PORCHIA ALBERT: No, it's not because they don't have the resources, it's because they don't have the training and the knowledge to be able to facilitate that.

COUNCIL MEMBER ROSENTHAL: Okay, alright.

DENISE BOLDS: Can I add something as well, speaking as a midwife who works in the H+H system. I've been in the system for ten years and I don't think my answer is as absolute as no and it's what I appreciate about doula's is that they are external to the system and so, they can — their ability to hold the system accountable it different than for those of us who are in the system, right.

So, we are seeing the system from a different perspective. I will say that I've definitely seen the rhetoric around maternity care quality change in

the H+H system. What I have seen slow to change is embracing the midwifery model of care. I will say also in full sort of transparency, I have been hired as a consultant by Health and Hospitals to do a broad overview of what midwifery care looks like in the H+H system because they realize that if they're going to make a full transformative responsive plan to address maternal morbidity and mortality, they're going to have to utilize a model that has been underutilized in the system.

But in places where it works, it works well. At Woodhull it's works well. At Jacobi it works well, at NCB it works well. So, I also encourage people to look at what is working in that system, so that we can replicate it and I do think that medical patriarchy is a very real absolute, as absolute as this table, it's not just conceptual.

It exists not just in H+H, we also have to hold the private hospitals feet to the fire. What are they doing for our communities because the people they don't take care of get absorbed into the H+H system.

COUNCIL MEMBER ROSENTHAL: And at Woodhull Hospital has maternal mortality decreased?

DENISE BOLDS: I don't know the statistic on that.

CHANEL PORCHIA ALBERT: I know I can speak personally as someone who had a home birth and had to transfer to Woodhull Hospital and who had worked with the midwives at Woodhull Hospital, that they offer excellent and professional and culturally relevant and culturally humble care.

Now, I will say the places that Dr. Mimi Niles has mentioned are places where there are individuals who are striving to make a cultural change within the environments that the are in and they are working really hard to ensure that things and they have worked really, really hard to ensure that those changes are being met and that they are being followed through and not, easily either. They are met with resistance on a consistent basis but yet, they still continue to fight for those changes and if we do follow the models that these individual have implemented within these particular places, I think that more individuals would be able to access services in a holistic way.

DR. MIMI NILES: Can I just in response to your question. This morning we heard from Health and

Hospitals. We heard testimony from Dr. Machelle Allen and Dr. Wendy Wilcox, we did not hear testimony from New York City Department of Health and Mental Hygiene, which I was very surprised. Because this is an effort, we are all involved in this effort and the efforts should include input from the hospitals, the Department of Health, which is very invested in this work and community based organizations.

So, I think as far as I'm concerned, we should have heard from New York City Department of Health and Mental Hygiene this morning. We community based organizations, we work very closely with them and the hospitals work very closely with them to improve maternal health outcomes.

So, they definitely should have been a part of this conversation. I also want to say that, in terms, as we all have to work together. That the Health and Hospitals facilities are all at varying levels of community involvement when it comes to prenatal care and working with pregnant and postpartum women. Yes, my organization, we have excellent work and relationships with Kings County.

I think there are various H+H hospitals that work very closely with their community organizations and

then there are some that are not, that don't and they don't have that community involvement.

So, I think in terms of improving overall outcomes, it would be beneficial for Health and Hospitals to focus on improving community collaborations for all of their institutions.

DENISE BOLD: So, I just want to say that I did listen to the report here this morning, since I was here since the beginning of the meeting. 55 years ago, 1964, my mother gave birth at Harlem Hospital. 29 years ago, I gave birth under PCAP, with a midwife for my son. Not very much has changed. It has just been given a different name. It has been shifted around. Somebody else now has to take the shit pot, excuse the expression, but not very much has changed. I'm out here in the frontlines as a doula. I am interfacing with advocacy. I'm dealing with staff with low expectations of the patient and of their families of the supports that they bring to the table. I'm dealing with the HUB of a teaching community which New York City hospitals are and that is a whole other culture that we have to talk about because I have to fight off residents who want to come in and put their hands up my clients vagina and

don't identify themselves and have a problem in doing so.

They don't get consent, they have low expectation, low regard and it is the same thing that happened to me 29 years ago. So, traumatic was the birth with my son. I had four miscarriages consequently. So, women are dealing with the trauma. They are not talking about it but it is still happening. Not very much has changed.

CHANEL PORCHIA ALBERT: And also, that Health and Hospitals; it is the parent organization but it not a monolithic organization. So, each, it's like a kingdom in Fiefdoms, right. So, then each individual hospital has its own individual culture and then each individual labor and birth unit has its own individual culture and you know, I really feel the disservice in the equity is that you can go to Kings County and have a very different experience. You can go to Woodhull and have a very different experience. You can go to Bellevue and you can go to Harlem. It shouldn't be that way for women and that is the injustice.

COUNCIL MEMBER ROSENTHAL: Thank you. It sounds like you have a lot of work on your plate. And

lastly, I just want to say to Ms. **[INAUDIBLE 2:43:36]**, on behalf of the City Council. I want to apologize. You and other people in your network have written a beautiful letter to the Council saying, where's my money? And much more eloquently and graciously than that. I apologize, very graciously and the system is betraying you. You know, I've been trying to put you in touch with the right people who can help you move it along. I hope it happens soon but it's really inexcusable and that you know, sounds like we're talking procurement, something not important but it's own set of cultural change that needs to happen there because they need to understand that the city is setting you up to fail when we don't pay for the work we're asking you to do.

DR. MIMI NILES: That's right, and doula's are working and not getting paid for eight to ten months.

DENISE BOLDS: And I just want to say lastly, you can have something on paper and it looks absolutely wonderful, try living it and evidence based shows, because I'm also an evidence based doula. It takes up to ten years to change a policy. So, we have a lot of work to do.

COUNCIL MEMBER ROSENTHAL: Thank you Chair Rivera.

CHAIRPERSON RIVERA: Thank you so much. You know, I just want to say when we were discussing consent and I just know that we structurally also our justice system and how we prosecute very, very recently even Dr. Robert Hadden and what he did to abuse pregnant people and the people of the city and our failure to prosecute those crimes is a disservice and a failure and is shameful.

And, so, everyone who is still here. I know we have one more panel to go. I just want to thank you all for your patience. The reason why we gave almost an hour to H+H today is because of the very reason that you mention. That there are 11 acute facilities throughout the city and every experience is different.

PANEL: Yes, yes.

CHAIRPERSON RIVERA: Bellevue and Kings and Coney Island and Jacobi, they are all different and that to me is something we're chipping away at and we're just not being given the tools. We need the sledgehammer and they are really having us chip away at what is a very, very serious issue.

So, I just want to thank you all for your years of dedication, for your service, for your commitment, for everything you said today and keeping it very, very real and thank you for your testimony.

PANEL: Thank you.

CHAIRPERSON RIVERA: I'm going to call up this last panel and I want to thank you for your patience. Thank you, thank you, thank you for your patience.

Becki Pine, Alesdair Ittelson, Katherine McFadden, Zama Neff and again, thank you and if I mispronounce your name, please, please feel free to correct me.

If there's anyone that wants to testify that did not fill out a slip, please do so, so we can add you to the panel. You must fill out a slip to join the panel.

I didn't see your slip. Sit down and we'll get you to fill out one. No problem, no problem. Everyone can sit, we can take four, we could take five. I just want to thank you all for your patience. I hope that some of what you heard today; you'll be able to help us rectify.

Again, everyone can sit, exactly, we're going to get to everyone here and I'm sorry, if you did not

fill out a slip, that's how I've been going through the panel.

ALESDAIR ITTELSON: So, I'm hear from InterACT; my name Alesdair Ittelson. I am deeply grateful to have the opportunity to speak with you all about this crucial topic. InterACT is the largest and oldest organization in the country dedicated to the approximately 1.7 percent of the population born with variations of their sex characteristics also called intersex. Intersex isn't rare, the incidents of these variations is equal, approximately to the population to Japan and the world. But it's unknown largely because of decades of a ratio in medical settings and especially in prenatal care.

The vast majority of intersex variations are medically benign and with increasing advances in technology these differences are likely identified now in the prenatal setting.

The reason why we are here now is because we're seeing an increase in discriminatory harmful treatment that starts in prenatal care. Folks at birth serve as the first resource to parents and have the opportunity to treat intersex people respectfully as something to be celebrated rather than corrected.

They have the opportunity to model good behavior instead of perpetuating years of shame and stigma that we've seen in the community.

In the prenatal care setting, what does correction of an intersex child look like. It's the assumption of termination of a pregnancy regardless of the health of the fetus as we will hear from one of our parents in a moment. After birth, these children are often subjected to irreversible and invasive surgeries like clitoral reductions and vaginoplasties without their consent. These are surgeries that the state is reimbursing for. What has been deemed a form of torture by the United Nations.

Regrettably, these responses to healthy intersex bodies are still happing in New York City today. To address this, InterACT is partnering with a bunch of folks on the City Council to bring proposed bill 1748, which will mandate that the DOHMH create an informational resource campaign, which we're really hoping will pass.

So, InterACT is proud to stand behind intersex New Yorkers as they create a world from LGBTQI discrimination. We hope you'll stand with us. My

colleague is going to read a brief statement from one of our parents who wanted to be heard but could not attend today's meeting if that's alright.

BECKI PINE: Hi, thank you for having me here to present this testimony on behalf of one of our parents and with permission. My name is Becki Pine and I also work with InterACT. So, our appearances, when I was almost five months pregnant with my first child in November of 2018, my husband and I went for a routine ultrasound at a well-known New York City hospital. We were excited to find out everything we could about what to expect.

We were fortunate everything had been normal up until then or as normal as being pregnant can be. During the ultrasound when we got to the genital area, the tech looked at the scan and asked if my husband and I knew the sex. We told her that the blood test said it was a boy. She told us, that couldn't be right and pointed to the screen.

My husband was a little confused but turned to me and said, oh, it's a girl, that's great. But the tech stopped and said, she would have to step out for a minute and get the doctor. The tone of the room immediately shifted from excitement to fear. No one

wants to hear that. The doctor came into the room and repeated the scan. He turned to my husband and I and said, this could be a very serious disorder.

I was stunned, terrified and so was my husband. As I tried to catch my breath, the ultrasound tech who was looking at my chart, asked if we had done genetic testing. When I told her, no, we hadn't, I could see she was disappointed, exasperated maybe.

The doctor told us we had to see a genetic counselor immediately and that was the start of the most terrifying two weeks of our lives. We scheduled a phone call with the genetic counselor the next day while we waited for our OBGYN, who we saw right away after the ultrasound appointment. When our OBGYN entered the room, the first words out of her mouth were I'm so sorry. She said, I had a case exactly like yours three years ago and I'm going to put you in touch with this person. You're not too late, you can terminate.

And so, the message was that whatever was happening, it was so awful that the option was an abortion without even talking about it. That was the message and what you have to understand is our child is perfectly healthy. She has a mild intersex

variation called androgen insensitivity syndrome, which means her body does not respond to androgens. So, while her chromosomes are X, Y, her body looks like a typical girl.

Instead of saying, this common intersex difference could be the cause and it's perfectly fine, everyone approached the situation as if it were horrible, as if we were horrible and if she was horrible. I wish I could go back in time and tell myself that we are going to have a perfectly healthy baby, but instead, we cried every night desperately researching whether there was actually any risk for a serious health problem.

We went for a second and third opinion and eventually found another OBGYN who told us about androgen insensitivity. He described what it was and he said it was very normal. Sorry, he was the first doctor who was more educated about intersex, who didn't treat our family like there was something wrong. Our child is one and doing great now. She is awesome. I knew deep down somewhere that what they were telling me wasn't right.

I had the maternal instinct but it's hard when people present things as facts that aren't true.

That being intersex is actually a sickness. But now, we know she's not different from any other child and that's why what they should have told us. Education is desperately needed.

I don't think our story is unique. That's why we wanted to share it with you all to raise awareness and urge you to support InterACT's legislation to show that these differences aren't something to be afraid of.

Doctor's in New York shouldn't be stuck back in a time when intersex was something to discriminate against. Our families deserve support. We learn that eventually, but it was at an enormous personal cost. When we look at our precious beautiful baby daughter, we cannot believe what we've been through. An ordeal we will never forget and that such negligent opinions were given from professionals we trusted.

Sincerely, the mother of a health intersex infant in New York City as told to InterACT staff.

ZAMA NEFF: Thank you very much. My name is Zama Neff and I'm with Human Rights Watch. I really appreciate the opportunity to testify before this committee today.

Human Rights Watch is an independent international research and advocacy organization. We are the only international human rights organization with a dedicated program on children's rights, which I'm very proud to leave right here from our headquarters in New York City.

Over the past three years, Human Rights Watch has conducted research and advocacy on the treatment of intersex youth. Including medically and necessary so-called normalizing surgeries on children born with intersex variations. We have interviewed intersex youth and adults, parents of intersex children and physicians who care for these families across the country, including right here in New York City.

In the 1960's, surgeons in the United States popularize so-called normalizing cosmetic operations on intersex infants, including reducing the size of the clitoris or increasing the size of the vagina. These surgeries are almost always medically unnecessary. They often involve giving general anesthesia at an age the FDA has deemed high risk. They are irreversible and, in some cases, sterilize the child.

I, myself, met with a team of doctors in Manhattan who continued to promote and perform interventions to erase intersex traits, such as surgeries that reduce the size of an infants clitoris purely for cosmetic reasons.

Currently, New York City's Human Rights Law protects intersex people from discrimination. However, there are no specific protections against these surgeries or other discriminatory interventions and no public awareness that intersex people are at risk for operations that are high risk and medically unnecessary in the first place. This leaves parents in the dark and means that children in New York City are vulnerable to irreversible harm.

As the mother of premature twins, I can empathize the vulnerability of having just given birth. Having someone come in and tell you that your babies are not okay and feeling utterly reliant on the doctors recommended course of action. As a New Yorker and a Human Rights Lawyer, I expect my government to protect me and my children from harm.

Since the 1990's, intersex advocates have asked governments in the medical community to prioritize their voices and defer interventions that can be

delayed until patients can participate in the decisions about what will happen to their own bodies. United Nations Human Rights Committees have condemned medically unnecessary surgeries on intersex children 48 separate times.

But a small subset of physicians, like the ones I met here in the city, defend the practice and continue to thwart efforts to protect children's human rights.

I am urging the city government to support Council Member Dromm's bill to develop materials to educate parents about risky and unnecessary medical interventions and to rely on medical evidence, medical ethics and patient advocates requests to further regulate the physicians to carry out operations that put intersex children at risk.

Thank you.

EUGENIA MONTESINOS: Good afternoon. Okay, finally, we are here at the table. Good afternoon, my name is Eugenia Montesinos; I am a midwife at Metropolitan Hospital, which I've been working for the past 20 years. This is a hospital that one of the hallmarks, it's giving the prenatal care in the

wrong language and most of our cliental are Hispanic speaking, which is Spanish and my first language.

So, I am here to tell you that how much is changing and what we are doing and how HHC should be approaching this. We have a model that we were working on medical residents and we are part of the team and we're having such good outcomes and being the hospital who has the lowest C-section rate in the state. And only because of the collaboration that we work together with midwives.

And I am also here, not only because I work in Metropolitan Hospital and I'm also with my colleague Sharon, we are representing New York City Midwives Association. We are a professional association of around 400 members. All of the hospitals working in the New York City area with the minority of us working in hospitals. And also, we have midwives who work in a private practice and lately, are developing even more midwives working in home birth practice.

And why it's growing, because of the patients are very dissatisfied with the hospital practices and that is another case, the necessity that is growing.

So, I'm going to try to, do you want to say anything else. So, I'm going to continue with that.

So, United States has the highest infant mortality rate in the world and New York is one and USA is the highest among those and industrialized countries which is very crisis. And having to spend so much money in just per pregnancy and yet, we have the highest mortality rate in infants and the mothers.

So, New York is one of the biggest cities that we have that and among those is Brooklyn and the Bronx. And one the things that HAC have at hospitals which is Kings County and they're not taking total advantage of the midwifery care. To the contrary, they are getting smaller and smaller and yet the maternal mortality is the highest in that area. The same thing happened with Lincoln in the South Bronx. It used to be a very high midwifery service and now, it's nonexistent. So, Harlem, the same thing. They completely disappear and we are here just to let you know that the midwifery care model is a model around the world for centuries and we've been having great outcomes all over the world and mostly because we approach in a holistic way. We see a woman not as a person who is pregnant. We see a women, what is going on in her life. The emotional issues, the mental issues, any comorbidities that is happening

and that is the midwifery model that we follow. And even though we are working in the hospitals, we try our best under circumstances having the smallest time that we can see per person, a patient, we still have the good outcomes when they come to us.

Lately, in Metropolitan Hospital because of the whole demand of midwives in the city, we're transforming our population in Metropolitan and we have more White people coming to us because they want a midwifery model. They want not a C-section; they want to have a change to have a normal birth. So, for us, it's just a model that everybody should have. Every woman should have, every woman should have an opportunity to you know, have a choice. If I want to go to the medical doctor, it's fine. If we want to go to the midwife, it's good.

So, we want here as a New York City midwife, we want to just give you that information that we are part and we are fighting a lot of the maternal mortality rate in the city.

SHARON MCDOWALL: To mirror what Eugenia said, I've been a midwife in the United States for 27 years. By the accent, I actually trained the European model of care and my career has only been at

H+H hospitals. I was at Harlem. I worked with Ms. Loftman and then I've been at Metropolitan for the last 23 years and I've been a Service Director for 14 of those.

She's right, at Metropolitan, we are changing our demographic and it is the collaborative care that we give with our medical staff. We work very closely and we also, all of our midwives are faculty to the medical school. So, we do impact what the dynamic with the residents and the medical students because yes, somebody spoke about earlier, about you know, not asking a patient, can you examine them. Not talking to a patient. This is one of the things that's got to change and it is changing at our institution.

So, everything here is a work in progress. It's going to take time; you have to have a change of culture. Yes, there are eleven municipal hospitals, only eight of them have midwifery services and of those eight, only four of them have 24/7 coverage on labor and delivery. And like Eugenia said, some of those services that had 24/7 coverage no longer do.

They've lost their midwifery services, so this is something that I think needs to be worked on. And that's it.

EUGENIA MONTESINOS: Yeah, one of the other things that we need to do for a change in mortality and mortality rate, we are proposing to change how we should approach the care. We should approach the care where care should be where the mothers live in the community. Not in the hospital when they have to come. We have to just have a space in the community and we as a midwife, we can take care of them in there. So, that mentality needs to change also. I think that that will be a better way that the woman can come, not thinking that it is a hospital. When you are in a hospital, there's a mentality there. There's something sick. You are going to the hospital when you are sick, when you have an illness. A pregnancy is not an illness. So, we should approach a little differently and we should offer prenatal care in the communities and the midwifery care is being known that we do provide in the community.

So, we propose that care that we should be in a community. We wanted to have providers that will

reflect the community population that are thoroughly competent that will understand their needs. So, we want that. For example, just me alone, I will be loving working in the Bronx which is all my Spanish speaking. I will talk to them in Spanish, you know, it's different. So, that is what we would like to offer.

We would like to provide also the care to mothers after working hours and mostly all our mothers who are in need, they have to work and most of them sometimes they don't even come to their prenatal care and we want to offer that. We want to change that. So, we would like to change that. If we do it in a community, we can provide it. We're not you know, bind to go eight to five, like an office. Which the care and the help is not an office, it is going on 24 hours a day. So, that is what we would like to change.

We would like to change also, offer care on the weekends. Why on the weekends? Because we want to involve the family. We want to involve the sister, we want to involve the partner, they can go together. So, it would be somewhat integrated how to approach maternal care.

And also, we want to talk a little bit at group visits. When we have hubby and group visit, it's much better. They can support each other, they can see it's not just a woman saying oh, this is just me. But when you have the group visit, it's much better. They can understand that they are not alone, they are having the same thing in pregnancy.

So, decision making should be done with the women. We can yes, tell them, you have to do this, you have to do that. We have to talk with the woman and say, these are the things that are going on. These are your options, let's work in that way. So, that will be the best option to approach. We can't be going and telling you got to be doing this. It doesn't work and it's not working and that is precisely the thing that we have in this issue. So, we want to approach birth as a healthy and holistic way, not that your going and it's the way that the hospital puts it. The way how you have to be sitting in a monitor, go to the bed and that is what we have to do. We're not, we want to change that moto. We want to work around the woman. How she wants, how she wants the labor. Maybe she just wants to walk, maybe she wants to sit. Whatever she wants, we

should be approaching on how she wants to do, not how we want it.

So, another thing that we wanted to do is also postpartum care. We have so much issues about postpartum care and a maternal death is also happening after having the babies. So, we want to have a community based postpartum care. We have to go to the mother. Why are we expecting a mother who just had a baby to come into us? We have to go to their place and it should be shorter, right. In two weeks, we're going to see, how is she doing? Is breastfeeding established or not? Is she alone or not? Does she have any community support or not? That having a family member that supports or not? We have no idea what's going on with the woman who just had a baby. We just say, okay, now you are a new mom with your baby. But that is a problem that we're having. So, postpartum care should be at two weeks, then six weeks and then we can see, but we should go to the mother because the mother doesn't have the time. We should be going. Why are we expecting them to come?

So, another thing that we wanted to do, everything should be evidence based approach. The

studies say that we have so much research done, how we approach maternal care.

One of the other things that we have seen maternal care or maternal birth on births at home is happening. One of things that we want is that H+H should be an easy transition when the birth happens at home and it should not be punishable. We should not be looking at them and saying, well, you're choosing this now. It should be an easy transition. We should work with the midwives; we should tell them when is a time. We should actually put in a document saying this and when this is not happening, we want you to come and bring us. Not bring us when it's too late when we get very upset, everybody gets upset but we should be looking for that. We should be helping the woman, helping the midwife and help everyone.

So, that is one of the things that we want to offer as a solution forward. A better maternal care in New York City.

Thank you.

KATY MCFADDEN: Hi, Councilwoman Rivera and Council Member Rosenthal, thank you so much for hearing our testimony. My name is Katy McFadden; I'm a midwife, a registered nurse certified in neonatal

intensive care and a volunteer and organizer with Ancient Song Doula Services.

I just want to highlight the things that we haven't talked about yet. We've talked a lot about racial disparities and maternal infant health outcomes and the root causes to that and we've talked about implicit bias and lots of other things, but the driving force of racial disparities in New York City is the lower quality of care provided at a concentrated set of minority serving hospitals.

So, we have a 2016 study that show that if Black women were going to the same hospitals that White women were going to, the severe maternal morbidity rate would drop by 47.7 percent. That's half and we have the same researcher put out a different study in 2018 again, looking just at New York City hospitals. So, this is you know, germing to us specifically and really no other place in the nation that if Black babies were being taken care of in the same neonatal intensive care units as White babies were, the differences in morbidity rates for very low birth weight babies would drop by 40 percent.

So, in the research those hospital are anonymized but if you are familiar with the landscape of New

York City, it's really Kings County, Brookdale and Suny Downstate. Half of Black women in Brooklyn give birth in one of these three hospitals that have a severe morbidity rate, six to nine times higher than Maimonides which is less than ten miles away.

So, why is care at those three hospitals so much worse than all of these other hospitals and I think along with like, historical racism which excuses some of the behavior in the minds of people with power who work in those institutions. A lot of it is the resource deprivation to the public serving hospitals because Medicaid pays about half as much for obstetric services that private insurance pays. So, if you have a hospital that serves a disproportionate amount of people on Medicaid, you're going to have half as much money coming in and that literally does not cover the Band-Aids, the salaries, to keep the lights on, to provide adequate standard care in the year 2019.

So, the fact that Medicaid reimbursements are inequal is tacitly admitted to within the legislation because there's a separate pool of money called the disproportionate share hospital pool and in most other state, that money is used as it is intended and

goes to the hospitals that serve a disproportionate share of hospitals.

However, in New York, there is a law from Albany that divides that money into two pools, one for the private hospitals to divide into and one for the public hospitals to divide into. So, for example, in 2016, NYU served 18 times fewer patients on Medicaid than Elmhurst did but got $5 million more from Albany to compensate them for that care.

So, the fact that the money isn't actually ending up in the institutions where it's needed, has caused decades of hiring freezes and layoffs, so that there is almost never the recommended amount of staff working at any period and time. I graduated from midwifery school in 2017, having just recently learned about these disparities and I did not want to take a position as a midwife working in a system where I would be perpetuating medical racism without understanding how or why, and so, I stayed in my position as a NICU nurse at Suny Downstate. I sent an email on August 8th, saying we are incredibly understaffed. What are we doing to get more staff here? August 9th, **[INAUDIBLE 3:15:53]** died, a mother of six from understaffing related causes. In the

next four months, I sent emails up to the entire chain of command including the president of the hospital saying, we are just as understaffed today as when a mother died. What are we doing to get more staff? And the only thing that happened to that was the administration beginning to take retaliatory actions against me for speaking up about safety issues. We never got more nurses.

What I did not realize at the time was that, like literally the same days I was sending emails, the headlines in the news was that Cuomo was holding on to disproportionate share hospital payment that was owed to our hospital that we had already paid. That he was going to hold onto because he wanted us to get used to what it would be like for future budget cuts.

The H+H hospital sued and ended up getting that money but Suny Downstate isn't an H+H hospital and it just dropped out of the news. And in November, Tanezio Walker[SP?], another Black woman died of understaffing related causes at Suny Downstate.

So, I think it is incredibly important that we, like, there is no health equity without equity in health financing. If you give some hospitals twice as much money as other hospitals, they're going to

provide better care. And when you overlay that with the state violence of segregation and discriminatory housing practices, this phenomenon, these three hospitals are probably responsible for about half of the disparity that we're seeing.

So, just a couple people today have talked about how the H+H hospitals serve underserved equal and I just want to challenge that language and that understanding. If people are underserved by public hospitals, it is us, the public who is underserving them. And so, I want to you know, often at Downstate, people would justify the suboptimal care we were providing by saying, well, they wouldn't get better care elsewhere. That was the exact same logic used during the Tuskegee Syphilis study. That, oh well, these people participated in the study wouldn't get better care elsewhere, so it's okay that we're doing what we're doing and that mentality that it's okay to provide worst medical care to people who are underserved. Well, no, they wouldn't be underserved if you were providing them adequate medical care.

Council Member Rosenthal, you had asked you know, if some of the misbehavior on the obese part was a training issue or a resource issue and I would offer

that it's all of those issues. It's hard to be polite to patients when you have two or three times the safe amount that you're caring for. You're the decision making process of how, if you are caring, how you keep three laboring patients safe is very different from how you could keep one laboring patient safe and it often cuts into the time you have to discuss options and to really get an attainful consent.

But to just bring this full circle, more doctors who practice in New York City are trained at Suny Downstate than any other medical school. So, if we send our med students to a 90 percent Black hospital, where it's okay that women just are dying left and right in childbirth and we don't get the money or the help we need to provide adequate care. And that's the mindset you are trained with as a doctor and then we send you out into the rest of the city even if you are not working with a more privileged population. It doesn't necessarily mean you can change on a dime going from seeing birthing people as sub-humans who you can boss around to being fully human that you are interacting with in a collaborative way.

So, the structural racism we have allowed to continue at Suny Downstate is making healthcare worse for everybody in New York City. And then, lastly, we've been talking a lot about midwives, but the three New York City Midwifery programs are NYU, Suny Downstate and Columbia, all three of which are institutions which exclude midwives from practicing in the hospital themselves.

So, there's this huge disconnect in the way that the organizations who are tasked with training midwives, like, do they actually respect us? Do they actually see us as valuable members of the healthcare team? If they will take our money to give us a degree but won't employ us or hire us afterwards.

So, some recommendations going forward, I think it's a lot easier, you know, we've talked a lot about what to do about racist providers. I think it is a lot easier to train a Black woman to be a midwife than it is to get a White woman to stop being racist. So, I think something to consider would be creating a midwifery program at NHBCU or perhaps like a futuristically Black college or university that has a midwifery program. See how much Helena Grant and Patricia Loftman who testified earlier today. How

much would they want to start a midwifery program where we could you know, if there was perhaps a program with a CUNY college attached to Woodhull, we could be producing ten amazing Black midwives a year that would over time transform or could potentially transform the midwifery scene in New York City. We need to pass New York Health Act because as long as we have private and public insurance, we are going to have — like, that is the mechanism that the private hospitals are using to cause racial segregation, is by practicing insurance segregation.

Insurance discrimination is illegal, it violates two federal, two state and one local law but when the New York Lawyers for Public Interest tried to challenge the practice several years ago, Cuomo, who was the attorney general at the time, refused to take it up. So, if we have these laws, but if we are not going to enforce them, I think the other way forward is to just get rid of that mechanism by which we're sorting people.

And then lastly, home wife, we need to have like a public option for home birth. So, the midwives who work — like, we should have home birth midwifery services that are as accessible and perhaps based out

of the public hospitals but that will come and do a home birth because it shouldn't just be privileged White women who can pay $10,000 out of pocket. Who have the option to keep themselves out of these violent places that we've allowed to exist in New York.

Thank you so much for your time.

CHAIRPERSON RIVERA: Thank you, thank you so much for your recommendations. And I think you'll find a lot of us are aligned and we've been joined by Council Member Reynoso. You can definitely ask a question and you missed the Woodhull, the whole thing. So, he'll tell you a story very quickly. Council Member Reynoso.

COUNCIL MEMBER REYNOSO: I just want to thank you for this hearing. As usual the Health and Hospitals Committee is really in the front line of taking on issues that have been foreign to this Council in the past or that we've not addressed in an intentional way. I had my child in Woodhull Hospital with a midwife or my wife had a child in Woodhull Hospital and a midwife assisted us.

I got to be very careful with the midwives in Woodhull Hospital have high standards as to how I

speak about delivery. So, I want to make sure I stay consistent with that. I wanted to just ask, just a numbers question, because Woodhull is also a public hospital and it's rate is significantly lower than these other three public hospitals in Brooklyn and the Midwifery program is one of those, I believe, is one of those reasons but do we have statistics related to like C-sections and just invasive procedures produced? In one hospital that has a similar demographic, like Kings County to Woodhull Hospital and a midwife told me that a surgeons job is to do surgery. If they are the ones that are in a room and they have to make a decision, they're going to attempt to use their talent or their profession to solve the problem. If they're not in the room, then surgery becomes something that's less likely to happen. If it's a midwife, they're not going to go in and cut someone open and so forth.

So, I just want to know, do we have information as to you know, C-sections and other procedures during birth and Kings County hospital different from Woodhull Hospital given again, same demographic when it comes to the population of people, they are serving both with income and race based.

KATY MCFADDEN: Yes, we do have those number and when you look at Central Brooklyn, the role of midwives comes through clear as day because you have Woodhull with a C-section rate in like the mid 20's low 30's. You have Brookdale and Kings County with cesarean section rates in the mid 30 percent and Suny Downstate has had a cesarean section rate somewhere between 45 and 50 percent over the past ten years.

So, what are the differences between those four hospitals? The first three all have midwifery services and Suny Downstate does not. So, you take away the midwives and you get a 15 percent jump in the cesarean section rate with like zero distinguishing factors between our patient population. We serve, you know, Kings County and Downstate, I can see the one hospital from the other, we're across the street.

And then, we've talked a lot about today about like, the midwifery model of care or just because you have midwives doesn't mean that the patients are receiving midwifery care. And so, when you look at the three hospitals that have midwives, the reason why Woodhull is doing so much better is because

Helena Grant is in charge and they let her run the show.

COUNCIL MEMBER REYNOSO: Yeah.

KATY MCFADDEN: And whereas at Kings County and Brookdale, the midwife is essentially treated like — the Director of Midwifery is essentially treated like a glorified nurse manager and they are essentially subservient to the obstetric staff. Their decision are override at any point and time by the obstetric staff with no consultation, with no conversation. I did my midwifery training at Brookdale and I was working with a midwife with 40 years' experience and a 30 year old OBGYN came in and told, like as we were talking with the patient, said, we're going to go for a C-section now. And we were like, ah, we're doing what? So, it wasn't even, she didn't even, the OB did not even like, skipped having the conversation with the patient, she even skipped having the conversation with the care providers.

So, I think it is an amazing testament to the power of midwives that even when we are deprived a structural power, there is still a 15 percent difference than a place where we are not.

COUNCIL MEMBER REYNOSO: Yeah, that's true.

KATY MCFADDEN: But if we really want to see the full benefit of midwifery care, we need to essentially reprimand and hold the obstetric teams at those hospitals accountable for the way they are using their male privilege to subjugate perfectly qualified women from meeting in their — to the full capacity roles.

COUNCIL MEMBER REYNOSO: Right, and I agree having Ms. Helena Grant in the hospital makes a big difference. I don't think anyone could tell her what to do even if she didn't have the title. But again, I really want to thank you for this information that we're getting and for attention to detail and I think that conversation about, it's not just about having midwives, it's about empowering them is very important because I think that a lot of folks are just looking for a place to go where there are midwives, not understanding the dynamics of what it means to have an empowered group, versus just a group that's seen as like a second hand assistant I guess. Where in Woodhull, the midwives run the whole show.

So, thank you so much for that information and I'm really looking forward to making this a very important part of the work that I do over the next

two years, so I'm very happy that we had this hearing and I apologize that I couldn't be here for the beginning but I'm looking forward to meeting with H+H to talk about how we can improve. I want Woodhull Hospital to be the premier baby hospital in all of New York, private or public alike and we're going to be investing in that and the midwife. The reason it got a solid foundation for that to happen is because of its midwife program.

So, thank you again for the great work that you guys are doing.

CHAIRPERSON RIVERA: Thank you Council Member and I just want to say, when we're talking about you know male privilege, it's also we have to recognize our own privileges each and every one of us. So, I just want to make sure that we just recognize that space. Sharon, can I ask you a question, because you were at Harlem Hospital before you went to Metropolitan.

SHARON MCDOWALL: Yes, yes.

CHAIRPERSON RIVERA: And they closed that program and based on your very I guess humble experience, I mean you have decades doing this. Did you find that it was necessary to close the Harlem program?

SHARON MCDOWALL: No, not at all. It's like, what you alluded to. It has a midwifery service is — Helena is a very, very strong woman but you still have to have a service director, a chair of OBGYN that is for one of a better phrase, midwifery friendly. Because if you have a midwifery friendly department chair, than your life is easier and what happened at Harlem was the power structure changed. When I was there, it was a different chair of the department who was midwifery friendly. The midwives had been there for decades, it was fine.

I left and then it all changed and as midwives left, they were not replaced. Same thing happened at Lincoln. Lincoln was one of the biggest midwifery service in the city, public or private. It has something like 18 to 20 midwives worked that hospital. There are now maybe one. You know, as they shut down, but that was twofold, that was Director of Midwifery plus the Director Chair of OB. It didn't work, they just got rid of all the midwives. As they left, they did not replace them.

Another thing you have to bring in is what into their whole structure is, whether the hospital it has a residency program. We do have a residency program

we're pretty unique in the way we work that we are still 24/7 in labor and delivery. It's a demand from the women, we've always been 24 — actually, no we haven't, I tell a lie. When I first started, no, we weren't 24/7. We became because as our service got bigger, we provide 24/7 service and it's a demand. We could not change that now, it would decrease the amount of women that are coming to the hospital but Harlem, yes. What happened at Harlem is very sad because I did love working there, it was very busy. But yes, it was a change in management. It was a change at the top, it changed everything.

EUGENIA MONTESINOS: Can I add one more thing. One of the things that why we are saying it is good in Metropolitan working with medical residents is they're exposed to us. They are exposed to our work and we work together. We train them, when they have to normal deliveries and normal care. So, they are being exposed.

So, if a doctor is not exposed to the midwifery care model, they're never going to know and that is one of the things that happens. If this doctor was not exposed, he is not going to know how midwives

work and that is one of the things that happened also in Lincoln.

Another thing that happens in New York is that the reimbursement issue. New York Presbyterian had the largest midwife carrier and now have none. What happened is that they were billing in the doctors name and not in a midwife's name because you get more money. If you get reimbursed for our job, we only get 85 percent and because of that, they bill in in the doctors name and because of that, they thought it was a fraud. So, what happened with that, New Yorkers Presbyterian said, okay, we don't need midwives. We want to get the 100 percent, so, we're not going to use you. So, that is one of the things but at the same time, their C-section rate and everything has changed.

But it doesn't change because they're going to get the money anyway. But what happens, what is the consequences of the women? Women have more C-sections, the morbidity increases, the mortality increases. That is the main issue here. It's just because you get the 100 percent reimbursement, at what cost? At the women's cost, at the babies cost, the premature cost. We pay $26 billion annually in

the United States for prematurity alone and we prevent that. We view the studies; we have so many studies we could have prevented that.

So, that is the reason why it's changing and what a change in HAC model that they got rid of those midwives.

CHAIRPERSON RIVERA: Thank you and thank you so much to this panel. Midwives, doula's, doctors, nurses, advocates. I know we're all supporting each other. The intersex community, I am supporting the legislation. You all have taught me a tremendous amount in these first two years in the Council and I hope that we can continue to — I hope we can change the formula on how we distribute our dollars in our healthcare system, because it's clearly not working.

EUGENIA MONTESINOS: It's a national issue, it's not just a state issue, it's not just a city issue, it's a national issue. We just need to change.

CHAIRPERSON RIVERA: Thank you and I will be there with you all. I mean here in Albany, there's a lot of work to do and I want to thank you for your time and your patience. I know we are in hour four of the hearing. So, thank you, thank you to everyone

who waited and I'm very, very appreciative and if there no longer any —

EUGENIA MONTESINOS: Well, we thank you for calling for this hearing and thank you for being an ally to all of you and thank you for understanding the crisis that we are and as a woman and I think we should work and fight together.

CHAIRPERSON RIVERA: Thank you and the largest healthcare system in the country and we should be leaders on this issue. Thank you everyone and with that, I'm going to close this hearing. [GAVEL]

C E R T I F I C A T E

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


Date April 1, 2018