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

Testimony

of

Michelle Morse, M.D, MPH
Chief Medical Officer and Deputy Commissioner of the Center for Health Equity and Community Wellness
New York City Department of Health and Mental Hygiene

before the

New York City Council
Committee on Health jointly with the Committee on Hospitals

on

Maternal Health, Mortality, and Morbidity in New York City

and

Introductions 86, 409, 472, 478, 482, 490, 508, 509 and Resolutions 201, 205, and 244

June 29th, 2022
City Hall
New York, NY

Good morning, Chairs Schulman and Narcisse, and members of the committees. I am Dr. Michelle Morse, Chief Medical Officer for the New York City Department of Health and Mental Hygiene and Deputy Commissioner for the Center for Health Equity and Community Wellness. I am joined here today by my colleagues, Laura Louison, Assistant Commissioner, and Dr. Tara Stein, Medical Director, both from the Department's Bureau of Maternal, Infant, and Reproductive Health. I am also joined by our colleague, Machelle Allen, Chief Medical Officer from NYC Health + Hospitals, Dan Pollak, First Deputy Commissioner, and Claire Levitt, Deputy Commissioner from the Mayor's Office of Labor Relations. On behalf of the Administration, we thank you for the opportunity to speak today on the important issue of maternal health, sexual health, and birth equity.

We want to first acknowledge the Supreme Court's decision to overturn Roe v. Wade, and with it, the U.S. Constitutional right to a safe abortion, a right that was in place for half a century, and the profound and devastating impact this will have on health in this country. The City is committed to ensure all people have access to the appropriate resources to make an informed decision about their body. We plan to address abortion access in detail at the reproductive health hearing later this week.

Maternal mortality is a grave and urgent issue with persistent racial and ethnic inequities in our nation, and New York City (NYC) is no exception. Although we have seen a statistically significant decline in the maternal mortality rate since 2001, unacceptable inequities among racial/ethnic groups remain. In NYC, the average maternal mortality rate among Black pregnant people is more than nine times the rate of white pregnant people. Our review of pregnancy-related deaths indicates that the vast majority of these deaths of Black people were preventable. The borough that accounted for the most pregnancy-associated deaths was Brooklyn, followed by the Bronx.

Before proceeding further, I want to pause and acknowledge the heartbreaking injustice and human impact represented in those statistics. Every person who dies during childbirth is a

parent, sibling, child, friend, and community member, suddenly and tragically absent from the lives of their loved ones, and in many cases, their newborns. Every loss is a profound tragedy, with ripple effects in our communities. When a mother dies, no community is ever the same.

We are compelled to action as a City to address this crisis and reduce preventable birthing-related deaths and eliminate the unacceptable injustices that these deaths represent.

Birth inequities are driven by racism and bias – in government, in medicine, in education, housing, and economic policies, and much more - and the downstream effects of these intersecting systems of oppression will take years and even generations to undo. Differential access to power and resources has created these health inequities and it requires the investment of resources, and deliberate corrective efforts to repair. It requires a true anti-racism approach.

Our work is grounded in data, with a focus on outcomes among Black and Latina people who are pregnant or may become pregnant. We use that data to drive and design the programs, strategies, and policies that will support individuals' access to the supports they need for healthy pregnancies, reproductive health and parenting. We support new families through the New Family Home Visit Initiative, a range of linked home visiting programs, including Nurse Family Partnership, Newborn Home Visiting, the Citywide Doula Initiative and the By My Side Birth Support Program. We support systems change in partnership with hospitals, clinicians and community-based organizations through the New York City Maternal Mortality and Morbidity Review Committee, the Maternity Hospital Quality Improvement Network, the New York City Breastfeeding Hospital Collaborative, Centering Pregnancy & Centering Parenting, By My Side Birth Support Program, our Midwifery Initiative, and the Department's Birth Equity working group.

I'd like to share a bit more information about some of these initiatives that have relevance to our discussion today. In 2018, the Health Department established the New York City Maternal Mortality and Morbidity Review Committee, referred to as the MMRC. The committee meets monthly to conduct a multidisciplinary expert review of each maternal death in New York City from both clinical and social determinants of health perspectives. MMRC consists of 31 diverse, multidisciplinary members from all five boroughs and includes community activists, doulas, midwives, nurses, maternal-fetal medicine specialists, cardiologists, oncologists, OB/GYNs, case managers, public health workers, and police. At the end of every calendar year, the committee reviews and decides upon key recommendations, which if enacted, would improve the care of pregnant people. We then publish these in the annual report. The goal of the MMRC is to reduce preventable maternal deaths by gaining a holistic understanding of each maternal death to determine cause, assess preventability, and identify contributory factors and actionable recommendations to prevent future tragedies. The Committee's recommendations address systems, facility, provider and patient level factors.

Another flagship initiative from the Department is the newly expanded New Family Home Visit Initiative, which expands access to home visiting programs and community resources to an estimated additional 22,000 newly eligible families. The New Family Home Visit Initiative offers a range of evidence-based home-visiting services via trained health care workers and clinical providers such as social workers, nurses and lactation consultants —from breastfeeding support and creating a safe home, to mental health screenings, to connections to social services. The initiative has been supporting the expansion of the Newborn Home Visiting Program, Nurse-Family Partnership, Power of Two, and the Citywide Doula Initiative (CDI). The program is open to first-time families in the Taskforce for Racial Inclusion and Equity (TRIE) neighborhoods, those who live in NYCHA in the TRIE neighborhoods, or those who are engaged with child welfare.

I want to highlight our Nurse-Family Partnership (NFP) program, one of the home visiting programs included in the New Family Home Visit initiative. NFP is longstanding, evidence-based

home visiting program that connects first-time expectant parents with trained nurses to promote healthy pregnancy outcomes, child development, and economic independence. New mothers who participate in NFP experience lower rates of hypertensive disorders, decreases in tobacco use and lowered risk for preterm birth.

The Department has also long acknowledged and embraced the role of doulas in improving maternal health and birth equity. The expanded Citywide Doula Initiative provides doula support both at home and in the clinical setting, with three prenatal home visits, support during labor and delivery, and four postpartum visits. Clients who give birth at home receive the same number of visits. The program includes screening and referrals for family needs and stressors, such as food insecurity. The Citywide Doula Initiative ensures that the model of care is consistent across the city, and uniform data is collected for a rigorous evaluation of the doula services provided through this initiative. Doulas lead to less c-sections, healthier birthweight, less depression, and increased breastfeeding.

The Health Department has developed a series of public awareness campaigns to promote citywide understanding of healthy pregnancies, reproductive health and parenting. To gain community input on these campaigns, we conducted listening sessions with community members, as well as focus groups with healthcare providers. These campaigns include: Safe and Respectful Care, aimed at community residents and healthcare providers to educate New Yorkers about their rights and options before, during and after pregnancy, and to promote the Standards for Respectful Care. This is just a sample of programs and work – all of which demonstrate our fierce commitment to this issue.

We must hold all levels of government and health care accountable to make health equity a reality for all New Yorkers. That is precisely what the City is trying to do. The work we do at the Health Department is grounded in science, equity, and compassion. We are committed to focusing on improving the overall health of New Yorkers, and on ending racial and ethnic inequity in health outcomes. We envision a world where all New Yorkers live healthy, fulfilling

sexual and reproductive lives, where all children are born healthy, nurtured and loved and where all births are safe. And we are committed to making that vision a reality (inequities= unjust, avoidable).

Turning to the legislation being heard today – the bills in this package cover a wide range of protections for pregnant people and those who may become pregnant. We are grateful to Council for bringing further attention to these critical issues. The City supports the intent of Introductions 86, 409, 472, 478, 482, 490, 508, 509, and we look forward to discussing the specifics with Council after the hearing.

Introduction 86 would require the Department to educate about city standards for health care proxy forms, patients' rights, and respectful care at birth. We share the intention of this bill. As we mentioned earlier, the Health Department developed the Standards for Respectful Care at Birth through careful engagement with community stakeholders. We currently provide education about the standards at birth facilities and in other facilities used by people of reproductive age. We believe this bill would be most impactful as a joint agency strategy to provide reproductive health resources in multiple languages that are safe and accessible for New Yorkers.

Introduction 409 would require the Department to post an annual summary of vital statistics regarding maternal mortality in NYC on its website, and we are pleased to report that these reports are online under our "Special Reports" section.

Introduction 472 establishes a pilot program to train doulas and provide doula services to residents in all five boroughs. We are pleased to report that the Department runs a Citywide Doula program, as detailed in the earlier portion of my testimony, and look forward to discussing this historic program with Council.

Introduction 478 would require the Health Department to provide outreach and an education campaign on the benefits and services provided by doulas and midwives. We are aligned with the intent of this bill. In fact, the Health Department supports a funded outreach and education campaign for doulas and midwives. Currently, DOHMH's Citywide Doula Initiative has an outreach and education campaign in TRIE neighborhoods showing the benefits of doula services and offers a paid doula apprenticeship for local community residents.

Introduction 482 requires the Department to report on polycystic ovary syndrome and endometriosis. We have operational concerns with this bill, as the Department lacks a feasible mechanism to collect this data. We are eager to discuss the bill further with you after the hearing, to better understand the intent and work with you to meet your goals to address these and other related gynecological health issues.

And Introduction 490 codifies an office of sexual and reproductive health with the Health Department. Fortunately, the Bureau of Maternal, Infant, and Reproductive Health exists within the Department's organizational structure, and we are pleased to have the opportunity to talk about some of our work with you today at this hearing. Our teams undertake tireless, and often unsung, incredible work for New Yorkers every day.

Thank you for your time today. We look forward to working with Council in partnership on this topic, and my colleagues and I are happy to take your questions.

New York City Council Committee on Health and Committee on Hospitals

Testimony by:

Daniel Pollak, First Deputy Commissioner, Mayor's Office of Labor Relations (OLR)

Claire Levitt, Deputy Commissioner, Health Care Strategy, Mayor's Office of Labor Relations (OLR)

on Int 508 – Family Building Benefits

June 29, 2022

Introduction

Good morning, Chair Schulman and Chair Narcisse and members of the Committees. I am Daniel Pollak, First Deputy Commissioner at the Office of Labor Relations, and I am joined by Claire Levitt, Deputy Commissioner for Health Care Strategy at the Office of Labor Relations. Thank you for the opportunity to testify today.

We're here to discuss Intro 508, which would require the City to establish family building benefits for City employees intended to cover some or all of the costs of assisted reproduction and adoption for City employees.

Taylor Law

Before going into the specifics of the current and proposed benefits, we want to provide some brief background for context. As you may be aware, since 1967, the City has been obligated under the New York State Public Employees' Fair Employment Act – commonly known as the Taylor Law - to bargain health benefits

with its municipal unions. The benefits that are the subject of Intro 508, like other health benefits and fringe benefits, are mandatory subjects of collective bargaining under the Taylor Law. This means that the City must negotiate these matters with its unions, and these benefits cannot be imposed by local law. Experience has also shown that the City and its unions, working together, can and do negotiate significant improvements in employee benefits.

Current Coverage

I now would like to take this opportunity to summarize our current relevant benefits. For context, the City spends over $11 billion a year currently for health benefits for employees, dependents and retirees. To put the enormity of that expense into context, it is over 10% of the entire City budget of $101 billion dollars. In accordance with State requirements, the NYC Health Benefits Program covers the following benefits related to infertility:

- Intrauterine insemination (IUI)
- Three cycles of IVF
- Medications, including prescription drugs and injectable medications
- Egg preservation where the patient is undergoing treatment like chemotherapy that would affect the viability of the eggs

Additionally, through our primary employee health plan, the City utilizes WIN Fertility, an organization that supports families with infertility issues. WIN Fertility helps families navigate the system with Nurse Case Managers that ensure that the highest clinical standards are met. We believe that our fertility benefits are very strong, and we currently spend over $100 million a year on fertility benefits.

Our fertility benefits, like all of our health benefits, are limited to City employees and their dependents. For example, we cover IVF for people covered by the health plan—not for surrogates, who are neither employees nor dependents. As we understand, this is the case for practically every other employer-provided health insurance. Moreover, as recent State Department of Financial Services guidance explains, while New York Insurance Law was amended in 2019 to ensure that existing coverage was afforded for individuals "who are unable to conceive due to their sexual orientation or gender identity," the amended changes did "not address surrogacy arrangements or require coverage for services that are not otherwise mandated to be covered under the Insurance Law."

Conclusion

The Office of Labor Relations strongly believes that all City employees deserve high-quality and equitable health care. As we have for many years, we will continue to work with our municipal unions to make appropriate modifications and enhancements to our health plan in the best interests of employees and taxpayers.

Thank you for this opportunity to testify, and we will be happy to answer any questions you may have.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

**TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEE ON
HEALTH AND COMMITTEE ON HOSPITALS
JUNE 29, 2022**

Good morning,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. I would like to thank Chair Schulman and Chair Narcisse and members of the Committee on Health and the Committee on Hospitals for the opportunity to share testimony. I have always been a longtime advocate for maternal health and these bills being heard today will further push our efforts to eliminate those negatively impacted before, during, and after the birthing process.

In New York City, Black women are 8 to 12 times more likely to die during childbirth than their white counterparts. This is often due to medical personnel minimizing, dismissing or overlooking the health concerns of Black patients. The maternal health crisis has exacerbated since the beginning of the pandemic. COVID-19 has caused a rippling effect on various pressing issues; obstetric care unfortunately was one that was directly impacted. According to numerous recent data recorded on hospital-based maternity care over the last 20 months, there has been a huge staff shortage, forced separation of birthing persons and babies, and limited telehealth.[1] These factors create an even more scary and unsafe environment for mothers and their newborns.

Today, I have one bill and two resolutions being heard that will further provide resources for maternal health. Intro. No. 0086 would require the Department of Health and Mental Hygiene to conduct a public education campaign in all facilities that provide obstetric and gynecological care. The main goal of this bill is to educate patients about the city standards for respectful care at birth, health care proxy, and different rights they have as a patient. The type of outreach that would be done would be through distributing posters, informative pamphlets, flyers, posters, and other written materials. New York City Health and Hospitals must give out and put up these materials at locations that give this type of care. Not to mention this will allow for more exposure of information to reach the public, especially those who lack access to safe services and resources. This is especially important for communities of more color and immigrant communities who only have access to their local public hospital and are disportionately affected by maternal mortality. We want to make sure that any person who is giving birth is fully informed of what is available to them when they undertake the birthing process.

Similarly, I have two resolutions that are being discussed today. Resolution No. 0092 which calls on the United States Congress to pass and President Joseph Biden to sign the Black Maternal Health Momnibus Act of 2021. This critical legislation is to further address the maternal health issue in America by building on existing legislation.[2] Previously, congressional members fought for a 12-month postpartum Medicaid

[1] https://gothamist.com/news/nys-nyc-officials-pledged-to-reduce-maternal-mortalitythen-the-pandemic-struck
[2] https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus

coverage that would make sure that mothers have access to the safe and needed care during their full postpartum period.[3] This legislation will address every aspect of the maternal health crisis by the twelve titles that are combined into this standalone bill.[4] Several notable mentions in this bill include pregnant and postpartum veterans, maternal mental health, incarcerated moms, climate change-related risks for moms and babies, etc.

As for, Resolution No. 0244 also presented today, calls on the Centers for Disease Control and Prevention to expand funding for By My Side, a doula program part of the Healthy Start Brooklyn. With more funding, this will allow doulas to be available to all low-income birthing people in New York City. This community-based program will allow birthing people to access support for prenatal care, obstetric care, and postpartum care. This will help birthing people feel safe and confident to deliver their child. Doulas also support practical, emotional, and physical issues around childbirth.[5] They address all needs of their clients whether it is through home visits or offering services and referrals.

For far too long, maternal mortality has been ignored and those impacts have been unheard. It is time to protect them, particularly women and all pregnant people in communities of more color, who have disportionately experienced maternal healthcare inequities. With my maternal health legislative package and others being discussed today, these programs will help change this unjust system that has long denied women of color in our city the care they need and deserve. It is essential that these bills are being heard today as they all can have lifesaving outcomes for future mothers.

Thank you.

[3] Ibid.
[4] Ibid.
[5] https://www1.nyc.gov/site/doh/health/health-topics/doula-care.page

BRONX BOROUGH PRESIDENT VANESSA L. GIBSON

Testimony of Bronx Borough President Vanessa L. Gibson
For the NYC Council Committee on Hospitals jointly with the Committee on Health
Oversight Hearing on Maternal, Mortality, and Morbidity

Re: T2022-1550; Int 0086-2022; Int 0409-2022; Int 0472-2022; Int 0478-2022;Int 0482-2022; Int 0490-2022; Int 0508-2022; Int 0509-2022; Res 0092-2022; Res 0095-2022; Res 0201-2022; Res 0205-2022; Res 0244-2022

Good morning and thank you, Chairperson Schulman, Chairperson Narcisse, and Members of the NYC Council Committees on Health and Hospitals for the opportunity to speak on today`s package of bills related to combating the high rates of maternal mortality and morbidity in our city and improving access to reproductive care.

At a time in which we are seeing an unprecedented attack on reproductive freedom, it is imperative that our legislators on the city and state levels take immediate action to protect women and birthing individuals. Despite our borough being one of two epicenters of maternal mortality in New York State, we have limited resources to address this issue and are in dire need of a birthing center in our borough.

This is why we initially created The Bronx Maternal Health Consortium which emerged from the Black Maternal Mortality Task Force with the purpose to affect change through public policy and borough-wide community activism. This is very much aligned with what we are discussing here today.

According to 2020 CDC data, Black women in New York City were three times likelier to die from maternal causes as white or Hispanic women, and each year the death count rises. This striking disparity persists and highlights the need for Intro 0409, a local law that will increase access to data on maternal mortality and morbidity. This law will crystalize that this inequity exists in New York City-based on race and signify the urgency to address racial disparities that leave Black women uniquely vulnerable to adverse outcomes in pregnancy and childbirth.

Birth workers such as midwives and doulas are an important part of the health worker landscape in The Bronx, however many facilities do not have midwifery services. The presence of doulas

improves the safety and overall outcomes of the birth experience; they reduce stress and can blunt the adverse effects of systemic racism in our healthcare system. Intro 0472 and Intro 0478 pertaining to establishing a pilot program to train doulas and expand on an outreach and education campaign on the benefits and services provided by doulas are critical. These critical services bring healthcare opportunities to Black women who are often marginalized and unheard when it comes to accessing culturally appropriate care.

New York lags behind other states when it comes to funding doula services through Medicaid. As of December 2021, 17 states were offering or are on the path to providing statewide doula coverage through Medicaid. I strongly support Res. 0205 which will make doulas more accessible to individuals with Medicaid as well as those without health insurance. **New York should extend doula coverage statewide, on a permanent basis, and increase the reimbursement rate to match our peer states like New Jersey, Virginia, and California.**

New York is at a historic moment with a female leadership team at Bronx Borough Hall, the New York City Council, and on the State level. Now, more than ever, with the ruling of Roe v. Wade, we need stronger legislation at the local level to support women and *lead* this progressive national effort to ensure that standards of respectful care at birth become *universal*. As a collective, these bills will help tackle the racial disparities in adverse maternal outcomes. The more we wait, the more women and birthing persons we lose. You have all been valuable partners in combatting maternal mortality and severe morbidity. **I commend you for this shared commitment and strongly endorse every bill herein.**

BRONX BOROUGH PRESIDENT VANESSA L. GIBSON

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For the NYC Council Committee on Hospitals jointly with the Committee on Health
Oversight Hearing on Maternal, Mortality, and Morbidity

Re: T2022-1550; Int 0086-2022; Int 0409-2022; Int 0472-2022; Int 0478-2022;Int 0482-2022; Int 0490-2022; Int 0508-2022; Int 0509-2022; Res 0092-2022; Res 0095-2022; Res 0201-2022; Res 0205-2022; Res 0244-2022

Good morning and thank you, Chairperson Schulman, Chairperson Narcisse, and Members of the NYC Council Committees on Health and Hospitals for the opportunity to speak on today`s package of bills related to combating the high rates of maternal mortality and morbidity in our city and improving access to reproductive care. My name is Janet Peguero, I'm the Deputy Bronx Borough President and I'm here to provide testimony on behalf of Bronx Borough President Vanessa L. Gibson.

At a time in which we are seeing an unprecedented attack on reproductive freedom, it is imperative that our legislators on the city and state levels take immediate action to protect women and birthing individuals. The Borough President was proud to introduce Int 0086 alongside Public Advocate Jumaane Williams to improve outreach and education regarding the standards for respectful care at birth and other information that will improve the birthing experience for women in our city.

Additionally, we are in support of these bills as they will strengthen, expand and provide the necessary resources we need to save lives in our borough and across the City of New York. The current city services are burdensome to our doulas and birthing workers who are already severely underpaid via public reimbursement. The Mayor announced a plan to expand doula access and though it is a start it is not nearly enough. Training 50 doulas to help 500 families in 3 months is not feasible and although we are grateful for the service providers none of them are based in the Bronx. The onus is not on our doulas to make up for the work that the city has neglected. It is up to us. That is why the borough president is in support of these bills.

Despite our borough being one of two epicenters of maternal mortality in New York State, we have limited resources to address this issue and are in dire need of a birthing center in our borough. This is why we initially created The Bronx Maternal Health Consortium which emerged from the Black Maternal Mortality Task Force with the purpose to affect change through public policy and borough-wide community activism. This is very much aligned with what we are discussing here today.

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Birth workers such as midwives and doulas are an important part of the health worker landscape in The Bronx, however many facilities do not have midwifery services. The presence of doulas improves the safety and overall outcomes of the birth experience; they reduce stress and can blunt the adverse effects of systemic racism in our healthcare system. Intro 0472 and Intro 0478 pertaining to establishing a pilot program to train doulas and expand on an outreach and education campaign on the benefits and services provided by doulas are critical. These critical services bring healthcare opportunities to Black women who are often marginalized and unheard when it comes to accessing culturally appropriate care.

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New York is at a historic moment with a female leadership team at Bronx Borough Hall, the New York City Council, and on the State level. Now, more than ever, with the ruling of Roe v. Wade, we need stronger legislation at the local level to support women and *lead* this progressive national effort to ensure that standards of respectful care at birth become *universal.* As a collective, these bills will help tackle the racial disparities in adverse maternal outcomes. The more we wait, the more women and birthing persons we lose. You have all been valuable partners in combatting maternal mortality and severe morbidity. **I commend you for this shared commitment and strongly endorse every bill herein.**

OFFICE OF THE BROOKLYN BOROUGH PRESIDENT

ANTONIO REYNOSO
Brooklyn Borough President

City Council Committees on Health and Hospitals
Oversight Hearing – Maternal Health, Mortality, and Morbidity
6.29.22

Good morning Chairs Schulman and Narcisse and members of the committees. Thank you so much for holding this hearing today and providing the opportunity to speak on this very important issue. I am Brooklyn Borough President Antonio Reynoso, and addressing the Black maternal health crisis in Brooklyn is my number one priority for my time in this office.

According to DOHMH, the highest rates of maternal morbidity occur among low-income Black and Latinx birthing people, especially those with limited prenatal care, those who use Medicaid, and those who are uninsured and/or undocumented. The often-cited and incredibly important statistic is that Black people are 9.4 times more likely than their white counterparts to die from pregnancy-related causes.

These disparities must be addressed, and that is why my goal is to make Brooklyn the safest place in New York City to give birth in the next four years, and the safest place in the country in eight. As soon as I took office, I put together a Maternal Health Task Force to guide this work, co-chaired by NYC Health + Hospitals Chief Women's Health Service Officer Dr. Wendy Wilcox and NYC Health + Hospitals/Woodhull Director of Midwifery Services Helena Grant, and made up of healthcare professionals and advocates. I appreciate this Task Force's guidance on the feedback I am providing you today.

I want to start by expressing my support for all the bills and resolutions in this package that expand training of and access to doula services for NYC residents. A successful birth takes a village. Even though doulas are not trained clinicians, they are a critical part of the birthing experience. Doulas provide hand-holding and multiple touch points of support that offer a safe space, establish trust, and promote mental health and wellness.

My office has worked with groups like Mama Glow, a Brooklyn-based, Black female-founded organization supporting a global community of doulas by providing doula training and doula matching, and a partner of the Citywide Doula Initiative. Many of the doulas they train carry

lived experiences from their own birthing journey and aim to give back to their birthing community.

A 2017 report published by Cochrane showed that people who had doula support were 39% less likely to have a caesarean section and 15% more likely to give birth without needing drugs or labor-inducing techniques. Critically, doulas provide support both before and after birth. People tend to believe that most maternal deaths happen during the birthing process, but in fact, most deaths occur in the months after birth as a result of mental health challenges and other social factors. Post-partum support from doulas can make a difference.

The New York State Medicaid Program reimburses participating doulas for up to four prenatal visits, support during labor and delivery, and up to four postpartum visits. While it has launched in Eerie County, this program has not been successful in Kings County because of its flawed Medicaid reimbursement rates that are insufficient to fully support doulas and their families.

These services – and in fact, all pre-natal and post-partum services – must be offered to all, without regard to health insurance status or ability to pay. One's socioeconomic or immigration status should not define whether or not they can give birth to a healthy child or survive a birth. I support efforts to make doulas more accessible in underserved communities by expanding access, increasing reimbursement rates, creating more welcoming hospital and healthcare environments for the doula community, and improving access to data.

On Intro 478, which would require DOHMH to conduct an outreach campaign about the benefits and services offered by doulas and midwives, I support this effort with two caveats – first, it is important to understand the differences between a doula and midwife. Both provide important services, but doulas are not a substitute for midwives. There is often confusion between the two.

Midwives are licensed professionals who provide medical care during pregnancy, birth, and the immediate postpartum period. Doulas provide birthing people and their families with emotional, informational, and physical support during pregnancy, birth, and the immediate postpartum period.

Second, we need to inform the birthing community of the full scope of services and resources available to them, in addition to doulas and midwives. This includes OB/GYNs and nurses. My office is committed to supporting campaigns to expand education on the roles of a birthing person's care team.

On the bill and resolution regarding creating awareness of the risk of caesarean sections, I support these efforts as well, with a note that the American College of Obstetricians and

Gynecologists (ACOG) has expressed opposition because of concerns that providing information on risks can discourage people from seeking care. However, the fact is that Black people are told by their doctors to undergo c-sections at disproportionately higher rates than their white counterparts. This is one of the causes of the high number of post-partum maternal deaths.

This crisis is driven by unconscious bias in the medical system and its actors. In a 2016 survey of white medical students, nearly half held false beliefs about biological differences in Black patients, including that they had thicker skin and less sensitive nerve endings, indicating that Black people's physical bodies are viewed as less fit to bear children without medical intervention. Furthermore, c-sections among Medicaid recipients are still being seen as profitable for institutions. Black mothers consistently undergo caesareans more than white mothers, even in low-risk situations. And as a result, they are more likely to suffer for longer after birth, to struggle to fully recover, or to die.

We need education on c-section risk so the patients can have all the information they need to make an informed decision on treatment of their physical bodies. Yet as noted, we must be careful about the messaging so as not to discourage birthing people from seeking care. We need to have leadership by those most impacted driving these discussions.

Along those lines, **I also support Reso 0092 in support of The Black Maternal Health Momnibus Act of 2021.** This bill would create opportunities at the Federal level to develop data-driven, evidence-based practices and programs that value and trust the lives, knowledge and leadership of Black mothers. It invests in their health – and creates opportunities for Black mothers to be heard.

Thank you again for your time today and for dedicating this hearing to this critical issue. I am willing and eager to partner with the Council, the Public Advocate's office, and our partners in the State and Federal legislatures to deliver all we can for birthing people in New York.

a better balance
the work and family legal center

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New York City Council Committee on Health & Committee on Hospitals
Oversight—Maternal Health, Mortality, and Morbidity

June 29, 2022

Testimony of Meghan Racklin, Staff Attorney
A Better Balance

Thank you to Chair Schulman, Chair Narcisse, and the members of the Committee on Health and the Committee on Hospitals for the opportunity to testify today. My name is Meghan Racklin and I am a Staff Attorney at A Better Balance. A Better Balance is a legal nonprofit headquartered in New York City. A Better Balance was founded with the goal of ensuring that all workers have the ability to care for themselves and their families without compromising their economic security. Here in New York City, we are proud to have drafted and shepherded to passage groundbreaking legislation, the 2014 NYC Pregnant Workers Fairness Act, and helped to draft New York City's caregiver discrimination law. The extension of both of these important laws to domestic workers, who are so often balancing the work of caring for their employers' families with the need to care for themselves and their own families, is urgently needed. We were also at the forefront of drafting and advocating for the New York City Earned Sick Time Act as well as the expansion of the law to include safe time and to broaden the definition of family members, as well as the City's Fair Workweek law. **A Better Balance was proud to work with the New York City Public Advocate, Jumaane Williams, on drafting Intro 0086-2022 and we urge the Council to pass this important bill into law.**

Through our work in New York City, and the calls to ABB's free legal helpline, we know how important it is to ensure that pregnant people and parents in New York City have the support they need to balance the competing demands of work and care. We know that workplace protections—such as access to time off, fair and flexible schedules, and reasonable accommodations—are a key social determinant of health for workers. For Black women and

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parents in particular, these supports are especially pressing as the Black maternal health crisis remains frighteningly persistent in New York City.

Yet, despite New York City having some of the strongest workplace protections, they remain inaccessible to those who often need them most, including Black parents. For instance, our recent report, co-authored with the Community Service Society (CSS), *Women in the Workforce: Advancing a Just Recovery in New York City*,[i] provides new data from CSS's *Unheard Third* Survey—the longest-running poll of low-income people in the United States—which clearly indicates that low income working women are not aware and have not been able to fully access their rights, specifically the New York City Earned Safe and Sick Time Act (ESSTA), New York State's paid sick time law, and New York State's Paid Family Leave law. Nearly six in 10 women who are covered by the New York City Earned Safe and Sick Time Act (ESSTA)[ii] had heard little to nothing about the law, which provides covered workers with job-protected time off from work that can be used for a number of purposes, including prenatal appointments and other reproductive healthcare, caring for a sick child or other loved ones, and when the worker is a victim of domestic violence.

At the same time, 59 percent of mothers and 36 percent of fathers who needed to stop working cited childcare as one of the reasons, and 53 percent of low-income workers who needed to stop working cited health or disability as one of the reasons. Additionally, only 36 percent of low-income women and 46 percent of moderate- to high-income women working in New York City's private sector reported having access to paid leave, despite the fact that New York State's paid family leave program covers most private-sector workers, and many workers reported leaving the workforce during the pandemic due to the need to care for themselves or loved ones. Taken together, this suggests that workers are not adequately informed about their rights to paid family leave, paid sick time, anti-discrimination protections for caregivers, and reasonable accommodations for disability or pregnancy.

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These findings echo and reinforce findings from our report, *Our Crisis of Care*,[iii] authored in conjunction with the Comptroller's Office and released last year, which surveyed New York City workers about their caregiving responsibilities and workplace challenges during the pandemic, we found women were significantly less likely to have access to workplace flexibility during the pandemic than men, and women of color had among the least access to flexibility. One woman, a Black mother working in healthcare, reported that her employer usually tells her that if they make accommodations for her, they would have to make them for everyone—a statement that makes clear the challenges Black women in particular face when seeking the support and respect they need at work in order to manage their health and caregiving responsibilities.

Intro 0086-2022 will help remedy this issue, by ensuring that pregnant New Yorkers who seek medical care are informed of their rights at work—such as their rights to sick time, paid family leave, and reasonable accommodations for pregnancy and disability. Having this knowledge will give Black mothers and parents the power they deserve: the power to access their rights, maintain their health, and support their families.

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[i] MEGHAN RACKLIN, DEBIPRIYA CHATTERJEE, SARAH BRAFMAN, EMERITA TORRES, DINA BAKST, SHERRY LEIWANT, A BETTER BALANCE & THE COMMUNITY SERVICE SOCIETY, WOMEN IN THE WORKFORCE: ADVANCING A JUST RECOVERY IN NEW YORK CITY (2022), https://www.abetterbalance.org/women-in-the-workforce/.

[ii] N.Y.C. Admin. Code § 20-911 et seq. For a model resource informing workers of their rights under this law, see Know Your Rights: New York City Paid Sick Time, A Better Balance (last visited May 24, 2022), https://www.abetterbalance.org/resources/know-your-rights-new-york-city-paid-sick-time/.

[iii] A BETTER BALANCE & BUREAU OF POLICY AND RESEARCH, OFFICE OF THE NEW YORK CITY COMPTROLLER SCOTT M. STRINGER, OUR CRISIS OF CARE (2021), https://www.abetterbalance.org/wp-content/uploads/2021/03/Crisis_of_Care_Report_031521.pdf.

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TESTIMONY OF:

Nila Natarajan,
Supervising Attorney and Policy Counsel

BROOKLYN DEFENDER SERVICES

Presented Before

The New York City Council Committees on Health & Hospitals

Oversight Hearing on Maternal Health, Mortality, and Morbidity

June 29, 2022

My name is Nila Natarajan and I am a Supervising Attorney and Policy Counsel in the Family Defense Practice at Brooklyn Defender Services (BDS). I am also a member of the New York City Maternal Mortality and Morbidity Review Committee. We thank the Committees on Health & Hospitals and Chairs Schulman and Narcisse for the opportunity to address the Council about maternal health, mortality, and morbidity.

BDS is a public defense office whose mission is to provide outstanding representation and advocacy free of cost to people facing loss of freedom, family separation and other serious legal harms by the government. BDS provides comprehensive public defense services to approximately 25,000 people each year. We are the primary defense provider for parents and caretakers in Brooklyn who are facing ACS investigations or child neglect and abuse cases in family court. We use a multidisciplinary approach that offers our clients access to social workers, advocates and civil and immigration attorneys who work to minimize any collateral impact of our clients' court cases. Our Family Defense Practice represents about 2,300 parents and caretakers each year. We have represented over 14,000 parents and caretakers in Brooklyn Family Court and have helped more than 30,000 children remain safely at home or leave foster care and reunite with their families.

Inequities and discrimination in family regulation system

Given our extensive experience working with parents and caretakers, we are keenly aware of the ways in which inequities in the City's provision of maternal, perinatal, and prenatal healthcare render Black and Latine parents and families vulnerable to the surveillance and punishment of the family regulation system, also known as the child welfare system.[1] Like the criminal legal system, race and poverty are

[1] Many, including scholar Professor Dorothy Roberts, have come to refer to the so-called "child welfare" system as the family regulation system, given the harms historically and currently perpetuated by the system. See e.g., Dorothy Roberts, Abolishing Policing Also Means Abolishing Family Regulation, The Imprint (June 16, 2020), https://imprintnews.org/child-welfare-2/abolishing-policing-alsomeans-abolishing-family-regulation/44480.

defining characteristics of the family regulation system. Most of the people we represent are people of color living in poverty, raising their children in homeless shelters or public housing, utilizing public benefits and healthcare, and living in highly policed and under-resourced neighborhoods, making them vulnerable to government surveillance. Poor communities and communities of color are disproportionately impacted by the state's family regulation system. In New York, Black children make up 40% of the children in foster care yet make up only 15% of the children in the state, whereas white children make up 25% of the children in foster care and 48% of the children across the state.[2] Black children also fare far worse in the foster care system and have much longer stays in care.[3]

This Council's commitment to improving maternal health outcomes must be rooted in an understanding of the intersections of maternal and perinatal health and the family regulation system, and how these systems perpetuate harm against Black and Latine parents and families. We encourage the Council to engage in robust dialogues with impacted parents, families, and their providers and to enact bold solutions that ensure healthcare that is non-discriminatory, culturally responsive, respectful, supportive, and patient-informed.

Medical care and family surveillance

Critical for the consideration of this Council is a primary way that pregnant people and new parents come to the attention of family regulation authorities: covert drug testing of pregnant people and infants. Frequently, particularly among low-income Black and Latine women, prenatal and postpartum care providers test birthing parents and their new infants without notice or their consent. In our practice, we have rarely—if ever—see a recorded rationale for drug testing nor indication that the test was deemed medically necessary in medical records.[4] Nevertheless, our city's hospitals routinely conduct these covert drug tests and report positive toxicology results to the Office of Children and Family Services' (OCFS) Statewide Central Register of Child Abuse and Maltreatment (SCR). This routine practice, sometimes termed "test and report," much like the policing practice of "stop and frisk," exposes families to harmful unnecessary government intervention, and in some cases, traumatic family separation.[5]

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[2] New york State Office of Children and Family Services, 2021 Monitoring and Analysis Profiles With Selected Trend Data: 2017-2021, Published 2022, https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20State.pdf, page 7.

[3] United States Accountability Office, African American Children in Foster Care: Additional HHS Assistance Needed to Help States Reduce the Proportion in Care, July 2007, Available online https://www.gao.gov/new.items/d07816.pdf.

[4] Of note, the American College of Obstetricians and Gynecologists (ACOG) opposes non-consensual drug testing and responding to drug use during pregnancy with punitive measures such as criminal prosecution or the threat of child removal. That criminalization and punishment for substance use disorder during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant person and their infant. Even though leading medical organizations agree that a positive drug test should not be construed as child abuse or neglect, biologic testing of pregnant people and newborns for the presence of licit and illicit substances, and reporting parents to authorities based on test results, is often an institutional policy put in place with the intention of promoting public health., See https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period.

[5] Movement for Family Power, et al., Family Separation in the Medical Setting: The Need for Informed Consent, Nov. 2019, https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5e6ac6f3ea60e51301d4ee47/15840 56 066082/Policy+Brief+2020.pdf.

Infants born to Black mothers are more likely than those born to white mothers to be screened for illicit drugs, regardless of whether they met hospital guidelines for screening.[6] Studies of the practice have demonstrated lower rates of positive screens for drugs among Black birth parents than their peers.[7] Despite similar or equal rates of illegal drug use during pregnancy, Black pregnant people are ten times more likely to be reported to family regulation agencies for prenatal drug use. This is true even though Black and Latine pregnant people use illicit substances at virtually the same rate as white pregnant people, and white pregnant people use cigarettes and alcohol at greater rates than Black and Latine people during the prenatal period.

Before performing any test on a pregnant individual or newborn, including screening for the presence of illicit substances, informed consent should be obtained from the pregnant person or parent. This consent should include the medical need for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and discussion of the possible outcome of positive test results. In addition, obstetrician–gynecologists or other obstetric care practitioners should consider patient self-reporting as an alternative, which has been demonstrated repeatedly to be reliable in conditions where there is no motivation to lie, and in clinical settings where there are no negative consequences attached to truthful reporting.[8] Similarly, in a recent position statement, the National Perinatal Association warned that treating perinatal drug use in pregnancy "as a deficiency in parenting that warrants child welfare intervention" has many risks, including the consequence of "pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk." As they put it, the "threats of discrimination,[9] incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care."[10] Although testing of pregnant people and newborns for the presences of licit and illicit substances in theory is intended to promote public health, these medical expert perspectives make clear the existence of the attendant risks of such testing.

Efforts to protect children from harm have expanded the surveillance responsibilities of actors who come into contact with families, such as health care workers and social workers, and perversely and needlessly exposed the most under-resourced and vulnerable families to separation and the disruption of maternal-infant bonding. The expansion of reporting obligations into the realm of reproductive

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[6] Amy Norton, Black Babies more often screened for drug exposure, *Reuters Health*, May 18, 2010, Available online at https://www.reuters.com/article/us-drug-exposure/black-babies-more-often-screened-for-drug-exposure-idUSTRE64H4LF20100518.

[7] Marc A. Ellsworth, BS, Timothy P. Stevens, MD, MPH, and Carl T. D'Angio, MD, Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns, Pediatrics, (May 17, 2010).

[8] Am. Coll. of Obstetricians and Gynecologists, Statement of Policy, Opposition to Criminalization of Individuals During and the Postpartum Period (Dec. 2020), at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/oppositi on-criminalization-of-individuals-pregnancy-and-postpartum-period (internal citations omitted).

[9] Nat'l Perinatal Ass'n, Position Statement, Perinatal Substance Use (2017).

[10] Id.; see also Shelly Gehshan, Southern Reg'l Project on Infant Mortality, A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women ii, 5 (1993); Steven J. Ondersma et al., Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response, 5 Child Maltreatment 93, 99 (2000) ("[B]ringing high levels of coercion to bear on parents increases the likelihood that contact with outside agencies and hospitals will be avoided by pregnant mothers.").

health care makes seeking care a precarious endeavor by traumatically interrupting access to health care. When pregnant people and new parents are reported to family regulation authorities their relationship with medical providers are damaged, and in some cases severed, and future engagement with providers precipitously drops. Distrust of medical providers may have a chilling effect for pregnant people, creating barriers to prenatal, maternal, and postpartum care.[11] Accessing reproductive health care, without fear of family regulation system involvement and family separation, is a reproductive justice issue.

A report made to the family regulation authorities leads to an invasive state investigation of a parent's most personal details and family life, often beginning with calls and visits to a birthing parent's bedside right after giving birth, and continuing with visits to a family's home, the homes of other family members, and interrogations of neighbors, teachers, and children. Such an investigation can then lead to court involvement where–even absent a removal of a child–a family will be subjected to unannounced home visits and all-pervasive surveillance for months, if not years. When a patient cannot be honest with their health care provider, they cannot receive the care and support they or their families need.

Introduction Number 1426

Considering the legal ramifications of a positive toxicology or assessment, it is imperative that patients be made aware of the health benefits as well as the legal consequences of submitting to a drug test and be empowered to make informed decisions about their medical care. To this end, we strongly support Int.1426-2019 which would require prior written informed consent by a pregnant or perinatal person for drug testing of themselves or their child. We are hopeful that this Council will reintroduce this critical legislation, first introduced by Brooklyn Borough President Reynoso during his tenure at the Council. We welcome the opportunity to work with the Council to strengthen this draft legislation.

Conclusion

We are grateful to the City Council for highlighting concerns about maternal mortality, especially for Black and Latine pregnant people. We see every day how low income Black and Latine parents are treated by the medical system and other helping professionals. We urge the City Council to consider the ways the family regulation system further harms low-income parents and children in the city. We welcome the opportunity to work with you on ensuring all pregnant and parenting people in our city receive quality care.

If you have any questions, please feel free to contact me at nnatarajan@bds.org.

[11] Jamila Perritt, M.D., M.P.H., #WhiteCoatsForBlackLives — Addressing Physicians' Complicity in Criminalizing Communities, England J. of Medicine (Nov. 5, https://www.nejm.org/doi/full/10.1056/NEJMp2023305?query=recirc_inIssue_bottom_article. 2020)

Brooklyn Perinatal Network, Inc.
http://www.bpnetwork.org/nyc/

Testimony for Hearing on Wednesday June 29th ,2022
Oversight Committee on Hospitals
Maternal Health, Mortality, and Morbidity

By Ngozi Moses, Executive Director, Brooklyn Perinatal Network
Convenor of the Brooklyn Coalition for Health Equity for Women and Families
Chair: Carine Joycelyn, CEO Diaspora Community Services

T2022-1551 Oversight - Maternal Health, Mortality, and Morbidity.

	Description	Comments
Int 0086-2022	A Local Law to amend the administrative code of the city of New York, in relation to education about city standards for respectful care at birth, health care proxy forms and patients' rights	BPN supports this legislation. Respectful care at birth is very important and doulas provide that care. ▪ However, doulas must be paid a living wage. Medicaid rate must be negotiated that provides pay for the services. ▪ Also, most community doulas prefer to be associated with a community-based organization that will provide administrative management for billing services.
Int 0409-2022	A Local Law to amend the administrative code of the city of New York, in relation to increasing access to data and maternal mortality and morbidity	BPN supports. It is important for CBOs to be able to get easy access to data related maternal health.

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	Description	Comments
Int 0472-2022	A Local Law in relation to establishing a pilot program in the department of health and mental hygiene to train doulas and provide doula services to residents in all five boroughs	Support this legislation. Current pilot Citywide Doula Initiative to be extended. DOHMH Healthy Start, By My Side Model. ▪ BPN did not apply for the pilot due to the short time frame. BPN will apply for the long-term program. ▪ Agencies that have already conducted doula training and doula services should be eligible. ▪ Doula training, 2 types: DONA and Community. The Community training emphasizes race/racial equity, cultural humility, navigating hospital systems. BPN provides the two types of training.
Int 0478-2022	A Local Law to amend the administrative code of the city of New York, in relation to an outreach and education campaign on the benefits and services provided by doulas and midwives	▪ Need to ensure that CBOs real partners in the planning and implementation of the outreach and education campaign. ▪ CBOs should be awarded contracts to develop the campaign on the benefits and services provided by doulas and midwives. ▪ Community resident voices/input is important to develop and implement the campaign through a structured process ▪ Campaign must have two components: community resident and health care providers ▪ Need to ensure that H+H hospitals participate in the Maternal Health Quality

	Description	Comments
		Improvement Network (MHQIN) to develop doula friendly hospital plans, avoid fragmentation of services. ▪ Currently, hospitals only permit two persons to accompany the pregnant mother for labor and deliver. ▪ Hospitals must include the CBO in the development of the doula friendly hospital plan.
Int 0482-2022	A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to report on polycystic ovary syndrome and endometriosis	▪ Support but would need more information.
Int 0490-2022	A Local Law to amend the administrative code of the city of New York, in relation to the establishment of an office of sexual and reproductive health within the New York city department of health and mental hygiene	▪ Need to be clear regarding the intent of the office. ▪ There are many different bureaus and offices involved with the areas mentioned. It can be complicated with so many sexual and reproductive health services mentioned.
Int 0508-2022	A Local Law to amend the administrative code of the city of New York, in relation to requiring family building benefits for city employees	

Brooklyn Perinatal Network, Inc.
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	Description	Comments
Int 0509-2022	A Local Law to amend the administrative code of the city of New York, in relation to a public education and outreach campaign on the risks of caesarean sections	▪ Need to ensure that CBOs real partners in the planning and implementation of the outreach and public education campaign. ▪ CBOs should be awarded contracts to develop the campaign on the risk of caesarean sections to ensure MCH CBOs are involved. ▪ Community resident voices/input is important to develop and implement the campaign through a structured process ▪ Campaign must have two components: community resident and health care providers
Res 0092-2022	Resolution calling on the United States Congress to pass and President Joseph Biden to sign the Black Maternal Health Momnibus Act of 2021	BPN supports
Res 0095-2022	Resolution calling on the New York State Legislature to pass, and the Governor to sign, A217/S2736, relating to informing maternity patients about the risks associated with cesarean section.	BPN supports
Res 0201-2022	Resolution calling upon New York State Legislature to establish full insurance coverage for fertility treatments.	BPN supports

	Description	Comments
Res 0205-2022	Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance	Doulas and doula CBOS need to be involved with the decision-making process.
Res 0244-2022	Resolution calling on the Centers for Disease Control and Prevention to provide expanded funding for the Healthy Start Brooklyn doula program known as By My Side in order to make doulas available to all low-income birthing people in New York City.	

Jointly with the Committee on Health

CACF
Coalition For Asian American Children+Families

New York City Council
Committee on Hospitals and Subcommittee on COVID Recovery and Resiliency
June 27, 2022

Testimony of Amy Lin, Policy Fellow
Coalition for Asian American Children and Families (CACF)

Hello, my name is Amy Lin, and I am the Health Policy Fellow at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Narcisse and Chair Moya for holding this hearing and providing the opportunity to testify.

Founded in 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian American Pacific Islander (AAPI) population comprises nearly 18% of New York City. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the AAPI community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized AAPI New Yorkers. Working with over 70 member and partner organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

Nearly 19 million people reside in the New York City metropolitan area, and over 800 different languages are spoken. Because of New York's linguistic diversity, it is incredibly important to ensure language access. Language barriers are a huge obstacle faced by many folks in immigrant communities, and especially in the AAPI community. In New York City, AAPIs have the highest rate of linguistic isolation of any group, as 46% have limited English proficiency (LEP), meaning that they speak English less than very well, according to a recent report from the New York City Department of Health and Mental Hygiene. Moreover, more than 2 in 3 Asian seniors in New York City are LEP, and approximately 49% of all immigrants are LEP.

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting healthcare settings in New York, many LEP patients still report facing difficulties like being unable to find an interpreter that speaks their dialect or being unable to fill out paperwork because a translated version in their language does not exist. A lack of linguistically accessible services in healthcare settings can have grave consequences: 52% of adverse events that occurred to LEP patients in US hospitals were likely the result of communication errors, and nearly half of these events involved some physical harm.

In the summer of 2021, we conducted a rapid needs assessment in collaboration with the NYU Center for the Study of Asian American Health and the Chinese-American Planning Council. We surveyed over 1000 adults of Asian, Hispanic/Latinx, or Arab descent living in the metropolitan New York area to assess the current and ongoing needs of the community during the COVID-19 pandemic.

CACF
Coalition For Asian American Children+Families

This study highlights the disproportionate impact that the COVID-19 pandemic has had on the New York Asian American community and demonstrates the importance of language access. Specifically, the study found 1 in 3 (34%) Asian American adults reported language barriers being a challenge during the pandemic. Furthermore, 27% of Asian American respondents indicated that they felt like they did not have regular access to timely, accurate information during the COVID-19 pandemic in their language. The study also shed light on the specific language barriers that Asian American folks were facing: Chinese, Korean, and Bangladeshi adults reported high rates of difficulty waiting for an interpreter, while Korean, Japanese and other Asian adults reported high rates of difficulty getting written materials in their preferred languages. Being unable to access vital COVID-19 information or health services can be a threat to one's livelihood, so ensuring language access for all New Yorkers must be prioritized. LEP patients undergoing long-term COVID-19 treatment in New York City hospitals deserve to have linguistically accessible and culturally responsive services so that they can remain informed about their health-related decisions and recover from COVID-19.

Because ensuring language access is necessary for LEP patients to receive long-term COVID-19 treatment, we strongly encourage the City to prioritize expanding language access and services for COVID-19 efforts and social services and to truly enforce the language access plans in hospitals so that LEP patients have equal access to long-term COVID-19 treatment.

In addition to a need for linguistically accessible services, many patients with long-term COVID-19 around the nation report having heightened mental health challenges. Experiencing COVID-19 symptoms for many weeks can exacerbate mental health problems, which is why mental health services must be an integral part of long-term COVID-19 treatment in New York City hospitals. AAPI New Yorkers are less likely to be connected to mental healthcare than White New Yorkers, as only 38.2% of AAPIs with depression self-report as receiving mental health treatment versus 58.3%. **The City must prioritize providing linguistically accessible and culturally responsive mental healthcare to all New Yorkers experiencing long-term COVID-19.**

Overall, we see a need for more intentional collaboration between the City and community-based organizations to better identify language access gaps and mental healthcare access gaps and to find solutions that will have a direct impact on our communities.

Thank you very much for your time.

COMMUNITY HEALTH CARE ASSOCIATION of New York State

NYC Council Committee on Health & Committee on Hospitals
Public Hearing: Oversight – Maternal Health, Mortality, and Morbidity
June 29, 2022

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide written testimony to NYC Council Committee on Health & Committee on Hospitals joint oversight hearing on maternal health, mortality, and morbidity. CHCANYS is the statewide primary care association representing New York's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs).

Located in medically underserved communities, CHCs provide high quality primary care to everyone, regardless of ability to pay, insurance coverage, or immigration status. New York City's community health centers serve 1.2 million patients at 490 sites annually. Community health centers are a vital safety net for quality affordable healthcare services for many New Yorkers who otherwise wouldn't have access to healthcare – 93% of NYC patients live below 200% of the federal poverty level. Among NYC health center patients, 40% are Hispanic, 33% are Black, 17% are White, and 10% are other people of color. Inclusive of the comprehensive primary care they provide, most CHCs provide family planning and OB/GYN services. Some CHCs receive state level grants to supplement their family planning programs.

Everyone deserves access to high quality health care, including reproductive health care. However, studies have shown that Black and Indigenous women experience disproportionate poor health outcomes compared to other races for a myriad of health issues, and the disparity is especially stark for pregnancy, delivery, and after birth. Due to systemic and pervasive inequalities, poverty, and racism, Black women are three times more likely to die in and around childbirth as compared to white women, and Indigenous women are twice as likely. Research has shown that these disparities decrease when there is racial concordance between patients and providers. However, more proactive action must be taken to eliminate race-related disparate pregnancy and birth outcomes.

The CHC care model focuses on treating the whole person. CHCs partner with social services providers to meet patients' health and social needs, including by connecting them to housing, nutrition services, providing behavioral health care or referring out to specialty care. As such, CHCs are a natural partner the NYC government and health system as we look to expand access to comprehensive family planning and pregnancy related services.

CHCANYS is supportive of the package of introductions and resolutions in front of the Council to enhance maternal health care across New York City.

With additional questions or follow up, please reach out to Marie Mongeon, Senior Director of Policy with CHCANYS: mmongeon@chcanys.org.

COMMUNITY HEALTH CARE ASSOCIATION of New York State
111 BROADWAY, SUITE 1402, NEW YORK, NEW YORK 10006

June 30, 2022

SEND TO: testimony@council.nyc.gov

SUBJECT: 6/29 Committee on Health and Committee on Hospitals joint hearing on Sanitation and Solid Waste Management Hearing

Written Testimony with Recommendations IN SUPPORT OF:

Int 0086-2022, Int 0409-2022, Int 0472-2022, Int 0478-2022, Int 0482-2022

FROM: Lorna Modeste-Thomas
Address: #### Clarendon Road
Email: clairina4076@gmail.com

Dear Chairperson Council Member Lynn Schulman and Other Council Members:

Thank you to the Committees and relevant personnel for giving me this opportunity to share my testimony on the Maternal Health, Mortality, and Morbidity crisis in New York City and the package of related legislation now before the City Council.

Much research has been conducted on the Maternal health, mortality, and morbidity crisis over the years. This research shows that black women are at the top of the spectrum regarding poor maternal health outcomes, postpartum recovery, and black infant's mortality. In light of this well-established research and my own experience, I am writing to express my concerns and in support of this much needed legislation centered around the Maternal Health Mortality, and Morbidity Crisis in New York City.

My name is Lorna Clairina Modeste-Thomas, and I am a mother. I hold a Master's degree in Community Health Education from Metropolitan College of New York and up until recently, I worked as a Community Liaison for The Department of Health and Hygiene. My Master's research included facilitating conversation and raising awareness around women's reproductive health issues with a special emphasis on Uterine Fibroids. In the Spring of 2022, I was selected to be a Peer Group Leader for MCNY Library's community engagement project, the Black Maternal Health Initiative.

I am writing to highlight the severity of the maternal health, mortality and morbidity and its impact on the Black population. According to the Centers for Disease Control and Prevention the (CDC), the disparities by ethnicity and race related to maternal mortality are staggering. The Mortality rate for Black women is 37.1 per 100,000 live births, compared to that of 14.7 person for White women, and 11.8 for Hispanic women. Furthermore, Black Women are dying in childbirth or within the stage of post-partum at a rate of three to four times higher compared to that of white women. In New York City, that rate is 8 to 12 times higher. The statistics further reveal that poor maternal health also plays a key role in the severity of the impact on black infants who are 2.4 times more likely to die than their White peers.

Therefore, I am strongly in support of all the legislation under consideration today:

- Public Advocate Jumaane Williams's bill for Education about New York City standards for respectful care at birth, health care proxy and patient rights addresses the structural racism and biases that play a major role in poor maternal health outcomes.

- Farah N. Louis's regarding the bill to increase access to data on maternal, mortality and morbidity ensures that the city be vigilant about the crisis and will provide researcher's and advocates with much needed data.

- Jennifer Gutiérrez's bill on establishing a pilot program in the Department of Health and Mental Hygiene to train doulas and provide doulas services to residents in all five boroughs will make available to all New Yorkers an evidence-based method of improving reproductive, maternal, and infant health outcomes.

- Crystal Hudson's bill to create an outreach and education campaign on doula and midwife care will play a critical role in informing residents within all five boroughs about the various services, benefits and access to care that are provided by doulas and midwives.

- Finally, Farah N. Louis's bill requiring the Department of Health and Mental Hygiene to report on polycystic ovarian syndrome and endometriosis will play a major role in identifying other reproductive health disparities and support scaling up the care and resources that need to be allocated for those most affected by these conditions, Black women.

While I am pleased to support this last bill pertaining to polycystic ovarian syndrome and endometriosis, I firmly believe that another top women's reproductive health issue should be added to this bill. The women's reproductive health issue I am referring to is Uterine Fibroids. According to the National Institutes of Health (NIH), Uterine Fibroids is a serious women reproductive health issue affecting Black women the most --at a rate of 80%-- compared to any other races. Black women have two to three times the incidence of fibroids compared to White women. Although women of White and Asian descent also develop uterine fibroids, studies have shown that uterine fibroids severely impact women of African descent women.

While all women of reproductive age can develop fibroids, black women are more likely to have fibroids than any other racial group. Black women develop fibroids at a younger age, and black women also have more or larger fibroids, along with more severe symptoms (mayoclinic.org). Additionally, data reveals that women of African American descent tend to wait longer to get treatment for uterine fibroids. As a result, black women are three times more likely to be hospitalized with complications associated with uterine fibroids, seven times more likely to get fibroids surgically removed, and less likely to receive the minimally invasive surgical procedure (health.ny.gov).

I am one of those black women whose life had been severely impacted by Uterine Fibroids. Twelve years ago, I was diagnosed with this women's reproductive health issue and experienced many day-to-day challenges because of uterine fibroids.

I am advocating for earlier screening, detection for uterine fibroids in women. I am also advocating for legislation to make ultrasound and sonogram screenings part of women's annual gynecological exams for detecting uterine fibroids. It is paramount that women receive the relevant health care screenings and resources for better health outcomes as a community. As an Advocate and Community Health Educator, it is my responsibility to raise awareness and advocate for women's reproductive health.

In closing, I would like to thank you again for this opportunity to present testimony on these crucial issues. I hope to hear from you. If you have any questions regarding the critical matter of Uterine Fibroids for Black women's reproductive health, I would be happy to assist with my experience and research.

Sincerely,

Lorna Modeste-Thomas
Community Health Educator

THE MOTHERHOOD CENTER of New York

New York City Council Committee on Health

Jointly with the Committee of Hospitals

Oversight Public Hearing on Maternal Health, Mortality and Morbidity

June 29, 2022

Paige Bellenbaum, LMSW

Founding Director

Chief External Relations Officer

The Motherhood Center

Members of the Health Committee and Committee of Hospitals. Thank you for the opportunity to testify here with you today.

My name is Paige Bellenbaum, and I am the Founding Director of maternal mental health clinic called The Motherhood Center. Opened in 2017 by Reproductive Psychiatrist and founder of the Payne Whitney Women's Clinic at Weil Cornell, Dr. Catherine Birndorf and myself, The Motherhood Center provides support and psychiatric clinical treatment to new and expecting mothers and birthing parents experiencing perinatal mood and anxiety disorders (PMADs) otherwise known as postpartum depression. We have since become a leading maternal mental health facility in New York City and nationwide, providing PMAD education and training to the medical community, outpatient therapy and medication management, and a NYS OMH Article 31 Perinatal Partial Hospitalization Program - the only such facility located in the state of New York, and one of only one of a few in the U.S. Over the past 5 years we have treated thousands of perinatal women in New York City struggling from PMADs. As a result – we have also saved thousands of lives.

Perinatal mood and anxiety disorders include perinatal (during pregnancy and postpartum) depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, bipolar disorder, and in rare but life-threatening instances – postpartum psychosis. 1 in 5 (20%) new and expecting mothers experience a PMAD – but those if us that do this work know that it's more like 1 in 3 (33%). Since the pandemic, global studies have found PMAD rates to be as high as 72%.

Sadly, 80% of all PMAD cased go undiagnosed and untreated due to the enormous shame and stigma that surrounds maternal mental health. For many new mothers, their greatest fear is that their child will be taken away if they tell anyone how hopeless and helpless and disconnected from the baby they feel, that they will be deemed an unfit mother. PMADs are the number one complication associated with childbirth in this country – far surpassing the rates of hypertension (2 – 8%), gestational diabetes (up to 10%). PMADs are also one of the leading cause of maternal mortality in the U.S., yet despite these startling statistics, receive little to no mention in conversations and policies pertaining to maternal health outcomes.

Though hormonal changes during pregnancy and the postpartum period can cause mood disorders or anxiety to surface, PMADs are not exclusively driven by neurochemical causes; other key factors,

including racism and low-socioeconomic status, can increase the risk and severity. These external stressors can have significant effects on pregnancy, maternal health, and a child's development.

Black, Indigenous, and other people of color, and those with low-incomes experience postpartum depression at significantly higher rates. Studies show:

- More than half of infants in low-income households live with a mother experiencing some form of depression.
- New mothers of color have rates of postpartum depression close to 38 percent, almost twice the rate of white new mothers.
- Nearly 60% of Black and Latina mothers do not receive any treatment or support services for prenatal and postpartum mental health. Reasons include lack of insurance coverage, social and cultural stigma related to mental health needs, logistical barriers to services, and lack of culturally appropriate care. Citation - (https://www.nationalpartnership.org/our-work/health/moms-and-babies/the-maternal-mental-health-crisis-undermines-moms-and-babies-health.html)

Today you have a set of important and necessary bills in front of you that speak to the right to be free from discrimination in the perinatal experience, the right to accommodations in the workplace for new mothers and birthing parents, protected family leave, doula support services, the promotion of midwifery, the reporting of maternal mortality data, sexual and reproductive health services, and more – all imperative efforts to improve birth outcomes and increase accessibility to reproductive supports and workplace protections, yet no where in any of these bills – is there mention of maternal mental health.

I am here today in support of these bills, but I would be remiss if I did not come her to say – shame on us as a city for neglecting the mental health needs of new and expecting mothers and birthing parents. I would venture to believe – that every single person in this room either knows someone who has experience postpartum depression – or experienced it themselves. Perhaps you yourself are all too familiar with the feelings of hopelessness, helplessness, shame, guilt, finding no joy, feeling disconnected to your baby, feeling alone, isolated, irritable, overwhelmed, feeling as though you made a huge mistake by having this baby, longing for your life before you became a mother, feeling panic regarding the health and wellness of your baby so much so that you can't sleep, eat, or think about anything other than something terrible happening, perhaps even thinking – I don't want to live anymore, this is too much, my

family would be better off without me, I am a terrible, awful mother. And because the shame and stigma that surrounds maternal mental health is so great – because we live in a society that glamorizes and romanticizes motherhood – presents it as the most blissful and amazing thing that will ever happens to a woman – a new or expecting mother can feel like a failure if she feels anything but. And she becomes one of the 80% who suffers silently.

I was one of those mothers. 16 years ago, I gave birth to a beautiful, healthy baby boy. A few weeks after he was born, I began to feel severely depressed and anxious. I couldn't take care of myself or him, I couldn't sleep, eat, or function. I was miserable and I didn't want to be alive anymore. I felt alone, ashamed, embarrassed, and I hated myself for being such a failure as a mother. I kept all of this to myself for 9 months, until one day – I decided I couldn't carry on and that my family would be better off without me. I am very lucky to be sitting here in front of you today. But according to data released by the NYC DOHMH Maternal Mortality and Morbidity Review Committee (of which I am proudly a member of) mental health conditions caused 18% of pregnancy associated deaths in 2016 – 2017. That is 16 of the 91 deaths that year:

- Most of these deaths (n=12, 75%) occurred between 43 and 365 days postpartum
- Racial/ethnic breakdown:
    - Black non-Latina (25%)
    - Latina (35%)
    - White (38%)
    - Asian/Pacific Islander (6%)
- 25% of these deaths were pregnancy related, 69% were not related to pregnancy but occurred within one year of pregnancy
- 87.5% of these deaths were contributed to substance use disorder
- And ALL BUT 1 were deemed potentially preventable, most with some chance of altering the outcome

These women were not as lucky as I was.

In fact, according to a Health Affairs article published in October of 2021, in review of fourteen state Maternal Mortality Review Committees (MMRCs) from the period 2008–17, among 421 pregnancy-related deaths, 11% were due to mental health conditions. Pregnancy-related mental health deaths were more likely than deaths from other causes to be determined as preventable (100% versus 64%), to occur

among non-Hispanic White people, and to occur 43–365 days postpartum. 63% of pregnancy-related mental health deaths were by suicide. Nearly three-quarters of people with a pregnancy-related mental health cause of death had a history of depression, and more than two-thirds had past or current substance use.

Citation - (https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00615#:~:text=Using%20data%20on%20pregnancy-related,determination%2C%20100%20percent%20were%20preventable.

According to a recent Surgeon General's Report, maternal mental health disorders contribute to the U.S.'s high maternal mortality rate, and they impact mother-infant bonding and infant development.

"Each year more than 20 percent of U.S. women experience a mental, behavioral, or emotional disorder, such as depression or anxiety. Mental health conditions are also common complications during pregnancy and in the postpartum period and may contribute to poor maternal outcomes. Data from 14 state [Maternal Mortality Review Committees] MMRCs between 2008 and 2017 showed almost 10 percent of pregnancy-related deaths were due (in whole or in part) to mental health conditions. These conditions serve as underlying factors in injury or death due to overdose or suicide. Mental health conditions in the postpartum period, such as postpartum depression, are associated with poorer maternal and infant bonding, decreased breastfeeding initiation, and delayed infant development."

https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf

And let's talk more about the impacts of untreated PMADs on mothers and babies.
https://www.nationalpartnership.org/our-work/health/moms-and-babies/the-maternal-mental-health-crisis-undermines-moms-and-babies-health.html

According to the National Partnership for Women and Families, rigorous systematic reviews have found that untreated PMADs cause a whole host of adverse impacts on both mother and baby: (https://www.nationalpartnership.org/our-work/health/moms-and-babies/the-maternal-mental-health-crisis-undermines-moms-and-babies-health.html) :

- According to one meta-analysis, women experiencing depression or anxiety at any time during their pregnancy are 40 percent more likely to have hypertension than those who do not.
- Women with untreated bipolar disorder are more likely to experience adverse pregnancy outcomes, such as gestational hypertension and hemorrhaging, and are nearly twice as likely to have a preterm birth compared to women without mental health challenges.
- Pregnant women with untreated anxiety have a higher risk of preterm birth, lower birth weight, and their infants have a higher risk of being small for their gestational age.
- Infants of women with untreated postpartum depression can experience long-term negative impacts on their weight, length, head circumference, motor development, cognitive development, and sleep patterns.
- Women who experience PTSD during pregnancy have a higher risk of preterm birth and poor fetal growth.
- Undiagnosed and untreated psychiatric disorders, such as depression, are a risk factor for suicide in new mothers, a leading cause of maternal mortality in the United States.
- If left untreated, postpartum psychosis can lead to an increased risk of suicide and infanticide.

New York City can and must do better in addressing the mental health needs of new and expecting mothers and birthing parents. We are thankful, in the past, to have joined forces with DOHMH and the Bureau of Maternal, Infant and Reproductive Health on efforts to educate and train the MHQIN network on PMADs, support the Nurse Family Partnership with consultation regarding clients experiencing maternal mental health issues, provide support groups for NFP clients struggling with PMADs, among other efforts, but there is so much more that needs to be done.

We can look to other states and localities that have embarked on government led initiatives that have made a significant impact on decreasing PMAD rates. Some of these initiatives for NYC could include:

Establish a Maternal Mental Health Task Force

- Responsible for identifying the scope of PMADs on a local level and devising policy and practice recommendations.

Initiate a City-wide PMAD Public Awareness Campaign

- Implement a PMAD public awareness campaign aimed at defeating the stigma that surrounds maternal mental health, normalizing the challenging parts of becoming a mother, communicating basic PMAD symptoms, providing support and treatment resources.

Initiate a City-wide PMAD Education and Screening Initiative

- Train hospitals, behavioral health clinics, OBGYN and pediatric offices on what PMADs are and how to routinely screen for PMADS with appropriate instruments and dialogue. An attempt was made at this effort 5 year ago as part of Thrive NYC but it somehow evaporated.

Provide PMAD Prevention / Early Education Campaign

- Implement education programs targeting teenagers and young women around maternal mental health in attempts to normalize PMADs and defeat the stigma that surrounds maternal mental health in advance.

Implement a NYC Well Training

- Create a training program for NYC Well counselors to recognize the signs and symptoms of PMADs, train them on short-term PMAD best practices, and equip them with appropriate referrals.

Enhance Specialized PMAD Treatment

- Invest in effective and affordable maternal mental health treatment programs for low-income women
- Train behavioral health clinicians and other municipal mental health providers on PMAD best clinical practices.

We can do better. We can support and treat new and expecting mothers that are struggling with postpartum depression and anxiety, we can save lives.

Thank you again for the opportunity to testify. I will now take questions.

Public Hearing "Oversight—Maternal Health, Mortality, and Morbidity."
New York City Council Committee on Health
&
New York City Council Committee on Hospitals
Testimony of Patricia O. Loftman, CNM, LM, MS, FACNM
cnm788@gmail.com
June 29, 2022

Greetings,

Thank you for this opportunity to provide testimony on "**Oversight—Maternal Health, Mortality, and Morbidity"** before the New York City Council Committee on Health and the New York City Council Committee on Hospitals**.**

I am providing testimony on behalf of and represent New York Midwives (NYM) as the Black, Indigenous, People of Color Representative. New York Midwives is the professional organization that represents Certified Nurse Midwives and Certified Midwives in New York State.

My name is Patricia Loftman. I am a Certified Nurse Midwife. I graduated from Columbia University Graduate School of Nursing with a specialty in midwifery in 1981 and practiced full scope midwifery caring for women for three decades. I was the Former Harlem Hospital Center Midwifery Service Director from 1984-1999. I am a Fellow of the American College of Nurse Midwives, past Chair of the American College of Nurse Midwives, Midwives of Color Committee and past member of The American College of Nurse Midwives Board of Directors. I am currently a member of New York Midwives Board of Directors, the New York City Department of Health and Mental Hygiene's Maternal Mortality and Morbidity Review Committee Mental Health and Injury Subcommittee and a member of the Health Equity Workgroup of the Advisory Committee on Infant and Maternal Morbidity and Mortality (AICMM). AICMM makes recommendations to The Secretary of Health and Human Service.

I reviewed the package of legislations that will be presented today and make the following comments.

I respect that these legislations are the work product of individuals who have the best intentions and whose goal is to improve the health status and decrease the maternal morbidity and mortality of Black women and reproductive aged persons. However, the question that must be asked is what will be the impact of these legislations?

The medical and public health community have accepted the thesis that institutional racism generates racial and ethnic health disparities. Racism is the power to control the distribution of necessary resources guaranteeing equal access to the systems that affect all phases of one's life – political, economic, social and health. In an ideal world racism would not exist. Without racism everyone would have impartial and unimpeded access to effective political representation, decent housing in safe neighborhoods, quality education with access to gifted and talented education and specialized high schools, employment opportunity with a living wage, merit-based compensation and quality health care. Health disparities in racial and ethnic communities would disappear if racism did not exist.

Today, words such as institutional or structural racism, health equity, diversity and inclusion, birth equity, reproductive justice and social justice have become such an integral part our daily language that they no longer elicit the sting and bite that they once had. Legislators and policy makers are quick to lament that "we can't undo racism." But racism must be dismantled. Legislation and health care alone **cannot** alleviate or mitigate the dire consequences of racism that was and remains embedded in the foundation systems that continues to affect the daily lives of Black, Brown and Indigenous communities. Only when racism is dismantled will Black, Brown and Indigenous communities' health statistics achieve parity with White communities.

I have taken the liberty to organize the proposed legislations based on similar themes that I noted while reviewing them. However, the overarching them was that it appears that legislators are operating in silos. You're not communicating with one another. The result is that legislation is being introduced as novel when similar legislation already exists rendering the proposed legislation redundant. The problem is lack of monitoring and/or enforcement of what already exists and does not represent a judicious use of meager fiscal resources.

Legislation that currently exists in either identical or similar language.

Education about city standards for respectful care at birth, health care proxy forms and patients' rights. Public Advocate Jumaane Williams. *There currently exists a pamphlet titled New York Standards For Respectful Care at Birth. This pamphlet discusses education, informed consent, decision-making, quality of care, support persons and dignity and nondiscrimination. While it does not address workplace accommodations for breastfeeding, disability insurance or paid sick leave the pamphlet can be corrected and updated to include these topics. Nurses are among the largest group of educators, yet they are missing from the list of providers and should be added to list of persons providing education. Additionally, while doulas provide a valuable service to Black women and reproductive aged persons, they are not clinical providers which might be confusing to the public so this information should also be corrected when the pamphlet is updated. Additionally, it would be helpful to explicitly state the scope of practice of all care providers listed.* ***Appendix A.***

Increasing access to maternal mortality and morbidity data. This bill would require the Department of Health and Mental Hygiene to post the annual Maternal Mortality and Morbidity report on its website. Farah N. Louis

The New York City Department of Health and Mental Hygiene formed the Maternal Morbidity and Mortality Review Committee in 2018. The purpose of the committee is to reduce preventable maternal mortality in NYC, *and to eliminate inequities in these outcomes. This is accomplished through reviews of the records of each maternal death by which we gain a holistic understanding of the contributing factors that led to each maternal death and to identify actionable recommendations to prevent future maternal deaths. The report is published on the NYCDOHMH website. The last report is dated October 28, 2021. As the committee goal is to decrease maternal morbidity and mortality, the public deserves to know the hospital identity where maternal deaths occur. This information should be reported yearly. There currently exists a pamphlet titled Maternity Information Childbirth Services which provides information about childbirth practices and procedures in all hospitals in New York State including Cesarean Birth rates, Vaginal Birth after Cesarean Birth rates, episiotomy rates, and other statistics birthing people should rightfully have access to. Hospitals are required to forward the data to the New York State Department of Health. NYSDOH compiles the data which is then published and becomes the Maternity Information Childbirth Services pamphlet. NYSDOH distributes the pamphlet to hospitals throughout the state and each hospital is supposed to be distribute the pamphlets to women and reproductive aged persons seeking care.*

The value of obtaining this pamphlet is that receiving this information empowers Black women and reproductive aged persons with the information that they need to make an informed choice about the site where they choose to receive services. The problem is that few legislators, policy makers, hospitals or even the public is aware that this document exists. There is no accountability or enforcement placed on the hospitals to forward this legally required data to the NYSDOH. Choice increases birth equity and birth equity decreases maternal morbidity and mortality. Consequently, New York City Department of Health and Mental Hygiene should be mandated to protect Black women and reproductive aged persons by generating the ***New York City Maternity Information Childbirth Services with an enforcement process*** *rather than relying on a state process that does not currently appear to be working.* ***Appendix B. Appendix C.***

Establishing a pilot program in the department of health and mental hygiene to train doulas and provide doula services to residents in all five boroughs. Jennifer Gutiérrez. *There currently exists a report produced by the New York City Department of Health and Mental Hygiene titled, The State of Doula Care in NYC 2021 exists and can be accessed at:* ***https://www1.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2021.pdf***
The report outlines in detail issues surrounding challenges in providing women and birthing people with doula care in New York City. The report also identifies doula programs that have completed their initiatives, are ongoing, at risk or off track. ***Appendix D.***

An outreach and education campaign on the benefits and services provided by doulas and midwives.
Crystal Hudson. *The public is currently unaware that midwives are available and accessible in many hospitals throughout New York City. Public Service Campaign (PSC's), like the PSC's around COVID-19 vaccination, about the benefits of midwifery care and where to find a midwife facilitates and empowers women and reproductive aged persons to connect with one another.*

Legislation that has already been introduced at the state level that would include New York City.

Public education and outreach campaign on the risks of caesarean sections. Althea Stevens
New York State Assemblymember Amy Paulin has introduced two bills to address Cesarean Birth. The first, Cesarean Birth Consent Bill (A. 217 (Paulin) / S. 2736 (Salazar) informs maternity patients about the risks associated with Cesarean birth. ***Appendix E.***
The second, Cesarean Birth Review Board (A. 9714 (Paulin) establishes a review board to improve Cesarean birth rates and outcomes. ***Appendix F.***

The following package of legislations suggests that women and reproductive aged persons are not whole human beings with integrated systems.

Requiring the department of health and mental hygiene to report on polycystic ovary syndrome and endometriosis. Farah N. Louis*.* Women want and deserve to be seen as whole human beings. Data on polycystic ovarian syndrome is already being captured and reported as a subcategory on monthly departmental statistics. If legislators are having difficulty extrapolating the data a specific request for this data to be highlighted within monthly reports will resolve this issue.

Establishment of an office of sexual and reproductive health within the New York city department of health and mental hygiene. Julie Menin.

Creating a new office of sexual and reproductive health would focus attention specifically on women and reproductive aged persons issues. All issues would be aggregated in one place as women and reproductive aged persons issues as they deserve specialized attention which would uplift women's health care.

Operating budgets, at all levels - hospital, city agencies, city council are not limitless and must be wisely distributed. It's critical that all expenditures yield maximum value. How can the budgets attached to these legislations be better utilized?

Recommendations:

Policy: Rethink how data is captured. Currently, data is obtained from each institutions via monthly reports. Data is also extracted from the maternal morbidity and mortality report. However, missing are the voices of the women and reproductive aged persons who utilize the services and who are most affected by the care that they receive. They have the answers. Create health delivery systems based on what they want not what policy makers believe they should receive. What is their perception of the quality of the primary and reproductive care that they have received?

Women and reproductive aged persons want respectful care based on a relationship. Black, Brown and Indigenous Women Reported That The Perinatal Care System Currently Available To Them Does Not Provide Them Access To Care By The Provider of Their Choice.
They report that the Ideal Perinatal System Would Have:

- More access to care by midwives.
- A midwife or doctor who shares their heritage, race, ethnic or cultural background.
- A provider with whom they can develop a trusting relationship.
- A doctor or midwife who is a good match for what they value and want for pregnancy and birth care.
- Continuity of care throughout pregnancy and birth.
- Shared decision making.
- A pregnancy and birth free of mistreatment.
- A pregnancy and birth characterized by respect, privacy, and dignity.
- A pregnancy free of pressure to accept interventions and procedures

https://www.birthplacelab.org/wpcontent/uploads/2019/03/GVTMExecSummary.pdf

Also missing are the voices of the leadership at the local level who women and reproductive aged persons identify as their advocates. For example, on bodies such as The New York City Maternal Morbidity and Review Committee how are the voices of the women represented? What is the racial and ethnic composition of the committee? Are there midwives, doulas, community health workers present who represent the geographic corners of the city? Or is the committee composed of providers who Black women and reproductive aged persons report have failed to render respectful care? Unpacking the issue around committee composition is critical because committee composition dictates the discussion direction and the recommendations that are put forth. Entities or organizations that have historically opposed policies that support birthing people choices or are not supportive of a shared decision-making

model of care should be precluded from participating on The New York City Maternal Morbidity and Review Committee.

Service Delivery: Black women and reproductive aged persons want access to midwives. One recommendation from the NYC Maternal Morbidity and Mortality Committee is that midwives must be integrated into obstetrical departments throughout the NYC. This recommendation is consistent with research findings that, "Poor coordination of care across providers and birth settings has been associated with adverse maternal-newborn outcomes. The integration of midwives into regional health systems is a key determinant of optimal maternal-newborn outcomes.
https://doi.org/10.1371/journal.pone.0192523

In closing, I hope that the message you hear from my testimony is that the proposed legislations were on the right track. It's just that they already exist. So, go back to the drawing board, identify, center and include in your deliberations those credible leaders and providers who possess historical knowledge about policy and service delivery, who align and integrate reproductive health care with social justice and cultural norms.

Testimony of

Deidre Sully, MPH
Senior Director of Health Policy and Community Affairs

On Behalf of

Public Health Solutions

Before the

New York City Council Committees on Health and Hospitals

Regarding

Oversight- Maternal Health, Mortality, and Morbidity

PURPOSE: To examine the quality of and access to perinatal care, as well as perinatal and maternal morbidity and mortality.

New York City
City Hall, City Council Chambers
June 29th, 2022, 10:00 a.m.

Public Health Solutions at 40 Worth Street, 4th Floor, New York, NY 10013
(646) 619-6450 | DSully@healthsolutions.org | www.healthsolutions.org

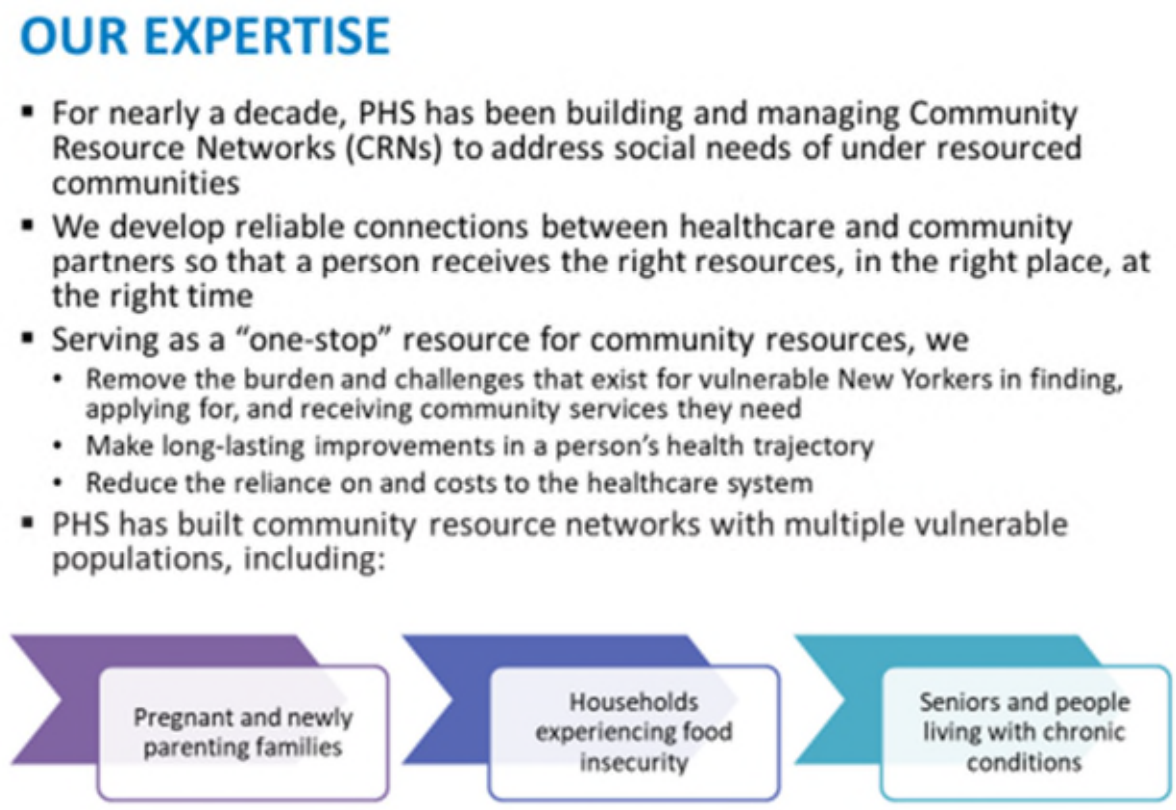
To the New York City Council Committee on Health and Committee on Hospitals, I thank you for your time today and your commitment to learning about and addressing maternal health access and equity. My name is Deidre Sully, I'm the Senior Director of Health Policy and Community Affairs at Public Health Solutions (PHS). At PHS, we work to support vulnerable NYC families in achieving optimal health and building pathways to reach their potential. PHS is working towards a city where New Yorkers have a fair and just opportunity to be healthy.

According to the Maternal Morbidity and Mortality Review Committee, every year in NYC we lose 25-30 mothers to a pregnancy-related death. There are thousands more who experience severe maternal morbidity, or significant complications where a mother almost loses their life. There are multiple driving factors leading to these outcomes and as you will have heard today, the inequities in these outcomes are stark and unacceptable, with Black/African American mothers experiencing perinatal morbidity or mortality at rates significantly higher than white mothers. In fact, some of the biggest risk factors for maternal morbidity and mortality are often driven by pre-existing chronic and/or mental health conditions. Nearly 70% of deaths of new mothers in recent years have had racial discrimination as a contributing factor.

Structural racism is the root cause of disparities in perinatal health and cannot be overlooked. It is known that patients respond better to providers that represent a shared lived experience. Many Black/African American women are denied optimal care because providers fail to impart and engage them with respect and dignity. Furthermore, 75% of pregnancy-related deaths of Black mothers are deemed to be preventable. Building capacity and opportunities to train black and indigenous persons of color as healthcare providers within the community is one step to decreasing the implicit bias that results in racial discrimination.

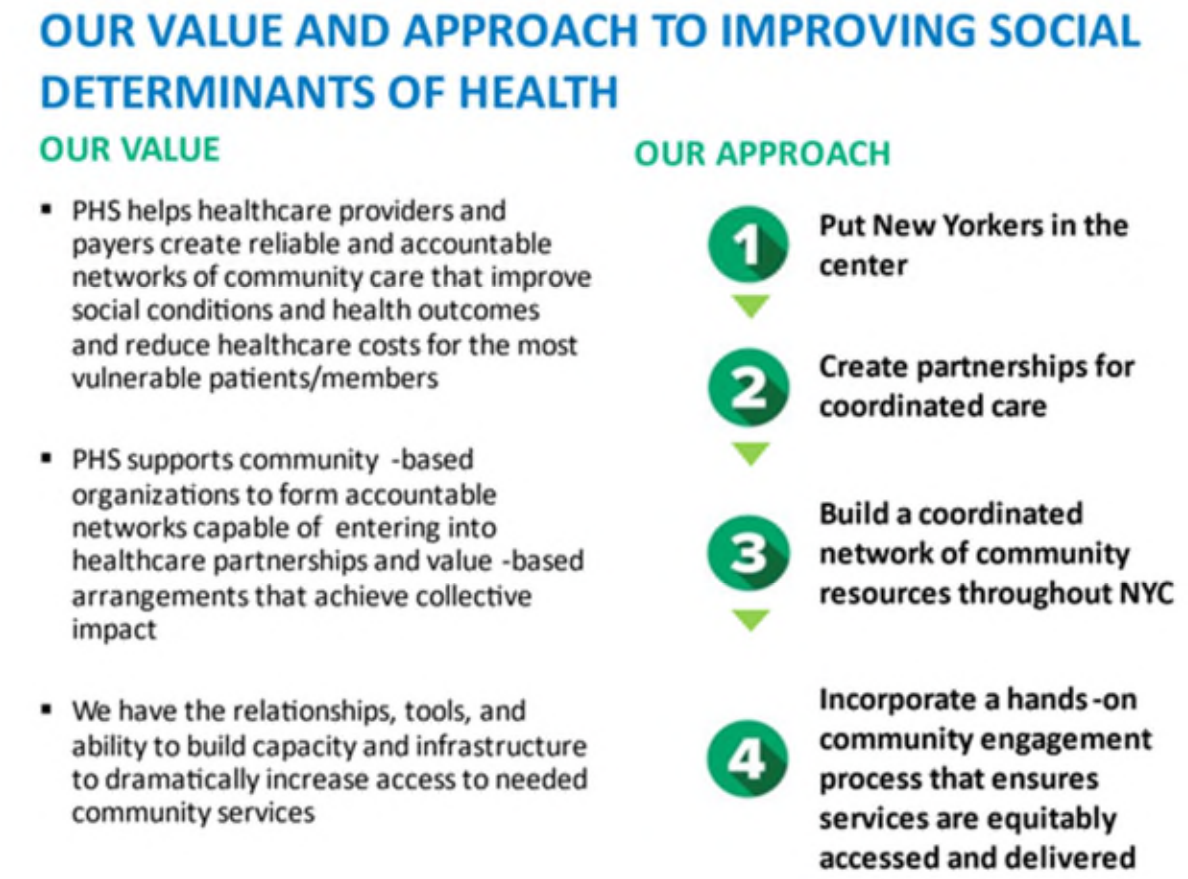
There are many critical touchpoints in the life of a pregnant or newly parenting family that heavily influence health and wellness. Our currently fragmented health and social service system creates barriers to optimal health, as opposed to providing an easily accessible, seamless care pathway before, during, and after pregnancy, especially for women of color and people with chronic and/or mental health conditions. Up to 80% of a person's health is driven by non-clinical factors and it is essential that we match clinical approaches to maternal morbidity and mortality prevention with community-based approaches. People do not live their lives in hospitals; they live in the community, and our approach to health, wellness, and prevention must be community

driven.



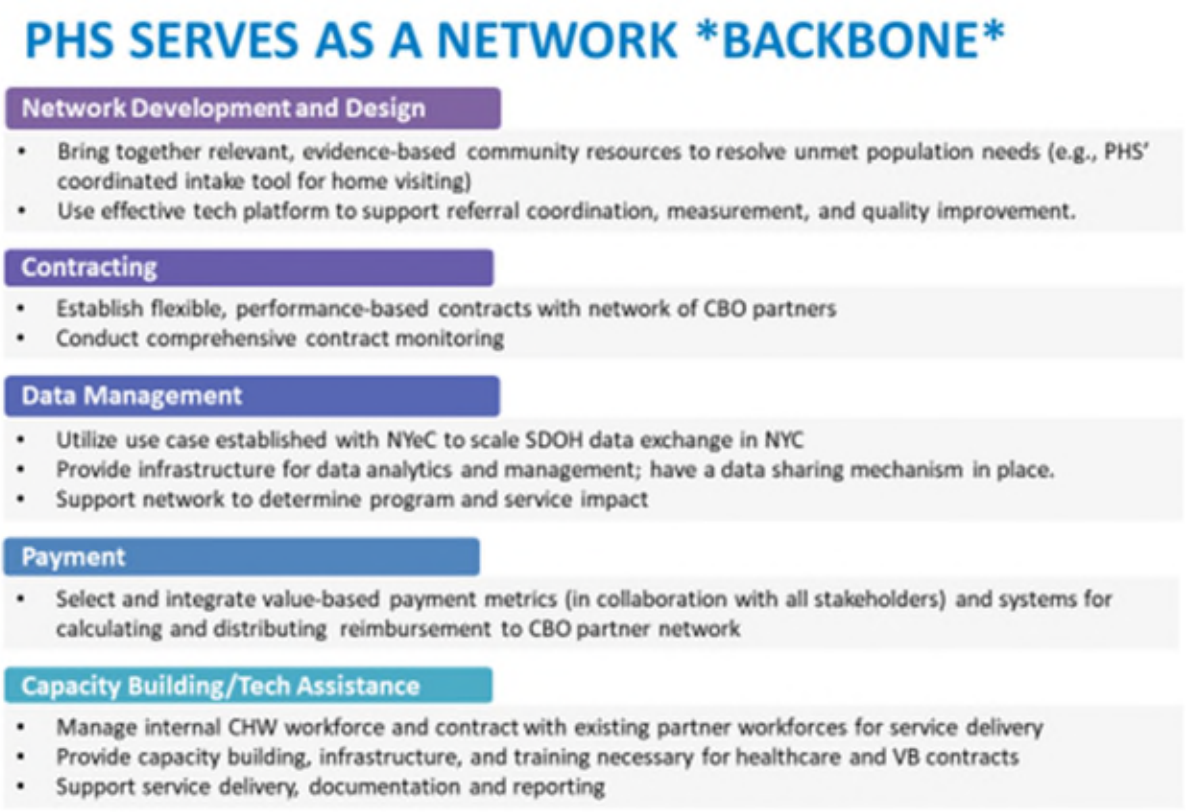
Strengthening maternal child health systems of care, and individual and family health and well-being, are powerful drivers of equity. At Public Health Solutions, we are creating partnerships and a technology driven network between clinical care providers, managed care payers, and community-based organizations providing maternal child health services to strengthen the

system of care and to unify access to proven programs that enhance maternal child health.



Research is very clear that increasing access across the perinatal continuum to home visiting and family support services improves health, stability, and outcomes related to the social determinants of health. These community-based services are essential to reducing racial/ethnic disparities in maternal and child health and reversing trends and inequities in New York's

maternal morbidity and mortality crisis.



Because health services are often fragmented and uncoordinated, PHS is working to implement a strong community resource network that connects New Yorkers to home visiting, doula care, breastfeeding support, fatherhood support, education on the NYC Standards for Safe and Respectful Care at Birth, and resources related to the social determinants of health.

Public Health Solutions is working to better integrate and streamline clinical and community services in support of pregnant and parenting New Yorkers. For example, for the Helping Promote Birth Equity through Community-Based Doula Care (or HoPE project), clinical providers at H+H/Elmhurst and Queens Hospitals utilize our Queens Family Connect coordinated intake and referral network in NowPow to make referrals for doula services. This community-clinical partnership helps to ensure that hospital providers, community-based organizations, and residents agree about and understand the role and value of doula care and helps to ensure hospital buy-in. It is also paramount that as the City of New York and DOHMH seek to fund community-based organizations to meet the needs of pregnant and parenting New Yorkers, that

they also work to build capacity and support CBO infrastructure and staff development to meet these new demands, as the quantity of service referrals can quickly become overwhelming.

Where you live and where you give birth should not dictate whether you live or die. Efforts to advance quality clinical care and anti-bias and discrimination in the hospital setting must be paired with comprehensive community support systems and infrastructure development for us to collectively move the needle on maternal morbidity and mortality.

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Public Health Solutions - the largest public health nonprofit organization in New York City, improves health among New York City's most vulnerable populations by tackling social, physical, and environmental factors that impact New Yorkers' ability to thrive. Today, PHS serves 200,000+ New Yorkers annually, and we support the work of more than 200 community-based nonprofit organizations. We implement innovative, cost-effective population-based health programs; conduct research providing insight on effective public health interventions; and provide services to government and other nonprofits to address public health issues. Together with our colleagues in the social services sector, government, philanthropy and policy organizations, we are thought leaders and cutting-edge public health professionals in New York City and New York State. To learn more, please visit us at http://www.healthsolutions.org.

Polonians Organized to Minister to Our Community, Inc. (POMOC)
Testimony: Long-Term COVID Treatment in New York City Hospitals

My name is Eva Kornacka and I am the Executive Director at Polonians Organized to Minister to our Community, Inc. (POMOC). POMOC serves approximately 3,000 clients annually, our target population are low-income immigrants predominately from Poland and other Eastern European countries. Many of them have very limited or no English language skills, making them severely disadvantaged due to lack of information and communication barriers.

For nearly 40 years we have been a direct service provider in public benefits entitlements, managed healthcare assistance, senior services, immigration-related assistance and housing and employment assistance.

The issue of this testimony is very personal to me in many ways. I myself am a COVID-19 long hauler, a term that is difficult to fully understand for so many including the medical profession providers. Most people who have tested COVID positive, experience a few days of illness or discomfort and after that regained their health.

For many who where not that fortunate the consequences continue to make their life a nightmare. It is estimated that approximately 10% of COVID-19 positive patients will develop long-term medical complications ranging from mild to very severe regardless of age and underlying conditions. Since this condition is fairly new there has not been that much research done on the subject and statistics to go by. I have made it my mission to speak about this condition and educate our community. During our small group NYC ACCESS HEALTH presentations I talk to our clients about my personal experience and invite them to share with the group. Many of them being in a safe and trusted environment and speaking in their native language, are willing to open up and tell us about what they have been through. The common theme is that they have received none or very little support or understanding from their medical providers, for those without health insurance it is even worse. Doctors are frequently unreceptive to their patients concerns and some have even been told to "shake it off" or "it will go away eventually". Not ONE of them has been offered any form of Long-Term COVID treatment in a NYC Hospital. No one assumes ignorance on behalf of the providers, maybe just lack of updated guidance on how to counsel and treat such patients. In the meantime people affected by this condition have a very poor quality of life, develop depression and other mental health issues as well as just

to name a few such as heart and lung complications, loss of employment and family related problems.
Thank you for this opportunity to submit our testimony before the New York City Council.

Sincerely,
Eva Kornacka

Legislative Affairs
One Whitehall Street
New York, NY 10004
212-607-3300
www.nyclu.org

Testimony of the New York Civil Liberties Union Before the New York City Council Committees on Health and Hospitals

Regarding

Oversight: Maternal Health, Mortality, and Morbidity

June 29, 2022

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding maternal health, mortality, and morbidity. The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices across the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing. The NYCLU supports legislation under consideration by these Committees that improves access to non-discriminatory health care and provides these comments on the bills and resolutions on the agenda today.

The NYCLU strongly supports improving access to the full spectrum of quality reproductive and pregnancy-related health care that empower people to make decisions about their lives, bodies, and families. Especially in the wake of the *Dobbs v. Jackson* decision overturning *Roe v. Wade*, New York must affirm pregnant people's bodily autonomy and right to receive safe and respectful care of their choosing. Collectively, the measures before the committee advance this objective by expanding patients' access to information and modalities of care so they are empowered to make the health care decisions that are right for them.

As New York positions itself as an access state for people around the country seeking reproductive care, the city must ensure it supports care that is accessible, patient-centered, and culturally competent. Even before the *Dobbs* ruling, reproductive

freedom and bodily autonomy remained a fiction for many pregnant people—especially those who are Black, Brown, Latinx, immigrant, and/or low-income. In New York City, Black maternal mortality rates remain startlingly high,[1] and pregnant people are frequently drug tested without their consent[2] and even forced to receive medical procedures against their will.[3] The bills before the committees today are much-needed steps toward empowering patients, improving outcomes, and reducing disparities.

In particular, expanding access to community-based doulas is a key step New York City can take to improve reproductive health care experiences. Doulas are associated with improved maternal health outcomes and lower rates of medical intervention in birth.[4] They can also play a role in combatting discrimination and bias in health care settings by advocating for their patients, while fostering their sense of power, autonomy, and trust.[5]

Additionally, the NYCLU hopes that Int. 0086, providing for public education about pregnant patients' rights, including the right to be free from discrimination related to their pregnancy status, will improve the tenor of interactions between patients and providers, and promote respect, autonomy, and patient-centered care.

The measures before the committees today represent important steps forward at a time of devastating national regression. The NYCLU is grateful for the Council's commitment to working towards reproductive health, justice, and equity, and is eager to continue to collaborate with you in support of these and future efforts.

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[1] In 2017, the most recent year for which data is available, Black mothers gave birth to 23% of New York City newborns, yet accounted for 55% of maternal deaths. Public Advocate Jumaane Williams, *NYC Public Advocate Releases Report on Maternal Health Inequities* (Nov. 11, 2021), https://pubadvocate.nyc.gov/press/nyc-public-advocate-releases-report-maternal-health-inequities/#:~:text=In%202017%2C%20Black%20women%20gave,insurance%20or%20socio%2Deconomic%20status; *see also* Public Advocate Jumaane Williams, *White Paper: Equitable Pregnancy Outcomes for Black and Brown New Yorkers* (2021), https://files.constantcontact.com/1c58f85b001/12ddd072-50eb-45ec-8bb7-28ab09ed45ce.pdf?rdr=true.

[2] *See* NYC Commission on Human Rights, *New York City Commission on Human Rights Launches Investigations Into Three Major Private Hospital Systems' Practices of Drug Testing Newborns and Parents*, Press Release (Nov. 16, 2020), https://www1.nyc.gov/assets/cchr/downloads/pdf/press-releases/Hospitals_Press_Release_11-16-2020.pdf.

[3] *Dray v. Staten Island Univ. Hosp.*, 74 N.Y.S.3d 69 (2018); See also National Advocates for Pregnant Women, *Rinat Dray Decision Proves How Hard it is for Women Subjected to Forced Surgeries to Get Justice* (Apr. 23, 2018), https://www.nationaladvocatesforpregnantwomen.org/rinat-dray-decision-proves-hard-women-subjected-forced-surgeries-get-justice/.

[4] Nora Ellmann, *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*, Center for American Progress (Apr. 14, 2020), https://www.americanprogress.org/article/community-based-doulas-midwives/.

[5] Id.

Good Morning my name is Charlene Magee, I am the aunt of Denise Williams. On August 28, 2021 my niece sought help for postpartum Depression at Queens Hospital Center. On August 30, 2021 Denise was DEAD! As a result my Family and I have became Advocates for Maternal Health. We are fighting for Doula's and Birthing Centers for those who fear having their babies in Hospitals

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Janet Peguero, Deputy BxBP

Address: _____

I represent: Bronx Borough President Vanessa L. Gibson

Address: _____

THE COUNCIL
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Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Teresa Ginger Davis

Address: 1 St. Johns Place

I represent: Sickle Cell/Thalassemia Patients Network

Address: _____

THE COUNCIL
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Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Patricia Loftman

Address: _____

I represent: New York Midwives

Address: _____

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Laura Lawson, Assistant Commissioner

Address: _____

I represent: NYC Health Department

Address: _____

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Tara Stein, Medical Director

Address: _____

I represent: NYC Health Department

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

(1)

I intend to appear and speak on Int. No. All Res. No. All

☒ in favor ☐ in opposition

Date: 6/29/22

(PLEASE PRINT)

Name: Paige Bellenbaum, LMSW

Address: _____

I represent: The Motherhood Center

Address: 205 Lexington Ave. 10th Fl
NY, NY 10016

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Appearance Card

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☐ in favor ☐ in opposition

Date: 6/29/2022

(PLEASE PRINT)

Name: Michelle Morse, MD (Medical Director)

Address: Deputy Commissioner

I represent: NYC Health Department

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Machelle Allen

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 508 Res. No. _____

☐ in favor ☐ in opposition

Date: 6/29/22

(PLEASE PRINT)

Name: Daniel Pollak

Address: 22 Cortlandt St., 14th Floor

I represent: Mayor's office of Labor Relations

Address: 22 Cortlandt St, 14th Floor

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 508 Res. No. _____

☐ in favor ☐ in opposition

Date: 6/29/22

(PLEASE PRINT)

Name: Claire Levitt

Address: _____

I represent: Office of Labor Relations

Address: 22 Cortlandt Street NYC

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