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THE COUNCIL OF THE CITY OF NEW YORK

BRIEFING PAPER AND COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION
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COMMITTEE ON HEALTH
Hon. Mark Levine, Chair

COMMITTEE ON WOMEN
Hon. Helen Rosenthal, Chair

June 27, 2018

Oversight: Maternal Mortality in New York City

INTRODUCTION NO. 913	By Council Members Rosenthal, Ampry-Samuel, Cumbo, Rivera, Chin, Levin, Levine and Ayala
TITLE:	A Local Law to amend the administrative code of the city of New York, in relation to access to doulas in New York City
ADMINISTRATIVE CODE:	Adds new section 17-199.9

INTRODUCTION NO. 914	By Council Members Rosenthal, Cumbo, Rivera, Chin, Ampry-Samuel, Levine, Ayala and Levin
TITLE:	A Local Law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality
ADMINISTRATIVE CODE:	Amends section 17-199.3; Adds new section 17-199.3.1

I. INTRODUCTION

On June 27, 2018, the Committee on Women, chaired by Council Member Helen Rosenthal, and the Committee on Health, chaired by Council Member Mark Levine, will hold a joint hearing examining maternal mortality in New York City (NYC). The Committee on Women will also hear Int. No. 913, a local law to amend the administrative code of the city of New York, in relation to access to doulas in NYC, and Int. No. 914, a local law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality. Witnesses invited to testify include representatives from the Department of Health and Mental Hygiene (DOHMH) and the Public Advocate, as well as advocacy groups, hospitals, medical training programs, doula organizations, labor unions and other stakeholders.

II. BACKGROUND

The ability to protect the health of mothers and babies in childbirth is a basic measure of a society's development.[1] Yet, not only are more women in the United States (U.S.) dying of pregnancy-related complications than in any other developed country, but only in the U.S. has the maternal mortality ratio (MMR), or the number of maternal deaths in a population that occur during a given year per 100,000 live births,[2] been increasing.[3] From 2000 to 2014, the MMR in the U.S.

[1] MacDorman MF, Declercq E, Cabral H, Morton C., *Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues*, Obstetrics and gynecology (2016), 447-455, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf.

[2] *See* "Maternal mortality ratio (per 100 000 live births)" World Health Organization, available at http://www.who.int/healthinfo/statistics/indmaternalmortality/en/. The World Health Organization (WHO) defines maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."

[3] *See* "Table 2. Estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births), number of maternal deaths, and lifetime risk by United Nations MDG regions, 2008;" *see also* "Annex 3. Comparison of 1990, 1995, 2000, 2005, and 2008 estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births) by country," World Health Organization, et al., Trends in maternal mortality: 1990 to 2008 (2010), 18, 28-32, *available at* http://apps.who.int/iris/bitstream/handle/10665/44423/9789241500265_eng.pdf;jsessionid=E07455C2099CB48EE28744F5BAAA2C34?sequence=1.

has increased by an estimated 26.6 percent.[4] Each year, 700-900 American women die and approximately 65,000 suffer potentially mortal complications from pregnancy- or childbirth-related causes.[5] Furthermore, according to a recent report from nine different maternal mortality review committees, over 60 percent of these pregnancy-related deaths were preventable.[6]

Health inequities significantly impact pregnancy outcomes. According to the Centers for Disease Control and Prevention (CDC), Black women in the U.S. are three to four times more likely to die from complications related to pregnancy than white women.[7] For Black women, the MMR is 42.8 per 100,000 live births, compared with 12.5 for white women and 17.3 for women of all other races.[8] Such disparities also affect birth outcomes. Government data suggest that Black infants are more than twice as likely to die as white infants; 11.3 per 1,000 Black babies, compared with 4.9 per 1,000 white babies, a racial disparity that is actually greater than in 1850, 15 years before slavery was abolished in the U.S. [9] Research points to race, rather than educational attainment or income level of the patient, as the cause of such discrepancies.[10] In fact, a Black woman with an

[4] M. MacDorman, E. Declercq, H. Cabral, C. Morton, *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues*, OBSTETRICS AND GYNECOLOGY 447-455 (2016), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf.

[5] Nina Martin and Renee Montagne, *Focus On Infants During Childbirth Leaves U.S. Moms In Danger*, NATIONAL PUBLIC RADIO and PROPUBLICA (May 12, 2017), *available at* https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger.

[6] *Building U.S. Capacity to Review and Prevent Maternal Deaths* (2018), *available at* http://reviewtoaction.org/Report_from_Nine_MMRCs.

[7] Centers for Disease Control and Prevention, *Pregnancy-Related Deaths, available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.

[8] Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System, available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.

[9] Linda Villarosa, *Why America's Black Mothers Are in a Life-or-Death Crisis*, NEW YORK TIMES (Apr. 11, 2018), *available at* https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html; *See also* J.D.B. De Bow, *Mortality Statistics of the Seventh Census of the United States 1850* (last visited June 15, 2018), *available at* https://babel.hathitrust.org/cgi/pt?id=uc2.ark:/13960/t4qj7qt8w;view=1up;seq=40 (showing that the government started to track vital statistics related to mortality, disaggregating info by sex and race, in 1850); University of Minnesota, *Vital Statistics of the U.S., 1850-Present* (last visited June 15, 2018), available at https://www.lib.umn.edu/govpubs/vitalstats_guide.

[10] *Id.* (explicitly making this point and explaining, "by the late 1990s, other researchers were trying to chip away at the mystery of the black-white gap in infant mortality. Poverty on its own had been disproved to explain infant mortality, and a study of more than 1,000 women in New York and Chicago, published in The American Journal of Public Health in 1997, found that black women were less likely to drink and smoke during pregnancy, and that even when they had access to prenatal care, their babies were often born small …. Though it seemed radical 25 years ago,

advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education.[11]

III. MATERNAL MORTALITY IN NYC

New York City and State have among the highest rates of maternal deaths in the country. Although the city's MMR is slightly above the national average, NYC accounts for about 30 of the estimated 700-900 women who die from pregnancy or childbirth-related causes each year nationally.[12] According to the New York State Department of Health (DOH), the MMR in NYC was 31 per 100,000 live births in 2015.[13] Moreover, research shows that racial disparities can have an impact on a person's health outcomes and care in NYC. Statistics show that while about 30 women in NYC die each year of a pregnancy-related cause, approximately 3,000 women "almost die," or experience morbidity during childbirth.[14] The World Health Organization (WHO) defines maternal morbidity as a spectrum ranging from the near death of a woman who has survived a complication occurring during pregnancy or childbirth (or within 42 days of the termination of pregnancy) to non-life-threatening morbidity.[15] Black, non-Latina women are the most likely to experience maternal mortality or maternal morbidity.[16] Additionally, a recent study published in

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few in the field now dispute that the black-white disparity in the deaths of babies is related not to the genetics of race but to the lived experience of race in this country").

[11] Richard V. Reeves and Dayna Bowen Matthew, *Six Charts Showing Race Gaps Within the American Middle Class*, BROOKINGS (Oct. 21, 2016), *available at* https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class/.

[12] The top causes of U.S. pregnancy-related deaths in 2011 were cardiovascular disease, 15.1 percent; non-cardiovascular disease, 14.1 percent; infection or sepsis, 14 percent; and hemorrhage, 11.3 percent. *See* Robin Fields, *New York City Launches Committee to Review Maternal Deaths*, PROPUBLICA (Nov. 15, 2017), *available at* https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, NEW YORK TIMES (Apr. 11, 2018), available at https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[13] "New York State Maternal Mortality Rate per 100,000 Live Births." *New York State Department of Health*, Oct. 2017, www.health.ny.gov/statistics/chac/birth/b33_999.htm.

[14] *See* New York City Department of Health and Mental Hygiene, *Severe Maternal Morbidity in New York City, 2008-2012* (2016), *available at* http://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf.

[15] *See* World Health Organization, *Measuring Maternal Health: Focus on Maternal Morbidity* (last visited June 20, 2018), *available at* http://www.who.int/bulletin/volumes/91/10/13-117564/en/.

[16] *Id.*

the American Journal of Obstetrics and Gynecology found that Black women in NYC are more likely to give birth in hospitals that already have a high rate of severe maternal morbidity or complications than white women. Only 23 percent of Black patients gave birth in the safest hospitals, compared 63 percent of white patients.[17] At the city level, recent data suggests Black mothers in NYC are 12 times more likely to die from pregnancy-related causes than white mothers.[18] From 2006 to 2010, residents of the Bronx had the highest pregnancy-related mortality ratio with 26.0 deaths per 100,000 live births, followed by Brooklyn with 25.7, Queens with 24.6, Staten Island with 17.4 and Manhattan with 13.9.[19]

Several factors appear to have a positive influence on outcomes for persons giving birth in NYC, including the presence of a doula.[20] A recent report reveals that women who had doula support were 39 percent less likely to have a caesarean section (C-section), and 15 percent more likely to give birth without needing drugs or labor-inducing techniques.[21] Additionally, a survey regarding doula care in NYC reveals that 72 percent of women reported that their doula helped them communicate their preferences and needs, while 80 percent of those surveyed reported that their doula helped them feel more empowered.[22] Furthermore, 83 percent of the surveyed women

[17] CNN, *Childbirth is Killing Black Women in the U.S., and Here's Why*, CNN (Nov. 15, 2017), *available at* https://www.cnn.com/2017/11/15/health/black-women-maternal-mortality/index.html; Rates were also high among Puerto Rican and other Latina women compared to White non-Latina women and overall when examining other risk factors. *Pregnancy-Associated Mortality in New York City, 2006-2010* (2015), *available at* https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf.

[18] ProPublica, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017), *available at* https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth.

[19] Rates were also high among Puerto Rican and other Latina women compared to White non-Latina women and overall when examining other risk factors. *Pregnancy-Associated Mortality in New York City, 2006-2010* (2015), *available at* https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf (providing data based on maternal borough of residence).

[20] A *doula* is a trained professional who provides continuous physical, emotional and informational support to 4 a pregnant person and the family before, during and shortly after childbirth.

[21] Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.

[22] "Doula Care in New York City: Advancing the Goals of the Affordable Care Act." *Choices in Childbirth*, 28 Oct. 2014, https://choicesinchildbirth.org/wp-content/uploads/2014/10/Doula-Report-10.28.14.pdf.

reported that having a doula made their labor and birth experience "much better" than if they had not used a doula, and it made them more relaxed before, during, and after birth.[23] However, 88 percent of this cohort reported that cost was an issue when opting to work with a doula.[24]

IV. Maternal Mortality in the Media

Serena Williams and Highlighting Racial Inequities

Recently, the issue of maternal and infant mortality and morbidity has garnered attention in the media. In January 2018, Vogue magazine profiled American professional tennis player Serena Williams about the life-threatening health emergency she experienced after giving birth to her first child.[25] Williams explained that while she had an "enviably easy pregnancy"[26] and her C-section was successful, her health abruptly deteriorated the day following her surgery when she began experiencing a pulmonary embolism and shortness of breath.[27] However, when the No. 1 ranked player in the Women's Tennis Association, who is Black, told the nurses she needed a computed tomography (CT) scan and a blood thinner right away,[28] she was ignored despite her documented history of the condition.[29] Instead of providing Williams with the scan, they ordered an ultrasound of her legs, which revealed nothing.[30] After once again requesting a CT scan and being ignored, blood clots were discovered in Williams' lungs; a common side effect of a C-section.[31]

[23] *Id.*

[24] *Id*. The average fee for doula services in NYC is $1200, which includes one prenatal visit, labor support, and a postpartum follow up visit. However, fees can range from $150 to $2800 per birth depending on experience.

[25] Vogue, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, available at https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018 (last visited June 7th 2018)

[26] *Id.*

[27] *Id.*

[28] *Id*.

[29] *Id.*

[30] *Id*.

[31] *Id*

Williams' self-diagnosis was not only correct, but her persistence and awareness of her own body as a professional athlete saved her life.

Further aggravating the situation, Williams began coughing from her pulmonary embolism while she was being given intravenous therapy (IV), which caused her C-section scar to open and her abdomen to fill with blood.[32] Williams, again, had to return to surgery to have a filter inserted into a major vein to prevent clots from entering her lungs, forcing her to spend the next six weeks on bed rest.[33] Williams' experience is the most high-profile story highlighting how U.S. pregnancy-, and childbirth-related deaths disproportionately affect Black women, regardless of income or education, and illustrates that Black women's medical concerns and pain are typically not taken as seriously as those of white women.[34] Williams should have been able to depend on the care and treatment during childbirth, yet, her medical team failed to diagnose and monitor her for common complications after delivery, despite Williams voicing her concerns.

The New York Times Story and Inequities in New York

While there have been a slew of other recent articles focused on maternal mortality, maternal morbidity and race,[35] the issue garnered even wider attention in April 2018 when a New York Times Magazine cover story profiled Black infant mortality and maternal mortality and morbidity of Black mothers.[36] As discussed in the article, there is now a growing acceptance amongst the medical

[32] *Id.*

[33] *Id*

[34] *Supra* note 7.

[35] http://observer.com/2018/02/how-do-we-fix-high-maternal-death-rates-among-black-women-in-america/; https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why; https://www.americanprogress.org/issues/women/reports/2018/05/10/450577/health-care-system-racial-disparities-maternal-mortality/; https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger; https://citylimits.org/2016/07/26/when-new-moms-get-sick-race-and-hospitals-matter/; https://www.nytimes.com/2018/04/20/opinion/childbirth-black-women-mortality.html.

[36] New York Times, *Why America's Black Mothers and Babies are in a Life-or-Death Crisis*, available at https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html (last visited June 7th 2018)

community that "toxic stress and trauma" and ongoing, chronic exposure to racism, violence, poverty and unemployment[37] can be a disproportionately strong predictor of whether a baby will be healthy or experience complications.[38] There is a strong correlation with race and these factors, as disparities for poor women and women of color in any context can lead to chronic conditions and stress.[39] Stress results in higher rates of medical conditions, including hypertension and pre-eclampsia.[40] The article also identified institutional policies that effectively dismiss the legitimate concerns and symptoms of Black women, such as when Serena Williams's nurse dismissed her complaints, assuming the pain medicine might be making her confused." Ignoring legitimate concerns and requests can help explain poor birth outcomes, even in cases of relatively privileged Black women like Williams.[41]

V. Recent Initiatives

In addition to the media focus on maternal mortality, there have been a number of recent government initiatives meant to address the issue. In March 2017, the NYC Council passed the Maternal Mortality Reporting Law, or Local Law 55 of 2017,[42] which requires DOHMH to issue an annual report on maternal mortality, tracking statistics in four areas.[43] In December 2017,

[37] Why More Black Women Die in Labour - and What NYC Is Doing about It." *Apolitical*, 14 Sept. 2017, apolitical.co/solution_article/childbirth-deadly-black-women-now-new-york-acting/.

[38] *Ibid.*

[39] *Id.*

[40] *Supra* note 7.

[41] *Id.*

[42] http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2709929&GUID=32D3EE5A-6F06-479D-BA51-F64D29EBAF6B&Options=ID|Text|&Search=55

[43] The four areas are: (1) The number of maternal mortalities, disaggregated by race or ethnicity and borough of residence; (2) The maternal mortality ratio, disaggregated by race or ethnicity and borough of residence where available and statistically reliable; (3) Recommendations regarding actions the department, the mayor, and the Council can take to improve maternal health, particularly in disproportionately impacted communities, and reduce maternal mortality; and (4) An update on the implementation of the recommendations made in previous reports made pursuant to this section regarding actions that the department or mayor can take to improve maternal health and reduce maternal mortality, if any.

DOHMH formally launched a city-specific Maternal Mortality and Morbidity Committee (M3-RC, M3RC, or "the Panel"), composed of up to 45 members, including doctors, nurses, the doula community, researchers, first responders and experts from various facilities and community based organizations.[44] The M3RC was a direct result of recommendations from the first annual Local Law 55 report, which was received by the Council in November 2017. The M3RC is expected to convene four times a year to examine maternal deaths, as well as to compile and analyze data on severe complications experienced by expectant and new mothers.[45]

In addition, in January 2018, Governor Cuomo announced a proposal to create a State Maternal Mortality Review Board ("Board") to review of each maternal death.[46] The plan is for DOH to convene a Board of diverse experts to conduct a confidential review of each maternal death, determining whether death was preventable and to identify recommendations. This Board proposal stems from recommendations from the New York State Council on Women and Girls (CWG),[47] and should to align with the objectives of the New York State Prevention Agenda 2013-2018: New York's State Health Improvement Plan, to track prevention objectives annually.[48] Further, on April 23, 2018, the Governor announced a series of additional new initiatives focused

[44] *See* Robin Fields, New York City Launches Committee to Review Maternal Deaths, PROPUBLICA (Nov. 15, 2017), *available at* https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths ("The Committee will holistically review every maternal death in NYC, using the CDC's Maternal Mortality Review Information App, MMRIA, which facilitates the collection of maternal death data and builds a database for national, standardized maternal death reporting").

[45] For every death, experts say there are dozens of cases of such complications, affecting more than 50,000 American women each year. *Id.*

[46] Note that both the Maternal Mortality Review board and 2010 Maternal Mortality Review initiative are (confusingly) referred to by the acronym "MMR." https://www.governor.ny.gov/news/governor-cuomo-announces-efforts-combat-maternal-depression-and-prevent-maternal-mortality (The governor directed the Department of Financial Services to require that all health insurance policies include coverage for maternal depression screening and that DOH and Office of Mental Health will launch a strategic awareness campaign to address stigma of maternal depression)

[47] https://www.governor.ny.gov/news/governor-cuomo-unveils-2018-womens-agenda-new-york-equal-rights-equal-opportunity

[48] NY's blueprint for state and local to improve health in five priority areas and reduce health disparities for racial, ethnic, disability, and low socioeconomic groups. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/; The Prevention Agenda aimed to reduce maternal mortality in NY by 10 percent (to 21.0 per 100,000 live births) and improve the racial and ethnic disparities in the state maternal death rate by 10 percent by 2018. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/tracking_indicators.htm

on Maternal Mortality and Disparate Racial including another taskforce, a pilot to expand Medicaid to cover doula services; a best practices summit, and a call for enhanced training for medical students.[49] Also in April 2018, DOHMH published the *Summary of Vital Statistics 2016 The City of New York: Infant Mortality*,[50] part of the maternal associated mortality reports known as Vital Statistics reports,[51] which have been issued every five years since 2000.[52]

VI. Conclusion

New York City and State have made strides in improving the health and well-being of New Yorkers over the last decade. Nevertheless, there exist glaring inequities with regard to protecting the health of mothers and babies, and specifically Black mothers and their babies. Recent studies show that these inequities, which are rooted in historical and contemporary injustices and discrimination, have not only persisted but worsened since the mid-nineteenth century. At this hearing, the Committees expect to gain a greater understanding of the issues surrounding maternal mortality and pregnancy-related care in NYC. The Committees are also interested in learning what steps the City must take to improve outcomes for women and their babies. Lastly, the Committee on Women is interested in hearing testimony on both Int. 913 and Int. 914.

VII. ANALYSIS OF INT. 913

Section one of Int. 913 adds a new administrative code section 17-199.9 that would define a doula as a trained professional who provides continuous physical, emotional and informational

[49] https://www.governor.ny.gov/news/governor-cuomo-announces-comprehensive-initiative-target-maternal-mortality-and-reduce-racial

[50] https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2016sum.pdf

[51] https://a816-healthpsi.nyc.gov/epiquery/IMR/index.html; Section 3.1.3 Infant Mortality of the DOHMH *2016-2018 Community Health Assessment and Community Health Improvement Plan: Take Care New York 2020* also addresses infant mortality (https://www1.nyc.gov/assets/doh/downloads/pdf/tcny/community-health-assessment-plan.pdf).

[52] See, e.g., https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf

support to a pregnant person and the family before, during and shortly after childbirth. The legislation would require that the Department of Health and Mental Hygiene (DOHMH) provide a plan to provide access to doulas for pregnant people in the city to assess the needs of pregnant people and the availability of free and low-cost doulas to meet such needs. Pursuant to Int. 913, the plan would assess information including but not limited to: the demand for doulas in the city; the number of doulas in the city and any appropriate qualifications; the average cost of doula services, and whether or not such services may be covered by an existing health plan or benefit; existing city programs that provide doula services; areas or populations within the city in which residents experience disproportionately low access to doulas; areas or populations within the city in which residents experience disproportionately high rates of maternal mortality; and the benefits associated with the use of doulas. The legislation would further require DOHMH to provide the Council with recommendations related to the expansion of doula programs to pregnant people in the city, including free and low-cost programs, on or before January 1 each year. The legislation notes that DOHMH would prepare, submit to the Council, and post on its website an annual plan for providing access to doula services to pregnant people who request such services, and that such plan would identify obstacles to making such services available to all those who need them and any additional resources necessary to do so.

Section two of Int. 913 would establish that this local law takes effect immediately after it becomes law.

VIII. ANALYSIS OF INT. 914

Section one of Int. 914 amends administrative code section 17-199.3 to expand upon the annual report on maternal mortality required pursuant to Local Law 55 of 2017. The legislation would require that the report be submitted in a machine-readable format, that data be anonymized

to comply with privacy considerations, and that additional information be included in the report, such as the total number of live birthday and disaggregating the number of maternal mortalities by information about the pregnant person, including but not limited to: location(s) where such person resided and received pregnancy-related care, by census block and tract; employment status; whether such person was uninsured or utilized health insurance other than Medicaid, Medicaid or other family planning services; whether such person saw a doula; whether such person visited a midwife or other licensed medical professional for obstetrics or pregnancy-related care; number of prenatal visits; any previous health complications; whether the person died and whether such person's death was pregnancy-related or pregnancy-associated and the cause of death; whether the person experienced a severe maternal morbidity event; whether such person is a first time mother; and whether the fetus or infant died. The legislation would also require that the report include recommendations regarding ways to enhance cooperation between city agencies that have a mandate related to maternal health, including but not limited to the commission on gender equity.

Section two of Int. 914 adds a new section 17-199.3.1 to require the creation of a maternal mortality and morbidity review committee (M3RC). The legislation would require that the M3RC study the nature and extent of maternal mortality and the impact of factors including: pre-natal care, doulas, economic, civic, and social well-being, and race on pregnant persons and mothers as it relates to maternal mortality; advise on ways to analyze complications experienced by expectant parents and mothers and ways to develop equitable strategies to respond to them; and to make recommendations to the mayor and the council for the reduction of maternal mortality and morbidity. Pursuant to Int. 914, the M3RC would represent a multi-disciplinary panel of representatives, including but not limited to representatives from various healthcare facilities, community based organizations with relevant experience, the doula community, researchers with

relevant experience, and first responders. Additionally, Section 17-199.3 would require the Department of Health and Mental Hygiene to consult with the M3RC on any reports made pursuant to section 17-199.3.

Section three of Int. 194 would establish that this local law takes effect 90 days after it becomes law.

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Int. No. 913

By Council Members Rosenthal, Ampry-Samuel, Cumbo, Rivera, Chin, Levin, Levine and Ayala

A Local Law to amend the administrative code of the city of New York, in relation to access to doulas in New York City

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding new section 17-199.9 to read as follows:

§ 17-199.9 Access to doulas. a. Definitions. For the purposes of this title, "doula" means a trained professional who provides continuous physical, emotional and informational support to a pregnant person and the family before, during and shortly after childbirth.

b. The department shall establish a plan to provide access to doulas for pregnant people in the city. In establishing such plan, the department shall assess the needs of pregnant people and the availability of free and low-cost doulas to meet such needs. Information assessed shall include but not be limited to:

1. The demand for doulas in the city.

2. The number of doulas in the city and any appropriate qualifications.

3. The average cost of doula services, and whether or not such services may be covered by an existing health plan or benefit.

4. Existing city programs that provide doula services.

5. Areas or populations within the city in which residents experience disproportionately low access to doulas.

6. Areas or populations within the city in which residents experience disproportionately high rates of maternal mortality.

7. The benefits associated with the use of doulas.

c. The department shall make recommendations to the council with respect to the expansion of doula programs, including free and low-cost programs, to pregnant people in the city.

d. No later than January 1, 2019, and on or before January 1 every year thereafter, the department shall prepare and submit to the council and post on its website an annual plan for providing access to doula services to pregnant people who request such services. Such plan shall also identify obstacles to making such services available to all those who need them and any additional resources necessary to do so.

§ 2. This local law takes effect immediately.

APB
LS #6547
5/4/18 12:00 pm

Int. No. 914

By Council Members Rosenthal, Cumbo, Rivera, Chin, Ampry-Samuel, Levine, Ayala and Levin

A Local Law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality

Be it enacted by the Council as follows:

Section 1. Section 17-199.3 of the administrative code of the city of New York is amended to read as follows:

§ 17-199.3 Maternal mortality annual report. a. For purposes of this section, the following terms have the following meanings:

Maternal health. The term "maternal health" means the health of [women] a person during pregnancy, childbirth, and the postpartum period.

Maternal mortality. The term "maternal mortality" means the death of a person while pregnant or within 42 days of the termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management.

b. No later than September 30, 2017, and not later than September 30 annually thereafter, the department shall submit to the speaker and publish in a machine-readable format in the annual summary of vital statistics the most recent calendar year data available regarding maternal mortality in New York City, to the extent such data is made available to the department, on an individual-person level, anonymized to comply with privacy considerations, including but not limited to the health insurance portability and accountability act (HIPAA), including, but not be limited to:

[1. The number of maternal mortalities, disaggregated by race or ethnicity and borough of residence;]

1. The total number of live births; and the total number of maternal mortalities disaggregated by information about the pregnant person or mother, including but not limited to: race or ethnicity; location where such person or mother resided by census block and tract; location(s) where such person or mother received pregnancy-related care by census block and tract; employment status; whether such person or mother was uninsured or utilized health insurance other than Medicaid, Medicaid or other family planning services; whether such person or mother saw a doula; whether such person or mother visited a midwife or other licensed medical professional for obstetrics or pregnancy-related care; number of prenatal visits; any previous health complications; whether the person or mother died, and if so, whether such person or mother's death was pregnancy-related or pregnancy-associated and, if pregnancy-related or pregnancy-associated, the cause of death; whether the person or mother experienced a severe maternal morbidity event and, if so, the type of event; whether such person is a first time mother; whether the fetus or infant died; and borough of residence;

2. The maternal mortality ratio, disaggregated by race or ethnicity and borough of residence where available and statistically reliable;

3. Recommendations regarding actions the department, the mayor, and the [Council] council can take to improve maternal health, particularly in disproportionately impacted communities; [and] reduce maternal mortality; and enhance cooperation between other city agencies that have a mandate related to maternal health, including but not limited to the commission on gender equity; and

4. An update on the implementation of the recommendations made in previous reports made pursuant to this section regarding actions that the department or mayor can take to improve maternal health and reduce maternal mortality, if any.

5. In the development of reports made pursuant to this section, the department shall consult any review or assessment produced by the committee established in section 17-199.3.1.

§ 2. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.3.1, to follow 17-199.3, to read as follows:

§17-199.3.1 Maternal mortality and morbidity review committee (M3RC). a. The department shall create a committee on maternal mortality and morbidity to, at a minimum, study the nature and extent of maternal mortality; study the impact of factors including but not limited to pre-natal care, doulas, economic, civic, and social well-being, and race on pregnant persons and mothers as it relates to maternal mortality; advise on ways to analyze complications experienced by expectant parents and mothers and ways to develop equitable strategies to respond to them; and to make recommendations to the mayor and the council for the reduction of maternal mortality and morbidity. Members of the committee shall represent a multi-disciplinary panel of representatives, including but not limited to representatives from various healthcare facilities, community based organizations with relevant experience, the doula community, researchers with relevant experience, and first responders.

§ 3. This local law takes effect 90 days after it becomes law.

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