Committee on Hospitals

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**THE COUNCIL OF THE CITY OF NEW YORK**

**COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION**

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**COMMITTEE ON HOSPITALS**

*Hon. Carlina Rivera, Chair*

**January 21, 2020**

**Oversight: Prenatal Care in NYC Hospitals**

1. **INTRODUCTION**

On January 21, 2020, the Committee on Hospitals, chaired by Council Member Carlina Rivera, will hold a hearing about prenatal care at New York City (NYC) hospitals. The Committee will examine the importance of prenatal care, and plans to discuss the prenatal services and programs offered by NYC Health and Hospitals (H+H). The Committee will also examine the availability and use of doula and midwife services in the City, including at H+H facilities. The Committee plans to hear testimony from H+H, voluntary hospitals, midwives, doulas, advocates, and other members of the public.

1. **BACKGROUND**

*Prenatal Care*

 The ability to protect the health of parents and babies in childbirth is a basic measure of a society’s development,[[1]](#footnote-1) and having a healthy pregnancy is one of the best ways to promote a healthy birth.[[2]](#footnote-2) Research suggests that early and regular prenatal care, which should begin with preconception care, increases the likelihood of having a healthy pregnancy.[[3]](#footnote-3) Such visits can include discussions about the parents’ health, the fetus’s health, and the pregnancy.[[4]](#footnote-4) Preconception and prenatal care can prevent complications during pregnancy by helping educate pregnant people about the importance of following a healthy and safe diet, getting exercise, controlling existing medical conditions, avoiding smoking and alcohol, and ensuring they are taking safe medications.[[5]](#footnote-5)

New York City has free and low-cost health care and health insurance programs and services to help with many pregnancy-related conditions, includes services to help pregnant people who drink, smoke, or use other drugs.[[6]](#footnote-6) Individuals who are pregnant are able to apply for Medicaid with more generous eligibility criteria than others, and regardless of their immigration status.[[7]](#footnote-7) Federal law requires that all states provide Medicaid coverage for pregnancy-related services to pregnant people and cover them up to 60 days postpartum.[[8]](#footnote-8) Late or no prenatal care are both risk factors associated with poor pregnancy outcomes, such as low birth weight and infant mortality.[[9]](#footnote-9) People who are minorities are more likely to have poorer birth outcomes than the rest of the population.[[10]](#footnote-10)

Although Medicaid covers individuals while they are pregnant, it does not necessarily provide coverage before conception. But, medical care is also important for people of reproductive age to receive before becoming pregnant. People who are obese or have chronic conditions like diabetes and high blood pressure are more likely to have complications during pregnancy such as preeclampsia, gestational diabetes, preterm birth, unplanned cesarean delivery, or a low birthweight baby.[[11]](#footnote-11) It is crucial to receive proper prenatal health care because complications during pregnancy can increase one’s chances of developing long-term health conditions.[[12]](#footnote-12) For example, one out of two people who has gestational diabetes will develop type 2 diabetes later in life, and people with high blood pressure during pregnancy have twice the risk of heart disease in the future.[[13]](#footnote-13) Additionally, a recent analysis from the health care alliance company Premier found that the costs of delivering a baby can nearly double if there are complications.[[14]](#footnote-14) The analysis found that vaginal births with complications cost about 80 percent more, on average, than ones without complications.[[15]](#footnote-15)

*Maternal Mortality and Morbidity*

Not only are more people in the United States dying of pregnancy-related complications than in any other developed country, but only in the United States 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,[[16]](#footnote-16) been increasing.[[17]](#footnote-17) Each year, 700-900 American people die and approximately 65,000 suffer potentially mortal complications from pregnancy- or childbirth-related causes.[[18]](#footnote-18) Furthermore, according to the Centers for Disease Control and Prevention (CDC), 60 percent of deaths from pregnancy-related complications are preventable.[[19]](#footnote-19)

Health inequities significantly impact pregnancy outcomes. According to the CDC, Black people in the United States are three to four times more likely to die from complications related to pregnancy than White people,[[20]](#footnote-20) and American Indian/Alaska Native people are three times more likely to die from complications related to pregnancy than White people.[[21]](#footnote-21) For Black people, the MMR is 42.8 per 100,000 live births, compared with 12.5 for White people and 17.3 for people of all other races.[[22]](#footnote-22)

*Maternal Mortality in NYC*

Statistics show that while about 30 people in NYC die each year of a pregnancy-related cause, approximately 3,000 people “almost die,” or experience morbidity during childbirth.[[23]](#footnote-23) The World Health Organization (WHO) defines maternal morbidity as a spectrum ranging from the near death of a person who has survived a complication occurring during pregnancy or childbirth (or within 42 days of the termination of pregnancy) to non-life-threatening morbidity.[[24]](#footnote-24) In March 2017, the Council passed the Maternal Mortality Reporting Law, or Local Law 55 of 2017, which requires the NYC Department of Health and Mental Hygiene (DOHMH) to issue an annual report on maternal mortality, tracking statistics in four areas.[[25]](#footnote-25) The latest report, issued September 30, 2019, includes information from 2016.[[26]](#footnote-26) That year, the pregnancy-associated mortality ratio was 30.7 deaths per 100,000 live births, and, of these deaths, 15 were pregnancy-related.[[27]](#footnote-27) That year, severe maternal morbidity occurred 257.3 per 10,000 live births, totaling 2,875 times.[[28]](#footnote-28)

At the City level, Black, non-Latina people are the most likely to experience maternal mortality or maternal morbidity.[[29]](#footnote-29) Data suggests Black people in NYC are 12 times more likely to die from pregnancy-related causes than White people.[[30]](#footnote-30) Of the 15 deaths in 2016, six were of people who were Black and six were of people who were Latina, accounting for nearly every pregnancy-related death.[[31]](#footnote-31) The rate of severe maternal morbidity was highest among Black people (428.6 per 10,000 births), followed by people of other, multiple, or not reported races (354.5), people who are Latina (288.3), Asian/Pacific Islander (207.9), and, last, people who are White (160.8).[[32]](#footnote-32) Additionally, a study published in the American Journal of Obstetrics and Gynecology found that Black people in NYC are more likely to give birth in hospitals that already have a high rate of severe maternal morbidity or complications than White people.[[33]](#footnote-33) Only 23 percent of Black patients gave birth in the safest hospitals, compared with 63 percent of White patients.[[34]](#footnote-34)

*Low Birth Weights & Infant Health*

Although the birthweight of a healthy infant can vary significantly, most babies born between 37 and 40 weeks weigh between 2,500 grams (5 pounds, 8 ounces) and 4,000 grams (8 pounds, 13 ounces).[[35]](#footnote-35) Several factors can influence a baby’s size at birth, including the size of the parents, whether the baby is a twin, birth order, gender, and the baby’s health.[[36]](#footnote-36) Often, however, a lower or higher than average birth weight is a reflection of the parent’s health.[[37]](#footnote-37) For instance, pregnancy-induced hypertension, as well as heart, respiratory, or kidney issues affecting the parent can reduce a baby’s weight.[[38]](#footnote-38) Smoking and drinking during pregnancy can also lead to lower birth weights.[[39]](#footnote-39) On the other end of the spectrum, gestational diabetes or excess weight gain during pregnancy can lead to larger babies.[[40]](#footnote-40)

While some babies with low birthweights can be perfectly healthy, having low birthweight can cause serious immediate and long-term health problems for some infants.[[41]](#footnote-41) In the short term, an infant with low birthweight may have trouble eating, gaining weight, and fighting off infections.[[42]](#footnote-42) Researchers have seen a persistent disparity in the birth weight of Black infants compared to the birth weight of White infants, and low birth weight is one of the leading causes of infant mortality in Black infants in the United States.[[43]](#footnote-43) African American infants are 3.2 times more likely than non-Hispanic White infants to die from complications related to low birth weight.[[44]](#footnote-44) Babies born with low birth weight may also be more likely to have certain chronic health conditions later in life, including diabetes, heart disease, high blood pressure, intellectual and developmental disabilities, and obesity.[[45]](#footnote-45)

Taking all causes into account, government data suggest that Black infants are more than twice as likely to die as White infants; the rate is 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. [[46]](#footnote-46) Research points to race, rather than educational attainment or income level of the patient, as the cause of such discrepancies.[[47]](#footnote-47) In fact, a Black person with an advanced degree is more likely to lose their baby than a White person with less than an eighth-grade education.[[48]](#footnote-48)

*Doulas*

 Several factors appear to have a positive influence on outcomes for persons giving birth in NYC, including the presence of a doula. A doulais a trained professional who provides continuous physical, emotional, and informational support to a pregnant person and the family before, during, and shortly after childbirth.[[49]](#footnote-49) Doulas are currently not required to be certified or registered by the State.[[50]](#footnote-50) A recent report reveals that people who had doula support were 39 percent less likely to have a caesarean section and 15 percent more likely to give birth without needing drugs or labor-inducing techniques.[[51]](#footnote-51) Additionally, a survey regarding doula care in NYC reveals that 72 percent of people 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.[[52]](#footnote-52) Furthermore, 83 percent 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.[[53]](#footnote-53) However, 88 percent of this cohort reported that cost was an issue when opting to work with a doula.[[54]](#footnote-54)

*Midwives*

Midwives are licensed, independent health care providers who specialize in reproductive health, including pregnancy, birth, primary, and newborn care.[[55]](#footnote-55) According to the New York State Association of Licensed Midwives, “midwifery affirms that everyone has a right to equitable, ethical, accessible healthcare that promotes healing and health, and respects human dignity.”[[56]](#footnote-56) According to the American College of Nurse-Midwives, the use of midwife services can lead to decreased risk of needing a cesarean, reduced rates of labor induction and augmentation, decreased infant mortality rates and preterm birth, and increased satisfaction with quality of care.[[57]](#footnote-57) In many other countries, including Great Britain, Canada, New Zealand, and Sweden, all of which have much lower rates of maternal and infant mortality than the United States, midwives oversee many, if not most, pregnancies.[[58]](#footnote-58) However, in the United States, midwives only attend around 10 percent of births, and their ability to participate in patient care varies widely by state.[[59]](#footnote-59)

A recent study found that empowering midwives could significantly boost maternal and infant health.[[60]](#footnote-60) The study, which was published in PLOS One, a peer reviewed journal, ranks each state using a Midwifery Integration Scoring (MISS) system, and high MISS scores were associated with significantly higher rates of spontaneous vaginal delivery, vaginal birth after cesarean, and breastfeeding, and significantly lower rates of cesarean, preterm births, low birth weight infants, and neonatal death.[[61]](#footnote-61) The study found that New York State has a MISS score in the highest quartile, as well as one of the lowest rates of neonatal mortality in the country.[[62]](#footnote-62) Notably, New York State has a high density of births for Black parents, and most other states with a high density of births for Black parents have low MISS scores and the highest rates of neonatal mortality.[[63]](#footnote-63)

1. **Recent Initiatives**

*Prenatal Care at New York City H+H*

 Each year approximately 18,000 babies are born at H+H hospitals, and all 11 H+H hospitals provide prenatal care and labor and delivery services.[[64]](#footnote-64) Services provided include high-risk pregnancy monitoring, a breastfeeding program, and Neonatal Intensive Care Units.[[65]](#footnote-65) H+H has nearly 100 midwives, who provide education, counseling, and health care services to parents in all stages of life at 10 of the H+H health care sites.[[66]](#footnote-66) Midwives perform deliveries on their own, and they also offer general health check-ups, screenings, vaccinations, and gynecologic care.[[67]](#footnote-67)

 In June 2019, H+H/Elmhurst and Centering Healthcare Institute announced the launch of a group prenatal care program for pregnant people.[[68]](#footnote-68) The goal of the program is to reduce preterm births and increase patient engagement during pregnancy.[[69]](#footnote-69) According to the press release, “[t]he program will feature group pregnancy visits with obstetricians, networking with other pregnant people, group discussions, and prenatal wellness and education classes on nutrition, stress management, and breastfeeding.”[[70]](#footnote-70) All pregnant people are eligible to participate in the group care sessions.[[71]](#footnote-71)

*Access to Doulas*

In 2018, the Council passed local law 187/2018, which required DOHMH to assess the needs of pregnant people in the City and the availability of doulas to meet those needs.[[72]](#footnote-72) This included assessing demand for doulas, the cost of doulas, existing doula programs, current availability of doula services, and the benefits of doula programs.[[73]](#footnote-73) The law also required DOHMH to provide the Speaker and the Council with a plan for providing access to doulas to more pregnant people who request doula services, as well as an annual report with information about known organizations that provide doula services or training and information on areas in the City that experience disproportionally high rates of maternal mortality, infant mortality, and other poor birth outcomes.[[74]](#footnote-74) DOHMH submitted the plan detailing the challenges to obtaining doula support and ways to expand access to doula services in the City in July 2019.[[75]](#footnote-75)

*Maternal Mortality*

In December 2017, 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.[[76]](#footnote-76) 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. In 2018, the Council enacted local law 188, codifying the M3RC and expanding its reporting requirements.[[77]](#footnote-77)

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 parents.[[78]](#footnote-78) In addition, in January 2018, Governor Cuomo announced a proposal to create a State Maternal Mortality Review Board (“Board”) to review each maternal death.[[79]](#footnote-79) Governor Cuomo signed legislation creating the Board in August 2019,[[80]](#footnote-80) and in October 2019 the CDC awarded $450,000 to the State Department of Health (DOH), working in partnership with DOHMH, to help fund the work of the Board in facilitating an understanding of the drivers of maternal mortality and complications from pregnancy, as well as racial disparities in maternal mortality rates. The Board will submit recommendations to the DOH for clinical and community interventions to improve outcomes for families and communities.[[81]](#footnote-81)

Further, on April 23, 2018, the Governor announced a series of additional new initiatives focused 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.[[82]](#footnote-82) Also in April 2018, DOHMH published the *Summary of Vital Statistics 2016 The City of New York: Infant Mortality*.[[83]](#footnote-83)

**VI. Conclusion**

 The purpose of this hearing is for the Committee to better understand the state of prenatal care in NYC, and to discuss the barriers to quality prenatal care. The City must do more to ensure that every single pregnant person receives the health care they require to have a healthy and safe pregnancy and birth.

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