CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON WOMEN AND GENDER EQUITY
JOINTLY WITH COMMITTEE ON HEALTH AND
COMMITTEE ON HOSPITALS

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December 7, 2020
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Recess: 4:17 p.m.

HELD AT: REMOTE HEARING

B E F O R E: Helen K. Rosenthal,
Chairperson for Committee on Women and Gender Equity

Mark Levine,
Chairperson for Committee on Health

Carlina Rivera,
Chairperson for Committee on Hospitals

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Laurie A. Cumbo
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COUNCIL MEMBERS(CONT.):

Farah N. Louis
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A P P E A R A N C E S

Jacqueline Ebanks
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Denise Bolds
Native New Yorker and a Hospital Doula

Debra Lesane
Director of Programs at Career of Young Women's Health Association

Eugenia Montesinos
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Neelu Shruti
Birth Advocate in New York City

Myla Floris[SP?]
Working with Annette Perel, a Community Member of the Birth Doula's and Birth Workers

Patricia Loftman
Certified Nurse Midwife, Fellow of the American College of Nurse Midwives

Tricia Shimamura
Proud woman of color, Social Worker, wife and mom

Thamar Innocent
Birth Worker

SERGEANT LUGO: Cloud recording good.

SERGEANT ?: Back up is rolling.

SERGEANT LEONARDO: Okay, Sergeant Martinez.

SERGEANT MARTINEZ: Good Morning and welcome to today's remote New York City Council hearing of the Committee on Women and Gender Equity jointly with the Committee on Health and the Committee on Hospitals.

At this time, would all panelists please turn on their video. To minimize disruption, please silence your electronic devices. If you wish to submit testimony, you may do so via email at the following address, testimony@council.nyc.gov, testimony@council.nyc.gov.

Thank you for your cooperation. Chair's, we are ready to begin.

CHAIRPERSON ROSENTHAL: [GAVEL] Good morning and thank you for joining today's Committee's on Women and Gender Equity, Health and Hospitals Virtual Hearing on Maternal Mortality and Morbidity in New York City. I am Council Member Helen Rosenthal, Chair of the Committee on Women and Gender Equity. My pronouns are she, her, hers and I want to start by thanking everyone who came out here to testify today.

Maternal mortality and morbidity is one of the greatest public health crisis in the country. Yet as a City we have been late to address what Black and Brown communities and many community-based organizations have been sounding the alarm on for decades.

So, I want to start by saying that while there are dedicated people working in hospitals in the City's Department of Health, some of you here today are doing your best and we appreciate that. But as a whole, as a City, we are failing and it is because of racism in all its forms, structural, environmental, direct and implicit.

Even after recent efforts to close the gap, the latest data still shows that Black and Brown giving birth in New York City are 8-12 times. That's at least 800 more likely to die than their White counterparts. And this is death exclusively, not to mention the thousands of cases in which people almost die of childbirth related causes.

Moreover, Black infants in the City are also three times more likely to die than White newborns. A gap that is nearly 50 percent greater than the national average. This committee last held a hearing

on maternal mortality in New York City in June 2018, when we heard two bills that have become law, both demand accountability.

The first, Local Law 187 requires DOHMH to assess the needs of pregnant people and the availability of Doula's to meet those needs, then produce a plan for increasing access to Doula's. DOHMH must also release an annual report with known organizations that provide Doula services and training and the information on areas on the City that experience disproportionately high rates of maternal mortality, infant mortality and other poor birth outcomes.

And second, Local Law 188 of 2018, which requires DOHMH to expand the City's annual reporting on maternal mortality and morbidity with additional reporting and a five year report. The law also codified the Maternal Mortality and Morbidity Review Committee M3RC and required DOHMH to post information on the disciplines represented by the members of the M3RC with the indication that more people with lived experiences should be on the Committee like Doula's, midwives and those who have experienced near death encounters.

The 2019 report gave us information on the 2016 mortality rate, 37 people died in childbirth in 2016. The 2020 report has not come in yet and we look forward to that data. Because of delays in reporting, we won't know the number for 2020 for some time which drives home a sobering point. We know very little about the experience people have had giving birth during COVID-19. The little we do know comes from the press and it is terrifying. We know that several women have died in childbirth since COVID, including Amber Isaac. A 26-year-old Black woman who left us a chilling final message about her experience with healthcare while pregnant just four days before she died.

We know that for a period of time, people giving birth in hospitals were without birthing partners and so, they didn't have anyone to advocate for them. To witness any mistreatment or just give support.

Today, we would like to learn more about how rates of maternal mortality and morbidity have been impacted by COVID-19 and as well, how the City is addressing, has addressed and is addressing factors that threaten to further exacerbate racial inequities

among birthing people and what steps the City plans to take to improve these outcomes.

As we all know, statistics only tell part of the story. We desperately rely on your stories. The qualitative data that is your lived experiences. If you or a loved on have had inappropriate experience in the New York City medical system, we urge you to submit written testimony which you can do on the record for this hearing until Thursday at 10 a.m. by sending it to testimony@council.nyc.gov.

Finally, the Committee's will be hearing several pieces of legislation today that my colleagues will discuss, including Intro. Number 2017 related to visitation policy guidelines for hospitals during public health emergencies like COVID-19. Intro. Number 2042 related to expanding access to resources by posting information about midwives online.

Resolution 1239 related to making Doula's more accessible to individuals with Medicaid and those without health insurance and Resolution 1408, which I am proud to be the prime sponsor on related to state legislation on the accreditation approval and operation of midwifery birth centers.

Thank you to my colleagues, Council Member Levine and Carlina Rivera for Co-Chairing this hearing and to all of the Doula's, mother's, father's advocates of every stripe. Thank you for your tireless work on this issue. Thank you for joining us and sharing your experience. As an advocate said at this morning's rally, the goal is for us to get where we don't have to hear from broken hearted loved ones.

Finally, I would like to thank my team Chief of Staff Cindy Cardinal, my Legislative Director Madhuri Shukla as well as Committee Staff for their work in preparing this hearing, Brenda McKinney Legislative Counsel, Chloe Rivera Senior Policy Analyst, Monica Pepple Financial Analyst, Elizabeth Artz[SP?] and John Valasgo from Community Engagement.

And I would now like to acknowledge my colleagues who have joined us, Council Members Levine, Rivera, Adams, Council Member Ampry-Samuels, Ayala, Barron, Cohen, Gibson, Kallos, Holden, Louis, Powers, Maisel, Council Member Rose and Council Member Eugene. I will announce more as they arrive and now, I would like to invite Council Member Rivera, Chair of the Committee on Hospitals to provide opening remarks.

CHAIRPERSON RIVERA: Thank you so much. Thank you so much. Good morning everyone. Thank you Chair Rosenthal. Thank you Chair Levine for Co-Chairing this hearing with me today. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals and I want to start by thanking everyone present today.

Maternal mortality and morbidity is a topic I care deeply about. We were just joined by almost 100 advocates, birth workers, elected officials and individuals with very, very, tragic experiences who all know that birth justice cannot wait.

Hundreds of years of race based medicine coupled with systemic racism and other forms of oppression have led to stark, desperate health outcomes. To reiterate some of the figures already shared, maternal mortality disproportionately impacts Black women and birthing people with Black people 8-12 times more likely to die when giving birth than their White counterparts in New York City and Latino's with three-times the rate of maternal morbidity compared to White women.

Studies have shown that regardless of educational attainment and income, Black women are still more

likely to die from childbirth than White women. According to the most recently released City data, while about 25 people in New York City die each year of a pregnancy related cause, approximately 2,800 people experience morbidity or almost die during childbirth. Morbidity disproportionately impacts Black, Latino and other racial and ethnic minority women and birthing people.

The fact that Black women and birthing people are not receiving the care and resources they need to survive childbirth is inexcusable. The fields of gynecology itself is rooted in racism and was only advanced because of the abuse of enslaved Black women.

A recent article from the journal of Minimally Invasive Gynecology notes that after public outcry and response to the murders of George Floyd and Breanna Taylor and others. Over 18 organizations signed the Collective Action Statement against racism in the field of obstetrics and gynecology.

A portion of the statement acknowledged many examples of foundational advances and the specialty of obstetrics in gynecology are rooted in racism and oppression. For example, in the mid-1800's surgical

experimentation of James Marion Sims was performed on enslaved Black women including women; Betsy, Lucy and Anarca[SP?] who underwent repetitive gynecologic procedures without consent. This historical context further highlights how deeply these injustices run and how rooted health care is in race based medicine and racism.

My Committee along with the Committee's at the Council have heard from the City and other experts over the years about the numerous initiatives at the state and city levels aimed at addressing maternal mortality and morbidity.

I look forward to hearing from the City and others today about these efforts, as well as our proposals for new legislation. COVID-19 has had an enormous impact on maternal health. There are renewed conversations and efforts around improving maternal care, such as ensuring access to midwife led birth centers. Something that is long overdue in New York City.

Intro. Number 2017, legislation I am proud to sponsor, relates to visitation policy guidelines for hospitals during public health emergencies such as COVID-19. During the COVID-19 pandemic there were

large gaps in information provided by hospitals to patients and birth workers regarding visitation policy, certification barriers and the possibility of being separated from ones baby.

Even though the state has issue guidelines and guidance permitting a partners and/or support person, including Doula's to attend the birth of a patient, we are still hearing about barriers to visitation. This legislation aims at ensuring the City creates clear guidelines for such instances, which can help ensure access to meaningful care.

We are also hearing Resolution 1239, which I am also proud to sponsor, calling on the New York State legislature to pass and the governor to sign legislation making Doula's more accessible to individuals with Medicaid and those without health insurance.

We know that Doula's improve maternal health outcomes. We know that they are critical in this fight for equity. The state should work alongside Doula's as partners to see if we can improve access to Doula care for those with Medicaid and other forms of insurance. This is a process that must be lead by

those on the ground. All of our actions are to prevent future and maternal deaths and near deaths.

Today, we must center ourselves on the purpose of the work and we must honor and remember those we have lost. Amber Isaac, a 26-year-old Black woman, died on April 21, 2020 shortly after delivering her son at Montefiore Medical Center in the Bronx. Shaasia Washington, also a 26-year-old Black woman died on July 3, 2020 during childbirth at Woodhull Hospital.

Pandel Lezzer[SP?], a 33-year-old Orthodox Jewish woman died on November 19, 2020 in Maimonides in Brooklyn from complications related to COVID-19 one day after delivering her fifth child.

We remember them today, as well as those who have died before them and anyone who may have died and who is not covered in the news. We are mindful of all those still with us today who nearly died while giving birth. My thoughts are with the families and friends of those mentioned.

I am also sincerely grateful for the advocates, Doula's midwives and other birthing professionals who have been working to address maternal mortality and morbidity for years. I hope you feel heard and seen today. While we look for your guidance regarding

birth workers, I know that we cannot task you with fixing this crisis alone. You have my commitment as a partner in this work and I look forward to hearing from you and continuing to work together.

I would like to thank the Hospital Committee Staff Council Harbani Ahuja, Policy Analyst Emily Balkan, Finance Analyst John Cheng and Data Analyst Rachael Alexandroff.

I also want to thank my team Alexis Richards, Isabelle Chandler, Jeremy Unger and a number of others, all who have been incredibly helpful in making sure we are hearing from as many people as possible.

Thank you so much. Thank you all for being here and I will now turn it over to Chair Levine for his opening remarks.

CHAIRPERSON LEVINE: Thank you so much Chair Rivera. Thank you Chair Rosenthal for all that you have done to advance this issue to ensure we have held this very important hearing today and I also want to thank the Chair of the City Council's BLAC Adrienne Adams who has been such a champion for this important cause and many other members of our women's

caucus including Council Members Louis, Barron, Gibson, Rose, Ampry-Samuel and others.

As Chair Rivera mentioned, I am City Council Member Mark Levine and I Chair the Health Committee in the City Council. Pleased to be Co-Chairing this hearing today in which we will be focusing on maternal mortality and morbidity in New York City, as well as considering a package of legislation including two bills and two resolutions relating to mental health.

The morally outrageous disparity and maternal mortality and morbidity in New York City between Black women and other birthing people and White New Yorkers was well known before COVID. But we have reason to believe that this crisis has exacerbated this terrible disparity by disrupting the normal channels of care, low-income birthing people in particular rely on. With decreased in-person appointments and a reliance on telehealth services, decreases in prenatal care service overall and postpartum follow-up. Persistent discrimination in healthcare and a risk factor which I fear we have largely overlooked isolation.

As for example, hospitals have been forced to limit the number of people in delivery rooms. Sometimes leaving mothers to deliver alone. So, we need to double down now on the strategies that we know can help reverse this terrible disparity. Addressing explicit and implicit biases in discrimination in healthcare systems among providers. Collecting and utilizing more data to understand risk factors. Addressing health inequities that persist before and during pregnancy, such as access to comprehensive healthcare including nutritious food. Educating and empowering birthing individuals, to advocate for themselves within a medical setting. Continuously reviewing and accessing medical practices to determine what improvements are needed and fostering collaboration among hospitals, providers, community-based organizations and government entities to ensure that the best care is being properly resourced and delivered.

Our hearing today will focus on the imperative [LOST AUDIO 19:15- 19:20] to support women who are being left behind in the maternal and birthing process. I look forward to hearing from the Administration and hospitals today on exactly what

they are doing to achieve these goals and I look forward to hearing from advocates on how New York City can bring justice for the women and birthing parents who are being left behind.

As always, I thank the Administration for your work and for being here today and I want to thank the staff of the Health Committee including Counsel's Harbani Ahuja and Sara Liss, Policy Analyst Emily Balkan, Finance Analyst Lauren Hunt, Data Team Rachael Alexandroff, Rose Martinez, Melissa Nunez, Mason Sarkissian and Julia Fredenburg and Amy Slattery, my Legislative Director.

Thank you so much and I will pass it back.

CHAIRPERSON ROSENTHAL: Thank you Council Member Levine. Before we turn it over to our Moderator, I now want to turn it to the Co-Chairs of the Council's Women's Caucus and BLAC Caucus who will also provide remarks starting with BLAC Caucus Co-Chair Council Member Adams followed by Council Member Gibson and then Council Member Louis from the Women's Caucus. Council Member Adams, please begin when you are ready.

COUNCIL MEMBER ADAMS: Thank you so much Chair Rosenthal and good morning everyone. I would like to

once again thank all of the Chairs, Council Member's Rosenthal, Levine and Rivera for convening this very, very, critical hearing this morning.

I am Council Member Adrienne Adams, Co-Chair of the Black, Latino and Asian Caucus of the New York City Council. Maternal mortality and morbidity has plagued us for far too long and the problem is much more severe in Black women. Despite advances in the healthcare system, we continue to go through this crisis, whether through personal experience or data. We all know that there are deep racial disparities in our healthcare system. We have the resources. We have the review boards. We have the data. We even have the protocols but women and more prevalently Black women continue to suffer disproportionately.

If economic class access to healthcare, education and genetics could not explain this crisis, we have to acknowledge several problems when it comes to maternal mortality. Ongoing systemic disparities, implicit bias and listening, actually listening to the patient. We need solutions to address this. It is not just a women's issue. This is a human and civil rights issue. It is clear now more than ever that we need solutions to address these problems and

I look forward to hearing from everyone today to working with you on this very, very important issue. We must work holistically to ensure that no one dies a preventable death while bringing beautiful life into this world.

Thank you again to our Doula's, our Midwives, our Advocates and other dedicated parties for your unwavering commitment to ending this moral, disgraceful crisis. Thank you Chair's for this hearing. Thank you very much.

CHAIRPERSON ROSENTHAL: Thank you so much Council Member Adams. I stand with you as an ally.

Next, we are going to hear from Council Member Gibson.

COUNCIL MEMBER GIBSON: Thank you so much Chair Helen Rosenthal and good morning everyone. It is a great honor and privilege to join with all of you. I also want to recognize my fellow Co-Chair of the Women's Caucus, Chair Farah Louis, our BLAC Co-Chair's, Chair Adrienne Adams and Chair Daneek Miller. I want to thank our Committee Chair's, the Committee on Women and Gender Equity. Thank you Chair Rosenthal. The Committee on Hospitals, Chair

Carlina Rivera and our Committee Chair on Health, Chair Mark Levine.

I also want to thank Majority Leader Laurie Cumbo, all of the women in the Women's Caucus and all of my colleagues in the City Council. Thank you so much. Today is a very important discussion on Black maternal mortality and morbidity and reproductive justice in our city.

Earlier this morning, we had a virtual rally and I want to lift up our brother Bruce McIntyre the Founder of Save A Rose Foundation for being an advocate. He lost his queen and he has turned his pain into purpose with a plan and we thank you so much for continuing to lift up the name of your queen and all of the work you are doing around advocacy.

We lift up all of the names of our sisters, so many, African American, women and Latina's that we have lost are in this fight for birth justice. Council Member Rivera called their names and we want to continue to pray for those families who will never be the same again. There are too many, too many stories that we have heard. High rates of Black maternal mortality and morbidity is really a result of years of systemic racism in our healthcare

industry that continues to contribute to the mistreatment and mishandling of Black women patients in this country. It is unacceptable in 2020. Too many women have died as a result of this public health crisis and we cannot wait for yet another preventable death before we take action. Black women and Black birthing individuals deserve our support. They deserve our love, our compassion. They deserve access to quality patient centered and comprehensive holistic treatment, reproductive healthcare that is culturally sensitive.

Policy makers, healthcare professionals, our CBO's, our Doula's, our midwives, all of our communities can work together to improve Black women's maternal health by expanding access to health coverage and information on midwives and doula's. I am very proud of the package that is assembled today and one of the bills I have is Intro. 2042, which will make public information on licensed midwives, so inspecting mothers can make informed decisions for their families as we work to dismantle medical oppression and undue the years of systemic inequality that has plagued our healthcare system.

I want to thank all of our advocates. I certainly want to thank Bronx Health Link, Bronx Health Reach and so many of the partners I had the honor of working with in the Bronx but all of our citywide organizations. The City Council has every year championed a City Council initiative on maternal healthcare because we recognize that we can't just talk about it, we have to be about it and put money where our commitment is.

All of our advocates, those that have shared your stories that are very influential and powerful and meaningful and I look forward to today's input and all of the advocates who are here, and I also want to thank the Administration for joining us today. Your partnership is critical in our overall work. Thank you so much Chair Levine, Chair Rivera and thank you Chair Rosenthal for today's important hearing. Thank you.

CHAIRPERSON ROSENTHAL: Thank you very much. Now, we are going to hear Council Member — sorry, Council Member Lander has joined the hearing and now we are going to hear from Council Member Louis. We are so glad you are here today with us Council Member Louis.

COUNCIL MEMBER LOUIS: Thank you so much Chair Rosenthal and I want to thank my colleagues, you Chair Rosenthal, Chair Rivera, Levine and my fellow Co-Chair Venessa Gibson and the BLAC Co-Chairs Adams and Miller for creating a space to hear untold stories from birth advocates, women and their families affected by the maternal mortality and morbidity issues here in our nation but most importantly in our city.

Today's oversight hearing is an opportunity to engage in thoughtful discussions about how the Council as a legislative body can reform our healthcare system to better support expected mothers.

I represent District 45 that includes East Flatbush and Flatbush in Brooklyn, a predominant Black and immigrant community that is disproportionately at risk for maternal morbidity and mortality.

As Black women, we are experiencing poverty, economic and social pressures at alarming rates. While coping with anxiety, isolation and pain, before and during and after children birth are largely ignored.

Economic housing and food insecurity would be stressful on many New Yorkers but the consequences would be dire for expected mothers. The additional stress could endanger the physical and mental wellbeing of both mother and child.

Before the pandemic, we were still compiling data to give us a clearer picture of our city's healthcare systems and racial disparities. Amid a global health crisis and the increased use of telemedicine to limit the spread of COVID-19, I hear that the maternal health outcomes in Black communities will worsen because of the digital divide. It is already difficult for patients to communicate their symptoms to nurses and doctors in person and feel acknowledged. I have experienced it myself.

Can you imagine how much harder it is to monitor high risk patients remotely let alone those who lack access to the devices or internet service to speak to their doctors. We are talking about actual people who reluctantly put their trust in a system where Black women are subjected to riskier procedures like cesarean section and denied medical treatment to address pregnancy complications until it is too late. We remember every day, especially today Amber Isaac,

Shaasia Washington and countless other women deprived of the opportunity to celebrate their child's birthday's the first day of school and graduations.

We owe their families answers and sweeping healthcare reforms. I look forward to hearing from the Administration, effected families, birth advocates, like the Caribbean Women's Health Association that is working very hard in my district to support pregnant and postpartum women, as well as other families through support groups. Parent workshops and expanded services. Thank you Chair Rosenthal and to all the Co-Chairs for working on this today. I look forward to today's hearing. Thank you.

COUNCIL MEMBER ROSENTHAL: Council Member Louis, thank you for stepping up for your community and engaging with those who are trying their best to make it better. I really appreciated your word reluctantly. You know, when you are birthing person, you don't have a choice. You have to give birth and yet, the systems are not there to protect you. Just who you count on are not there. Thank you for your leadership Council Member Louis, appreciate you.

Now, I am going to turn it over to our Moderator, Committee Council Brenda McKinney who will review some procedural items relating to today's hearing and call on our first panel of witnesses.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. My name is Brenda McKinney and I am the Legislative Counsel, the Committee and Women and Gender Equity at the New York City Council. I will be moderating today's hearing and calling on panelists to testify.

Before we begin, please remember that everyone will be on mute until I call on you to testify. After you are called on, you will be unmuted by the host. Note that there will be a few second delay before you are unmuted and we can hear you. You may also see a box pop up click on to accept the unmute.

Please listen for your name, I will periodically announce the next few panelists. Council Member questions will be limited to five minutes. Council Members note that this includes both questions and witness responses. We will be allowing a second round of Council Member questions today.

For public testimony, I will be calling up panelists in panels. I will be calling up

individuals in panels. Council Members, if you have questions for a particular panelist, please use the raise hand function in Zoom. You will be called on in order after everyone on the panel has completed their testimony.

For public panelists, once I all on your name, a member of our staff will unmute you and the Sergeant at Arms will set a timer and give you the go ahead to begin your testimony. All public testimony today will be limited to three minutes. After I call your name, please wait a couple of seconds for the Sergeant at Arms to announce that you may begin before starting your testimony. And again, you will see a box pop up to accept the unmute request.

With this, we will move to Administration testimony. At today's hearing, the first panel will be the Commission on Gender Equity, the Department for Health and Mental Hygiene DOHMH and the Department of Health + Hospitals for the Administration H+H followed by Council Member questions then public testimony.

I will list the names of each member of the Administration as a group and then call on you individually to reply to the oath.

So, I will now call on members of the Administration to testify. In order of speaking we will have Jacqueline Ebanks Executive Director from the Commission on Gender Equity or CGE, Estelle Raboni MPHMCHES Acting Assistant Commissioner from the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene or DOHMH and Dr. Wendy Wilcox Clinical Service Line Lead from Maternal Mortality Reduction at the New York City Health + Hospitals H+H and the Women's Health Chair of the OBGYN at H+H of Kings County.

Additionally, we will have several members of the Administration on hand for technical support and I will also be calling on them to respond to the oath. This includes Maidel De La Cruz from H+H, Chelsea Cipriano from DOHMH. Please excuse any pronunciation error. Patricia Moncure from DOHMH and Gale Black from CGE.

I will now administer the oath to the Administration. When you hear your name, please respond. Thank you. CG Director Jackie Ebanks?

JACQUELINE EBANKS: Yes.

COMMITTEE COUNSEL: DOHMH Assistant Commissioner Estelle Raboni?

ESTELLE RABONI: Yes.

COMMITTEE COUNSEL: Thank you so much and there is a delay, so thank you so much, apologies. Dr. Wendy Wilcox from H+H?

I think you are still on mute Dr. Wilcox.

DR. WENDY WILCOX: Yeah.

COMMITTEE COUNSEL: Great thank you so much. Just for the record, we need the sound. Thank you. Ms. Maidel De La Cruz?

MAIDEL DE LA CRUZ: Yes.

COMMITTEE COUNSEL: Thank you so much. Ms. Cipriano? Ms. Chelsea Cipriano from DOHMH? I will come back. Ms. Moncure?

PATRICIA MONCURE: Yes.

COMMITTEE COUNSEL: Thank you so much. Ms. Black from CGE? We can come back if we need to do and administer the oath later, if we need to. Just one last check for Ms. Cipriano? Okay, we will move on and if we need to, we can administer the oath for those individuals on hand for technical support.

So, today, we will be starting with testimony for CGE followed by DOHMH followed by H+H. So, first we

will hear from Director Jackie Ebanks from CGE. You may begin your testimony once the Sergeant at Arms has given you the queue.

SERGEANT AT ARMS: Starting time.

JACQUELINE EBANKS: Thank you so much. Good morning Chair's Rosenthal, Rivera and Levine and members of the Committee's. I am Jacqueline Ebanks, Executive Director of the Commission on Gender Equity. I am joined today by my colleague Estelle Raboni, Acting Assistant Commissioner for the Bureau of Maternal Infant and Reproductive Health at New York City Department of Health and Mental Hygiene, DOHMH and Dr. Wendy Wilcox Chairperson of Obstetrics and Gynecology from New York City Health and Hospitals H+H.

As Executive Director of the Commission on Gender Equity, I also serve as an Advisor to the Mayor and First Lady on policies and issues impacting gender equity in New York City. For all girls, women, transgender and gender nonbinary and nonconforming New Yorkers regardless of their ability, age, race, faith, gender expression, immigrant status, sexual orientation and socioeconomic status.

CGE works to create deep and lasting institutional commitment to tearing down equity values across New York City and we carry out our activities in three areas of focus within a human rights framework and using an intersectional lens.

These areas of focus are first, economic and mobility opportunity. Where we strive to create a City where people of all gender identities and gender expressions live economically secure lives and have access to opportunities to thrive.

Second, our health and reproductive justice focus area has a goal to foster a city free from gender and health disparities. And thirdly, our safety focus area has a goal to foster a city free from gender and race based violence.

Within our health and reproductive justice portfolio, CGE recognizes the importance of ensuring access to and affordability of comprehensive, culturally competent sexual and reproductive healthcare services for all New Yorkers regardless of gender identity and gender expression. With this in mind, in our 2018-2021 strategic plan, CGE identified reducing infant and maternal mortality in Black and Latinx communities as one of our lead initiatives.

As a result, we maintain key partnership with proud advocates and our colleagues at DOHMH and Health + Hospitals. In doing so, we are able to ensure responsiveness to the needs of pregnant and childbearing women and gender nonconforming and nonbinary New Yorkers.

We are pleased to count health advocates as members of the Commission. With their involvement, we have numerous direct opportunities to learn about issues of sexual and reproductive health that face New Yorkers where they live and work.

At this moment, I would also like to thank Chair Rosenthal.

SERGEANT AT ARMS: Time expired.

JACQUELINE EBANKS: Chair Rosenthal and Chair Rivera for their leadership on our Commission as members and really their involvement also in our health and reproductive justice work group.

May I proceed or?

CHAIRPERSON ROSENTHAL: Go ahead.

JACQUELINE EBANKS: Our partnership with the colleagues at DOHMH has included serving as a member of the Maternal Morbidity and Mortality Steering Committee, which participated in the M3RC.

As members of the Steering Committee, we worked with a multidisciplinary team to explore policy in programs recommendations to reduce maternal mortality and severe maternal morbidity in New York City with an equity focus.

We advised and supported DOHMH and its partners on ways to implement the recommendations and participated and communicated in the findings and the recommendations to key stakeholders and constituents and advocating for their support. In our 2019 annual report, CGE was proud to highlight Health + Hospitals comprehensive offering of blended training programs to build competency in providing affirming services for members of the LGBTQ community.

This work has significant positive implications for the provision of support in sexual and reproductive healthcare services for LGBTQ New Yorkers. In fact, also in 2019 for the 4th year in a row, 23 patient care locations within the Health + Hospital Network received the designation leader in LGBTQ healthcare equality by the Human Rights Campaign.

Through our partnerships with health advocates, the DOHMH and H+H, CGE strives to develop and

maintain a comprehensive solution oriented approach to New York City's high maternal mortality and morbidity rates in Black and Latinx communities. In so doing, CGE is able to amplify and support various programmatic policy and public education initiatives launched and managed by our colleagues at DOHMH and Health + Hospital. This helps us better connect to pregnant and childbearing New Yorkers at critical times and in a timely manner responsive to their pregnancy related medical care needs.

We look forward to deepening our work with these partners in New York City in the next year. I think it is essential to create the shifts that we so desperately see in improving conditions for Black, improving outcomes for Black and Latinx pregnant and childbearing communities.

Regarding the bills under consideration today, I want to turn to my colleagues Estelle Raboni at DOHMH and Dr. Wendy Wilcox to provide comments. CGE stands in support of their recommendations. Again, thank you for this opportunity to testify on this critical issue. I look forward to continuing our partnership in improving outcomes for Black and Latinx pregnant and childbearing communities. Thank you.

CHAIRPERSON ROSENTHAL: Director Ebanks, I just want to thank you for coming today and your leadership in this in many areas. Thank you.

JACQUELINE EBANKS: Thank you. Thank you so much.

COMMITTEE COUNSEL: Thank you so much. We will now hear from Assistant Commissioner Raboni from DOHMH. You may begin once the Sergeant at Arms gives the queue. Thank you.

SERGEANT AT ARMS: You may begin.

ESTELLE RABONI: Good morning Chair's Rosenthal, Rivera and Levine and members of the Committee's. I am Estelle Raboni, Acting Assistant Commissioner for the Bureau of Maternal Infant and reproductive Health at the New York City Department of Health and Mental Hygiene.

I am joined by my colleagues Jacqueline Ebanks, Executive Director of the Commission for Gender Equity and Dr. Wendy Wilcox, Chairperson of Obstetrics and Gynecology from New York City Health + Hospitals. On behalf of Commissioner Chokshi, I want to thank you for the opportunity to testify today on this important topic and for your commitment to improving maternal health outcomes for New Yorkers.

I want to say here loud and clear; racism is a public health crisis and one of the most startling statistics we have in New York City to demonstrate this crisis pertains to maternal health and mortality. Black women in New York City are eight times more likely to die from pregnancy related causes than White non-Latino women. In fact, White non-Latino women without a high school diploma have better maternal health outcomes than Black women with a college degree.

This is the unacceptable and unjust reality in New York City. Decades of structural racism and pervasive historical disinvestment of Black and Brown communities have led to these avoidable disparities. Despite improvements and reducing deaths related to pregnancy and childbirth, more needs to be done.

Reducing maternal deaths and life threatening complications is a priority for this Administration. Access to quality family planning services, maternal healthcare and sexual and reproductive healthcare services are foundational components of our work to eliminate disparities in Black and Brown communities. The Health Departments five year plan has been pivotal in our efforts to change the narrative and

achieve health equity and injustice for Black New Yorkers.

In 2017, the Health Department established the New York City Maternal Mortality and Morbidity Review Committee referred to as the M3RC. The goal of the M3RC 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.

More recently in 2018, the Health Department in partnership with H+H worked together to bolster the city's — I am sorry, I just lost my place. Efforts to reduce racial and ethnic disparities in maternal health. This work includes enhanced public health surveillance through M3RC and deploying a three pronged strategy to improve the quality of maternity care at hospitals. This strategy includes: One, developing a pilot project with three hospitals to conduct in hospital quality improvement reviews of severe maternal morbidity SMM cases. These are life threatening events that occur after childbirth and include heavy bleeding, blood clots, kidney failure, stroke and heart attack.

Two, implementing a qualitative research study to explore the perceptions and experiences of pregnant and parenting people who experienced a severe maternal morbidity while giving birth and the consequences of the severe complication on their lives. And lastly, three, informing and supporting mobilization around maternal health by sharing findings, engaging community stakeholders and hospital partners to change the systems and structures in which people give birth with a focus on SMM.

Additionally, the Health Department works directly with communities facing the most significant social and economic challenges by engaging birth justice defenders to conduct community outreach and education about the New York City standards for respectful care at birth. These standards were created to inform, educate and support people giving birth. These standards encourage pregnant people to know their basic human rights and be active decision makers in their birthing experience and are also helpful for providers to remind them to respect and be aware of their patients human rights during pregnancy, labor and childbirth.

We are currently implementing the New York City standards for respectful care through virtual trainings with 14 maternity hospitals who serve the majority of pregnant Black and Brown people in the city.

I will now share more detail on some of the work led by the Health Department beginning with the M3RC. The Health Department formed and convened its first ever M3RC Review Committee in 2017 using methods, guidance and tools from the Centers for Disease Controls Maternal Mortality Review Information Application. The Health Department reviews all maternal deaths through this multidisciplinary, multiethnic and racially diverse M3RC.

Membership of this Committee is drawn from clinical and nonclinical providers across all specialties and includes Law Enforcement, Community Partners, the New York City Medical Examiners Office and key leaders within American College Midwives and New York Medical College. The M3RC contributes to the larger repository of data and literature in this field.

Most recently, the M3RC made recommendations based on in-depth review of all pregnancy associated

deaths that occurred in 2016 and 2017. These recommendations address improvements in systems and facilities in which pregnant people give birth, improving provider care and raising public awareness among community stakeholders and pregnant people of postpartum warning signs and their basic human right to respectful care.

Since the start of the pandemic, the Committee has been working — sorry, the Committee has been meeting virtually and has continued this important work. This Committee meets every two to three months to conduct a multidisciplinary expert review of each maternal death in New York City from both clinical and social determinates of health perspectives. At the end of every calendar year, the Committee proposes key recommendations to improve the care of pregnant persons.

With respect to the Departments work on SMM, we are convening a virtual New York City Maternal Health summit called Improving Care and Supporting Healthy Childbirth Experiences on Wednesday — sorry, Tuesday, tomorrow, December 8th. To date, there are over 300 people registered for this event reflecting interest to hear from experts from clinical and community

settings to discuss findings from the severe maternal morbidity project, the virtual summit will also include web-based panels that will explore the various components of the project and offer participants an opportunity to learn about SMM's efforts, projects efforts to address maternal health inequities.

Another significant component in our work to improve maternal outcomes is the Maternal Hospital Quality Improvement Network or MHQIN. Spearheaded by the Health Department and in partnership with H+H, MHQIN is a comprehensive strategy with the New York City public and private maternity hospitals to address the root causes of persistent racial and ethnic disparities and maternal mortality and severe morbidity with an emphasis on establishing an in-house quality improvement process. Specific efforts taken include implicit bias training for clinical and nonclinical staff at the City's maternity hospitals to improve equity in childbirth and training on trauma and resilience informed systems, which provides a shared language and understanding of how stress and trauma effect individuals, institutions

and communities along with practical tools to address implicit bias in clinical decision making.

We have supported clinical training and medical simulation for leading causes of SMM and improved hospital Doula collaboration by focusing on capacity building. At the start of the pandemic, public health emergency, we face some challenges in this work. For example, case abstractors were not allowed on site as hospital facilities do to infection control measures and virtual meetings with hospitals were temporarily paused as staff were entirely dedicated to immediate COVID-19 response.

Since May, we have reinstated monthly calls with most of the MHQIN Hospitals and case abstraction has resumed at most sites. Both our Doula capacity building and implicit bias trainings have moved from in-person to virtual modalities. Furthermore, under MHQIN, the Birth Justice Defenders continued their engagement efforts in communities impacted by maternal health disparities and worse health outcomes. Virtual webinars reviewed 7,000 times by community members. In order to meet emerging health needs resulting for the public health emergency, we also developed tailored resources including a

specific web page dedicated to addressing the needs of pregnant persons during the pandemic.

In addition to these resources, the Health Department has developed a series of public awareness campaigns to compliment our community-based work. To gain community input on these campaigns, we conducted listening sessions with community members consisting of persons of reproductive and parenting age representing the five boroughs. 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. A public health detailing campaign for health providers centering on having a healthy pregnancy and educating patients on chronic disease prevention and management as well as providing tools and resources to support diabetes and hypertension self-management and finally, the M3RC tool kit for healthcare providers community organizations and local Health Department summarizing our work on this topic and making the knowledgeable accessible for others. We are fiercely committed to changing the

culture around birthing care in New York City and are proud of the work this Administration has led to taking significant steps toward reducing disparities and care.

I will now speak to the bills being heard today before handing it over to my colleague Dr. Wilcox from H+H. Intro. 2017 would require the Health Department to develop voluntary guidelines for hospital visitation policies in the event of the public health emergency and to distribute such guidelines to every hospital in New York City. Post such guidelines on the agencies website and submit such guidelines to the Mayor and Speaker of the Council. The Health Department understands Council's interest in ensuring there is clear guidance during an emergency and that public health considerations are incorporated into any emergency measures taken by the healthcare facility.

However, the Health Department does not have regulatory authority over hospitals. That authority sits with the State Health Department and as such, it would be problematic and confusing to the public to issue voluntary guidance that could conflict with state guidance and regulations. With regard to

Intro. 2042; Intro. 2042 would require the Health Department to post information about midwives including the services they offer and how to find them on our website in English and each of the citywide designated languages. We support this legislation and Council's interest in making more information on midwives available and accessible to New Yorkers. We are open to discussing what would be most useful to share on our web pages.

I do want to thank the Council for their dedication to this topic and for holding this hearing today. We are proud to be partners in this work and I am happy to answer any questions. At this point, I would like to pass it to my colleague Dr. Wendy Wilcox of H+H.

COMMITTEE COUNSEL: Dr. Wilcox, we should be unmuting you as soon as the Sergeant calls the clock, you may begin. Actually, apologies, we don't have a clock. You may begin when you are ready.

DR. WENDY WILCOX: Thank you. Can you hear me?

COMMITTEE COUNSEL: We can hear you. Thank you Dr.

DR. WENDY WILCOX: Thank you. Good morning Chairperson Rivera, Chairperson Rosenthal,

Chairperson Levine and members of the Committee on Hospitals, Women and Gender Equity and Health.

My name is Dr. Wendy Wilcox, I am Chair of the Department of Obstetrics and Gynecology at New York City Health + Hospitals Kings County and Clinical Service Line Lead for the Maternal Mortality Reduction and Women's Health for New York City Health + Hospitals. I am also the Co-Chair for the New York State Task Force on Maternal Mortality and Disparate racial outcomes.

I have been a practicing clinician for over 20 years and have worked for New York City Health + Hospitals since 2008. I am joined by my colleagues Jacqueline Ebanks, Executive Director from the Commission on Gender Equity and Estelle Raboni, Acting Director of the Bureau of Maternal Infant and Reproductive Health for DOHMH. Thank you for the opportunity to discuss maternal mortality and morbidity in New York City today.

New York City Health + Hospitals have a long history of working to improve the health of women and children and pregnant persons in the City. As you are aware, our patients are often un or under insured

and may come from underserved neighborhoods. Thereby necessitating a more urgent need for attention.

For over 10 years, Bellevue Hospital has served as the New York State Department of Health Regional Perinatal Center for New York City Health + Hospitals. As a Regional Perinatal Center, Bellevue's responsibilities include monitoring quality metrics from across our system holding educational events for Health + Hospitals perinatal staff accepting transfers for complex and higher equity patients from the other 10 Health + Hospital facilities and providing 24 hour specialty and subspecialty consultation services as well as patient transport.

The Regional Perinatal Center conducts onsite visits to the other facilities within Health + Hospitals to review cases and conduct quality reviews.

In 2013, Health + Hospitals joined the American College of Obstetrics and Gynecology Safe Motherhood Initiative, which implemented standardized intervention to reduce adverse events related to sever hypertension in pregnancy, prevention of thromboembolic events of pregnancy, meaning of

prevention of life threatening clots. Which can be caused by deep vein thrombosis or pulmonary emboli and managing severe life threating maternal blood loss or maternal hemorrhage.

The three leading causes of maternal mortality at the time. And still, among the top causes of maternal mortality. In fact, at the time, New York City Health + Hospitals was recognized by ACOG District II as the only health system in New York State which had every hospital in its system participating in the safe motherhood initiative.

In 2014, New York City Health + Hospitals established the Institute for Medical Stimulation and Learning, also known as iMSAL, where we prepare for real life threatening events. We developed simulated scenarios in obstetrics and other clinical areas, so that our provider and nursing teams can practice the skills necessary to respond to these rare events. Those rare events were a quick and correct response can make the difference between life and death.

For obstetrics, we have simulations in shoulder dystocia, a revised and improved maternal hemorrhage stimulation course and when to respond to cardiac arrest in pregnancy. Our stimulation course to

manage severe hypertension in pregnancy will begin once our hemorrhage stimulation has been completed. We anticipate this will be late 2021. The implementing of obstetric stimulations, we have seen an improved response in these occurrences and a reduction in medical malpractice indemnities paid.

In 2015, all 11 hospitals the Health + Hospital system joined the Greater New York Hospital Association Depression Collaborative, which was part of New York City Thrive and implemented perinatal depression screening as part of the prenatal, postpartum and new born visits. 85 percent of people who screened positive for depression work method directly to care.

In 2018, New York City Health + Hospitals invented Reliance, an online educational course that provides assessment based personalized learning and is accepted by the American Ford of Obstetrics and Gynecology for maintenance of license insured certification.

Health + Hospitals invested in Reliance to increase the clinical knowledge and judgement of our provider team, adopt best practices, improve teamwork and communication, decrease variation among

clinicians and reduce clinical errors. Thereby reducing the number of obstetrical adverse events. Reliance is now required for attaining and maintaining privileges in our perinatal services.

Also, in 2018, Health + Hospitals partnered with City Hall and DOHMH to begin implementing a comprehensive quality improvement program, to improve the care of pregnant persons and focus on reducing pregnancy related morbidity and mortality for persons of color.

In our maternal medical home, also known as MMH, care coordinators and social workers provide enhanced support and wrap around services for pregnant persons who are at risk for undesired pregnancy outcomes due to medical, behavioral health or social determinants of health factors. The maternal medical home provides health education and encourages self-efficacy. It helps build trusting and lasting relationships between the patient and the MMH team, as well as between hospitals and community-based organizations. It helps standardize obstetric screening and assessment across the New York City Health + Hospitals system and it connects patients with needed resources and services.

The maternal medical home also encourages and facilitates patient autonomy for patients in their prenatal care and birthing experiences.

As I previously mention in the stimulation program, it trains the OB healthcare team to manage the top three causes of maternal mortality, cardiovascular collapse, acute life threatening blood loss, also hemorrhage and severe hypertension.

The Interval Pregnancy Optimization Program helps to improve maternal health by training primary care providers to ask patients specifically about pregnancy intensions. The patient is asked whether they are planning to become pregnant in the next year. If yes, they are referred for preconception counseling. If not, they are referred for effective contraception of their choice.

Our Mother, Baby Coordinated Visit Program aims to increase adherence to the postpartum visit by having the patients postpartum visit scheduled with the babies pediatric visit.

In terms of addressing implicit bias, this is a priority at New York City Health + Hospitals. Health + Hospitals has conducted implicit bias training for our board of directors and for medical and

operational leaders in all 11 of our facilities plus our Gotham sites with perceptions institute.

We have also worked hand-and-hand with DOHMH to provide training sessions to the Maternal Hospital Quality Improvement Network OR MHQIN. Which you heard my colleagues Ms. Raboni discussed.

The MHQIN is a comprehensive partnership between DOHMH and 14 New York City maternity hospitals to address the root causes of persistent racial and ethnic disparities in maternal mortality and severe maternal morbidity with emphasis on the importance and the how to of setting up quality improvement process in their department.

With DOHMH support, MHQIN integrates reviews of all cases of obstetrical hemorrhage in ICU admissions into OB Department Quality Improvement Prophecies. MHQIN hospitals also provide data back to DOHMH to inform future population based strategies to address these conditions.

New York City's Health + Hospital's Community Care Program ensures that pregnant women have access to the highest quality care in a home setting. This includes but is not exclusive for anti-partum assessment and instruction, teaching and support for

breastfeeding and supporting care of infants who are at high risk for neonatal morbidity or mortality.

As part of the New York City's Birth Equity Initiative, Health + Hospitals partnered with DOHMH and the Centering Healthcare Institute to launch censoring pregnancy and evidence-based group Prenatal Program at New York City Health + Hospital Elmhurst Hospital. Although further research is needed, there is evidence that centering pregnancy can improve maternal and infant health outcomes including preterm birth reduction in certain populations. Centering encourages greater patient engagement during the prenatal experience. The program features group pregnancy visits with a provider networking with other pregnant women, group discussions and prenatal wellness and education classes on nutrition, stress management and breastfeeding.

All pregnant women are eligible to participate in a group care sessions and are asked to join the group during their initial prenatal visit unless the pregnancy shows signs of being already or becoming very high risk. The sessions begin at about 16-20 weeks gestation and occur with the same frequency as routine prenatal care visits.

Midwifery services are offered throughout New York City Health + Hospitals to improve patients experiences. New York City Health + Hospitals employs over 70 midwives across the system and is the largest employer of midwives in New York City.

Patients may access Doula services through our relationship with community-based organizations. Patients who request Doula services are referred to community providers including Brooklyn Perinatal Network, By My Side, Caribbean's Women's Health Association, Bronx Rebirth and [INAUDIBLE 1:05:30]. Over the last three years, we have made many referrals for Doula support for patients and are looking to expand these referral services.

In conclusion, we would like to thank the Council for its support of Health + Hospitals to improve the care and outcomes for the women we serve. I am happy to answer any questions. Thank you.

COMMITTEE COUNSEL: Thank you so much for your testimony. At this point, we will be moving to Council Member question and answer. Chair Rosenthal?

CHAIRPERSON ROSENTHAL: Great, thank you. Thank you so much and thank you all for your testimony and

obviously all your care and your dedication to addressing this crisis.

I am going to start with the maternal, the DOHMH Maternal Hospital Quality Improvement Network. I am wondering if you can tell us a little bit about the impact of that and whether or not the Mayor has committed to continue the funding for it in the coming fiscal year and beyond?

ESTELLE RABONI: Thank you so much Chair Rosenthal for your question. The impact is being measured in terms of, it is very early in this process. We are conducting these trainings, most recently we conducted with 13 hospitals and what we have seen is qualitative research, qualitative information, which suggests that first acknowledging that there is implicit bias in the hospital institution or the facility. There is bias among providers and recognizing what those biases are. Recognizing that a White presenting physician may have a bias towards someone who does not look like that person and acknowledging that that needs to change and that the interaction that that patient has with the hospital is likely to be compromised in some way.

Some of the qualitative research has shown that there is overwhelming support to integrating a lot of the changes and the perspectives found in the implicit bias training and that has been operationalized and we are starting to roll that out. Up to this point, we have trained 700, both clinical and non-clinical staff on all levels from leadership to administrative staff and midwives as well as others and with regard to funding, we are committed to this work. We know that this is important work. This is what we need to do in order to change bias that is being performed in all the spaces in which Black and Brown pregnant people are in and we are moving forward with that.

CHAIRPERSON ROSENTHAL: Are you saying that the Mayor is committed to the funding for this?

ESTELLE RABONI: I am sorry, the beginning of your question dropped out.

CHAIRPERSON ROSENTHAL: Sure, sure. So, my understanding is the funding ends this year. The money is not in the budget for Fiscal Year, it would be ’22. Has the Mayor committed to keeping the money in the budget or adding now money to the budget for the continuation for this program? Or do you feel

that the work that you have done, that you have completed so far has taken care of this issue?

ESTELLE RABONI: No, I think the work needs to continue and certainly the Department of Health has that commitment. It is a core value of the Department of Health to improve maternal health citywide.

CHAIRPERSON ROSENTHAL: Can you confirm that they will continue the funding? Have you put in a request to the Mayor's Office for funding for the network program and have they already said yes? Was the money put in the November plan? Is it expected to be put in the January plan? It's just yes or no and no shade, whatever the answer is on you.

ESTELLE RABONI: We have put forward that we want to continue this work. I don't have any other information, whether or not —

CHAIRPERSON ROSENTHAL: It's put in the budget though, right? It's not in the budget? Can you confirm the funding is not in the budget for Fiscal Year 2022?

ESTELLE RABONI: I don't have the answer to that Chair Rosenthal. I apologize.

CHAIRPERSON ROSENTHAL: Do you think you can text somebody and ask them to get the answer to that before the end of your time as a panelist?

ESTELLE RABONI: I will certainly do that.

CHAIRPERSON ROSENTHAL: Great, thank you. I will come back for the answer to that. Second question is, can you tell us one or two, you said the M3RC with an instituted formerly in 2017, can you tell us one or two findings from the most recent M3RC meeting that has led to and what the tangible change is that you have made in the way care is provided for Black pregnant people?

ESTELLE RABONI: Much of the findings are actually being operationalized in the programs that we have now, so I terms of MHQIN changing hospital cultures, changing providers, making sure that both providers and community stakeholders are aware of the —

CHAIRPERSON ROSENTHAL: Right, forgive me for interrupting. We just have so many people who want to testify. I think I didn't articulate the question the right way. In the M3RC Committee meetings, it is my understanding that you take a specific case, in other words, you go through the example of a

situation where a physician who was caring for in this case, a Black pregnant person and the Black pregnant person died and you go through exactly what happened and you learn from that to change something for the better.

Can you tell us about, not with the names or no privacy you know, indicating information but something you learned, one thing that was learned from the most recent M3RC Committee meeting. It could be hospital specific. It could be physician specific. That's fine but I just want to hear what it is.

ESTELLE RABONI: I would say with regard to that, I think it was mentioned by one of the Council Members. One of the largest issues is listening to Black and Brown pregnant people when they air concerns and taking those concerns very seriously. That initial interaction between provider and a pregnant person is very important because if their concerns are dismissed, they are unlikely to go back to that provider or to raise additional concerns.

CHAIRPERSON ROSENTHAL: I mean, that's a hell of a finding. It's a hell of a finding and you said you

have trained now 700 medical professionals. How many more need to be trained?

ESTELLE RABONI: Our goal for this year was 1,000. We did have a little bit of loss in momentum when the pandemic hit because originally all of our trainings were in-person.

CHAIRPERSON ROSENTHAL: Right but how many medical professionals are there in total?

ESTELLE RABONI: It's the majority. I don't have a number off the top of my head but it's overwhelming it's the majority. The majority of those trained are clinical people. We are trying to make a big impact on those.

CHAIRPERSON ROSENTHAL: Do you do follow-ups in the M3RC to learn whether or not in fact behavior has changed?

ESTELLE RABONI: Yes, the relationship is long-term. We don't just provide a training and then leave those people trained. We follow up and then we operationalize a plan on how can we make changes within the system to change outcomes.

CHAIRPERSON ROSENTHAL: Alright. Local Law 914 of 2018 codified the M3RC and expanded on maternal mortality reporting requirements. Would it make

sense for the M3RC to share an annual report? Why or why not?

ESTELLE RABONI: Thank you Chair Rosenthal. I understand the question. The fact is that the timeline from maternal death to M3RC review actually meets the gold standard for timeliness according to the CDC guidelines for maternal mortality review. And it is the result of the time required for case ascertainment, collection of medical and other relevant records and case abstraction and case review. I recognize that every maternal death is a tragedy and we agree. However, it is a very rare event and unfortunately it requires time for us to see changes.

CHAIRPERSON ROSENTHAL: So, last year I think it was, 26 women died in childbirth. The ratio of 8 to 1. Eight Black women died for every one White woman. How many of the cases of Black women who died went through a quality review whether or not it rises to the level of an M3RC or just a basic quality review? How many of those cases for the Black women?

ESTELLE RABONI: I would have to take a look. I don't have the answers to that. I know that we receive information of maternal deaths and we look

into those and that becomes part of the conversations with the M3RC but I don't have that information. I would like to ask my colleague Dr. Wilcox, who does sit on the M3RC if she could answer that question.

DR. WENDY WILCOX: Sure, thank you Ms. Raboni and Chair Rosenthal. So, all of the maternal deaths are reviewed as a group and a death is any death with temporal proximity to a pregnancy of a year.

So, for 2018, not just the women who died in the hospital, the women who died at home or in other locations within a year of a pregnancy, no matter how far along are all put in a cohort and then reviewed. This year, we are reviewing deaths from 2018. Because it takes that long to you know, have someone abstract the charts, so that things are identified and no personal information is known to any member of the group. Only the person who abstracts the chart knows the actual details of the nonclinical and non-circumstantial details of the deaths, everything is to be identified. The group then comes up with recommendations and I would say that as we go through the review of the deaths, the recommendations are collected and what you find is similar recommendations being made along the way.

The way that CDC has set it up and the M3RC follows the CDC guidelines, those guidelines, is to come up with recommendations whether it is on a hospital level, a provider level, a patient level, a city level. And then the how to is kind of sorted out and then people have to work on that. I would say the deaths are often incredibly complex. We find I would say, you know, how the CDC says communication is the number one cause for adverse events in the clinical realm. Communication whether its from where someone received prenatal care to the hospital and then from the hospital to other specialties or from the hospital to other entities. We frequently are coming up with recommendations that involve improving communication between all of the different entities.

CHAIRPERSON ROSENTHAL: Got it, thank you. You know, I think one of the things that everyone is talking about is the fact that — is the fact that you know, these deaths are preventable. According to the CDC, it is 3 out of 5 are preventable.

When we look at New York City, it is clear we have a segregated hospital system, right. Where the big network hospitals, New York Presbyterian, Mount Sinai, etc. You know, are not taking the patients

who they should take. Would it be possible for the City, have you considered requiring these hospitals as part of your affiliate contract for example, to take more prenatal, more Black pregnant people for prenatal and postpartum care?

ESTELLE RABONI: I would have to —

CHAIRPERSON ROSENTHAL: It is my understanding that the City can order hospitals to care for more Black and Brown patients or take away some privileges.

ESTELLE RABONI: Thank you Chair Rosenthal for your question. I think we would certainly take that under consideration. Currently —

CHAIRPERSON ROSENTHAL: Is it part of the discussion in any meetings that you have been in?

ESTELLE RABONI: I would like to defer to Dr. Wilcox if that has been part of any discussion.

CHAIRPERSON ROSENTHAL: Wow, I mean, I really have to say that's heartbreaking. New York City, I mean, I have been working, thinking about those affiliate contracts since I worked under the Koch Administration. You have so much leverage under those affiliate contracts. Your hospitals provide the patients for these medical students. So, the

fact that the City according to what your knowledge is has never used this opportunity to require the private hospitals take the affiliate hospitals do more prenatal and postnatal care never? I will move on.

ESTELLE RABONI: I would have to — Chair Rosenthal, thank you. I would have to go back to my colleagues as this is not work that falls under my bureau but I can take this question to my colleagues and —

CHAIRPERSON ROSENTHAL: Yeah, I would love to hear from the legal team on this and I see you taking notes Director Ebanks. I appreciate you, it's a perfect sort of overview question. I appreciate your following up on this, I really do.

Last set of questions, given that Black women are eight times more likely to die from pregnancy related cases than White women and three times more likely to have a life threatening complication, I am interested to know if you plan to extend the pilot project you mentioned with three hospitals to conduct the quality improvement reviews. Whether or not you plan to extend that to eleven hospitals now?

ESTELLE RABONI: Yes, thank you Chair Rosenthal, we do. This cohort is just the first cohort. The plan was always to expand to all the maternity hospitals. Our initial attempt was to use the limited resources that we have to impact those hospitals that are responsible for [LOST AUDIO 1:23:53] among Black and Brown pregnant people.

CHAIRPERSON ROSENTHAL: Should I ask you which those three hospitals are? Is that public information?

ESTELLE RABONI: I would have to get back to you on that. I am sure I have it here.

CHAIRPERSON ROSENTHAL: If it is public information, by the end of your time as a panelist, I would love to hear the answer to that. I am going to turn it back to my colleagues — or to the Moderator. Thank you very much for your testimony.

ESTELLE RABONI: Thank you.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. We will now move to Chair Rivera and Chair Levine if they have questions before moving to other Council Members.

CHAIRPERSON RIVERA: Thank you so much for your testimony. Just a few questions because I do realize

the time and we have many people waiting to testify whose I think experiences, stories and testimony are important to get on the record.

I guess I will start with Health + Hospitals or anyone can really answer this question and I want to ask a little bit about kind of where we are right now during this pandemic. So, how do Health + Hospitals currently admit birth workers such as Doula's to pre—and postnatal visits during deliveries?

DR. WENDY WILCOX: Thank you Chairperson Rivera. So, during the first surge, all patients visitation at New York City Health + Hospitals was suspended with a few exceptions including for a visitor of a woman in labor, an infant in the neonatal ICU or pediatric patients.

Doula services during this time became very innovative and provided services virtually. Our current policy follows New York State's guidance, which is that patients may have one support person during labor and a Doula when the patient has a Doula.

CHAIRPERSON RIVERA: I will ask you about those guidelines in a second. What certification and

testing requirements are in place for birth workers during the pandemic?

DR. WENDY WILCOX: I am so sorry; I am not understanding. What — please rephrase.

CHAIRPERSON RIVERA: Sure. For birth workers and during the pandemic, how are you offering services certification to make sure that they can continue to do their work to make sure that we can get people continuously certified during the pandemic, so that they can continue to provide these services?

DR. WENDY WILCOX: To my knowledge, there is no certification for Doula's. We certainly, as I said in my testimony refer to our community-based organizations. We refer patients to them for Doula services and our patients obtain Doula services through the community-based organizations. We do not employ Doula's.

CHAIRPERSON RIVERA: What I mean is certification requirements to enter the hospital.

DR. WENDY WILCOX: So, again, a patient may enter with a support person. Our admitting procedures are made aware to the people at the front desk as well as our patients are available on our website. So, patients are aware that they are allowed a support

person when they come in for their birthing experience and the Doula may come with the patient.

CHAIRPERSON RIVERA: Understood. I ask because laying the ground work for consistently positive relationships between hospitals and birth workers is critical as you mentioned in your testimony. So many Doula's have shared with us that they have been turned away or been told that hospitals would only accept certification from certain organizations.

So, how can we work with hospitals to ensure that birthing persons are not in a position where they are chosen and often paid out of pocket, Doula will not be turned away when they need them the most.

DR. WENDY WILCOX: So, as you are aware, the patients sometimes do not have means and so, certainly our expectations when we refer is that patients without means will be provided with you know, Doula services that are compensated in other ways and we refer, like I said, patients to these organizations that will help provide these services for our patients.

CHAIRPERSON RIVERA: I will ask about the organizations in a second as well. It is just that some hospitals require some certification, others

don't. It has been very unclear and I realize these are unprecedented circumstances but in regards to what you mentioned on state policy, how can — may be this is for the Department of Health. How can pregnant people and birth workers currently find hospitals visitation policies, both for support for family members, familial support and birth workers. How do New York City hospitals communicate state guidance on visitation policies and can you clarify why the state guidance on visitation policies has resulted in different policies in different facilities?

DR. WENDY WILCOX: I will just answer for New York City Health + Hospitals, our visitation policies are on our website and also during the care that we give our prenatal patients, the providers and nursing staff will let the patient know what our policies are.

CHAIRPERSON RIVERA: Does Department of Health have anything to add? I just want to be clear. So, you are saying it is in-person to the patient and it is online?

ESTELLE RABONI: That's correct and I believe it was also in the New York State website as well when the executive orders were established.

CHAIRPERSON RIVERA: And you know, I just want to emphasis Council Member Farah Louis, Co-Chair of the Women's Caucus mentioned how there is a digital divide, not everyone has access to internet and so, having those conversations in different ways is really important and mentioning specifically Brooklyn and I know there are amazing organizations that have been doing this work for a very long time. Brooklyn Perinatal Network is certainly I know a partner of yours.

So, despite all the efforts made by DOHMH and H+H and other hospitals, we are still seeing the disparate maternal health outcomes and there are those long standing CBO's working to address these outcomes and they are pillars of our community as we all know. How has the Department of Health partnered with these CBO's and actively engage with them to continue to improve our efforts to save lives?

ESTELLE RABONI: We engage with many community stakeholders because we recognize the expertise in the community. So, to Dr. Wilcox's point, we do work

with you know, community-based Doula programs in New York City such as By My Side, Birth Support Program. We do work with other you know, community stakeholders to improve the quality of service to pregnant people.

CHAIRPERSON RIVERA: Okay, do you believe that there are enough resources for pregnant women in New York City?

ESTELLE RABONI: I think there could be more services certainly, as I mentioned, we are trying to concentrate the resources that we do have on those hospitals that manage the highest number of births among Black and Brown pregnant people but of course there could always be more and there could be more coordinated communication and information sharing, so that more people are aware of what services are available to them.

CHAIRPERSON RIVERA: And you know, during the pandemic, I feel like with the strain on our hospital system, patient advocacy is very, very important and that's why I was so committed to making sure that the visitation guidelines were changed or really amended to make sure that people felt like they had that support.

I am a little torn on whether we have enough resources. I don't think that they are there. I just feel like the evidence is clear, whether qualitative or quantitative and it's systemic and it has been going on for a long time. What resources does a pregnant person have if they do not feel like they know how to navigate the medical system or they experience complications and they do not feel like they are being heard?

ESTELLE RABONI: Chair Rivera, I understand the passion behind your question. There are services within the City. We also have other programs that advocate on behalf of pregnant people. For instance, the Health Department regardless of the pandemic, continues to support vulnerable families and new families through our Newborn Home Visiting programs, as well as the Nurse Family Partnership program and serving thousands of families every year to make sure that pregnant people and postpartum people have all the services that they need to raise healthy and happy children, as well as to maintain maternal health.

There are other programs throughout the City that support people. Can we have more services?

Absolutely and more coordinated services and more coordinated communication of services. But to your point, it takes time to change hospital culture and that's what we are trying to do. So, we need long term investment to change what's going on.

CHAIRPERSON RIVERA: And in speaking of those services, Doula's and midwives, I think we could all agree improve maternal health outcomes full stop.

Can Health + Hospitals just give an update about — I know there was some in the testimony and I appreciate the length of your testimony. Can you provide an update about on how you are working to improve access to midwives within the hospital system?

DR. WENDY WILCOX: So, midwives are at all of our facilities, except for three. Certainly during the initial prenatal visit, a patient a lot of screening is done, some of which is clinical and certainly if someone from a clinical standpoint can have you know, is eligible for midwifery services, then they are referred at that site. As well as if a patient would like midwifery services and does not have it at that particular facility, they can certainly access it at another open hospital facility.

CHAIRPERSON RIVERA: I am sorry, I didn't understand the last part. They can go to a different hospital.

DR. WENDY WILCOX: Within Health + Hospitals. We can help facilitate that.

CHAIRPERSON RIVERA: There are three of them that do not have the services. Can you tell me why? Where are those hospitals?

DR. WENDY WILCOX: It really is just a way that the Department of Obstetrics and Gynecology just evolved over time.

CHAIRPERSON RIVERA: Okay, so you are saying that there are reasons for why there are no midwifery programs in these hospitals? What are the factors that would lead to that decision ultimately?

DR. WENDY WILCOX: I don't necessarily think it was an intentional decision. Just over time there were some departments, three out of eleven that just do not have midwifery services.

CHAIRPERSON RIVERA: But you are not sure why? I am sorry, I am just really want to clear that up.

DR. WENDY WILCOX: I am not sure that there was actually a definite plan. We certainly think that is just the way the department has evolved. Throughout

Health + Hospitals, there are more than 70 midwives, includes of a full-time, part-time and peridium employment status and again, Health + Hospitals is the largest employer of midwives in New York City.

CHAIRPERSON RIVERA: Are there expectations to expand that program given the crisis?

DR. WENDY WILCOX: Expand what program, excuse me, sorry.

CHAIRPERSON RIVERA: To expand those services.

DR. WENDY WILCOX: Midwifery services?

CHAIRPERSON RIVERA: Yes.

DR. WENDY WILCOX: So, in a lot of our facilities, midwifery services compliments the full breath and depth of obstetrical services that are offered at the facility.

CHAIRPERSON RIVERA: And I ask because also at a January 2020 hearing, that I Chaired, Dr. Katz shared that Health + Hospitals partnered with Department of Health at the Mayor's Office to begin implementing a comprehensive maternal care program.

DR. WENDY WILCOX: Yes.

CHAIRPERSON RIVERA: In that you have a focus right, on identifying and responding to pregnancy related morbidity and mortality for women of color.

Well, I want to just say, I know we bring up morbidities and high risk pregnancies, I think it is important to note that we know most people who give birth are healthy but we need to focus on systemic failures rather than an individuals health status.

So, having said all of that, can you please provide an update on those efforts that Dr. Katz mentioned.

DR. WENDY WILCOX: I would be happy to, thank you. So, the maternal medical home staff, as you know, we have embedded in maternal medical home within our facilities and the purpose of this maternal medical home staff is to really provide wrap around and enhanced service for individuals and to also provide screening, standardized screening so that we can identify those women who maybe at risk for having an adverse outcome due to medical complications, behavioral health or social determinates of health factors.

Since that time, our maternal medical home staff have seen more than 2,500 clients and made over 1,800 referrals to services such as Doula services, nutrition counseling, behavioral health services and counseling, WIC, nurse family partnership, SNAP,

substance use, just to name a few. And our maternal medical home members have also made over 650 referrals to community-based organizations.

We have trained over 1,100 clinical staff in our OB life support simulation course. Our OB hemorrhage course is launching. The didactic sessions are now underway and we intend to train the same number of clinical providers to reach a saturation of about 90 percent trained.

For our pregnancy intention, that was embedded in our epic electronic medical record and so, patients are being asked about pregnancy intention and our newborn and postpartum coordinated visit program did have to halt a little bit during you know for infection control reasons during the height of COVID. The COVID surge but those are starting to get off the ground again.

CHAIRPERSON RIVERA: What does patient monitoring and care look like from when a person first expresses interest in becoming pregnant to when they are postpartum?

DR. WENDY WILCOX: Thank you for asking that question. So, from the moment a patient expresses interest in becoming pregnant, she is referred for

preconception counseling. This may include her taking folic acid supplementation, general health screening and possibly changing the patients medication regime if she is on any.

Once she becomes pregnant, she may access midwifery services, as previously discussed if health allows and if she is at one of those other facilities and once in care, the patient receives the highest evidence based standards of prenatal care. This includes genetic screening, ultrasound services, other fetal testing, as well as standardized screening and referrals when necessary.

CHAIRPERSON RIVERA: And I wanted to ask because Health + Hospitals provided an update about a maternal depression screening initiative through Thrive NYC.

DR. WENDY WILCOX: Yes.

CHAIRPERSON RIVERA: And what is the status of this work? And I just want to add, in terms of depression, mental health, we want to do this work you know trauma informed and so, I would like to know the status of that work for maternal depression but also through entire kind of gynecological services whether pregnant or not. I think asking questions

about trauma to really make sure the work is holistic and comprehensive is incredibly important. So, can you give us the status of that work?

DR. WENDY WILCOX: Sure, so the maternal depression collaborative with Thrive ended on December 31, 2019 but really our depression screening has become hard wired into our normal and regular processes.

So, patients are routinely screened during prenatal, postpartum and newborn baby visits. 48 clinic sites and 25 New York City hospitals were involved. Over 36,800 prenatal women were screened. Over 23,100 postpartum women were screened and 85 percent of patients who screened positive were directly connected to care. It really is part of just standardized processes and how we do business.

CHAIRPERSON RIVERA: No, I understand and I realize that I think all of you wake up in the morning to do your very, very best and to take care of people in hope that they feel seen and heard. Just the stories and the experiences are just, they are showing otherwise and it is leading to tragic, tragic outcomes and families devastated.

So, I want to just thank you for answering my questions. We have many people here including Mr. Bruce McIntyre who has been here for the duration of the day with his own story to share and I want to thank you for your testimony. I am going to turn it over to Chair Levine to ask question because like I said, for sake of time. Thank you for being here. Thank you for answering our questions.

CHAIRPERSON LEVINE: Thank you so much Chair Rivera and thank you Chair Rosenthal for what's already been an important and impactful hearing.

I want to ask a few brief questions and I will be brief about data. Because there is no way we can measure our progress in solving this crisis unless we have clear transparent and regularly reported data. In fact, it is one piece of data, the horrifying disparity of 12 to 1 in maternal mortality between White and Black mothers which has really led to unprecedented and long overdue attention to this issue in the last two years with more media coverage. It has finally belatedly focused attention of the public on this reprehensible disparity.

So first, I would like to ask about news that I think you have broken in the last day or two about

what appears to be a new figure you are using or the disparity in mortality between Black and White mothers in New York City. Which you are now saying is 8 to 1. I wonder whether this perhaps could be a question for Assistant Commissioner Raboni. Whether that number has or the data behind it has been yet made public and if not, when we can expect that? And whether we can expect regular updates on this critical statistic going forward?

ESTELLE RABONI: Thank you Chair Levine for your question. Yes, the data that says that Black women are 12 times more likely to die from a pregnancy related death is actually from the 5 year report that spans 2006 to 2010. The most recent report that spans between 2011 and 2015 actually shows 8 times more likely. Still concerning in terms of the disparity but heading in the right direction.

Our next report is scheduled to be released in I believe it is 2021 and we are looking forward to seeing if there is a downward trend, to see if there is an improvement in that respect.

CHAIRPERSON LEVINE: But Commissioner, how is that we are operating on 5-year-old data even with your update?

ESTELLE RABONI: It does take time to collect information, as I mentioned previously, it takes time to abstract the cases, assess the cases, evaluate them. It is a CDC best practice in terms of timeline and because as tragic as maternal deaths are, it is a very rare occurrence and so, we require having to get more information and more data in order to make any kind of determinations.

CHAIRPERSON LEVINE: But we have all sorts of health data in this city, which is updated yearly, quarterly, monthly, in some cases, even daily. Surely we can have an annual update on data which is just so critical.

ESTELLE RABONI: I have to say again, it really is based on the science and what the best practices are and the best practices suggest that in terms of maternal mortality and severe maternal morbidity, it requires some amount of time. I would love for Dr. Wilcox to opine, as she is also part of these conversations as well.

DR. WENDY WILCOX: Thank you Ms. Raboni. Again, you know the data that we are looking at is for an entire year. It is suggested that you look at them not as they come in but as an entire cohort and I

think it has been getting faster. When we first started, we were reviewing I don't know 2015-2016 data and so far it has been 2018. The addition of the pregnancy check box on death certificates which is unfortunate and morbid topic but has enabled easier identification of persons for review.

So, you know it would be nice if it was an easier thing to do but it is a lot and it is complicated.

CHAIRPERSON LEVINE: Right but the Surgeon General, the American Medical Association Society for Maternal Fetal Medicine, they all talk about the importance of regular data and they really are the science authorities that we need to be listening to. But I do want to move on for time and ask what the data that we have is telling us about the trend. To the extent to which the data you believe is indicating progress or heaven forbid that we might be stalling or backsliding.

ESTELLE RABONI: I hesitate to suggest that we are making progress because again, I feel that we need to see the next cohort of data to make that determination if it's a downward trend or not. It could fluctuate so much within a particular year that

I think it would be responsible for me to suggest that there is a trend at this point.

CHAIRPERSON ROSENTHAL: I am sorry Council Member Levine, can I just follow-up.

CHAIRPERSON LEVINE: Please.

CHAIRPERSON ROSENTHAL: Really nailing it questions. Are you saying — what I think I just heard you say is that you don't know the information about whether or not the death was related to pregnancy until the death certificate comes out and so, you are waiting for that until you have the data? But even if that's true, which is mind numbing because I would imagine given that the number is so little that every death would send a red flag immediately up the chain to tracking.

So, but even if you are waiting to review death certificates, surely you can review the death certificate, you have the data from calendar year 2019 now. You have the data from calendar year '18, '17, '16. So, given the data that you have for that four year period, because I understand you know, it is important for privacy to you know, not use specific figures or names in a current year. What were the numbers for each of those four years and

then let other people think about patterns or whatever. But what was the number of people who died in 2017, 2018 and 2019?

DR. WENDY WILCOX: May I just — would it be okay if I just added something. I think it might have been helpful to have an overview of pregnancy associated versus pregnancy related deaths.

CHAIRPERSON ROSENTHAL: Look, I am down with you on all of this nuance and specifics, so you can report it the way that it is accurate. I am not going into the details and I know you have the medical specifics on this. I just, and I understand every nuance. So, if you want to have those two different categories, you know, what ever the right way is to show it but surely you have the numbers now for each of the last four years, no?

ESTELLE RABONI: We do have data which we are looking at and currently doing data analysis on.

CHAIRPERSON ROSENTHAL: Right, no I am not asking for the analysis. I am not asking for the review; I am asking for the raw numbers.

ESTELLE RABONI: I don’t have that information with me at this time.

CHAIRPERSON ROSENTHAL: Okay, gosh.

ESTELLE RABONI: Dr. Wilcox, would you like to weigh in on that?

DR. WENDY WILCOX: I just think that it is a little difficult because there are some deaths that are incidental to a pregnancy that really have nothing to do —

CHAIRPERSON ROSENTHAL: Of course and the CDC says 3 out of 5 are related to preventable issues. Obviously that means 2 are not preventable but I just am interested in the raw numbers.

ESTELLE RABONI: We can give you that information Chair Rosenthal.

CHAIRPERSON ROSENTHAL: I mean, that would be great. Maybe by the end of — if staff are watching now, if they could send that over to you and put a big old foot note on it with the nuance. That's important to put on but I would imagine you could have that information from your staff before this panel closes. Chair Levine, I am so sorry to have interrupted you.

CHAIRPERSON LEVINE: Not at all Chair, those are excellent follow-ups. I want to ask similarly about data on underlying conditions, which we know contribute to mortality and morbidity in birth, in

childbirth. Here again, there are enormous racial disparities driven by a variety of environmental factors from lack of equal access to healthy food to broader stress arising from racism in society. Do you have data on the prevalence of such conditions and people giving birth in New York City. For example, rates of diabetes that we could compare across various racial and ethnic groups?

ESTELLE RABONI: Thank you Chair Levine for your question. It is safe to say that what we are concentrating a lot of our work in, in the Health Department are the same neighborhoods that have multiple health indicators that are fairly negative. Whether it is diabetes or hypertension or maternal health outcomes during pregnancy. These are neighborhoods that been historically tested that have been impacted by racism. We are doing everything possible to mitigate the effects of that racism and disinvestment.

COMMITTEE COUNSEL: Estelle Raboni, I am so sorry to interrupt. We are getting a bad audio feed from you. It is almost skewed, so we are going to try to mute you and unmute you again. It wasn't happening earlier but it started now.

ESTELLE RABONI: Can you hear me?

COMMITTEE COUNSEL: We can. There is some feedback, it sounds like you are under water with the microphone.

ESTELLE RABONI: Should I log out and log back in?

CHAIRPERSON LEVINE: Yes and while you are perhaps — while you are dealing with that technical issue Commissioner perhaps I could just follow-up with Dr. Wilcox. The Commissioner very accurately stated the broad conditions which are leading to these inequalities but my question is whether we are collecting data. If we knew for example that certain groups of people coming in to give birth had higher rates of diabetes, that would indicate a real problem related to medical risk at birth and we could track that over time.

It would be one indicator of progress that perhaps we could have real time because it doesn't have the complexity that tracking birth certificates does. Are we collecting data on underlying conditions in people giving birth in New York City and what is it telling us over time?

DR. WENDY WILCOX: I do think Ms. Raboni would be better to answer that. However, I will let you know from being a member of the Committee what I have seen and also, from being one of the authors of the maternal mortality report from 2006 to 2010. One of the authors of the New York City Department of Health Report and what that showed was over 50 percent of the women who died had one and or more, it was greater than 50 percent. One and or more preexisting conditions, inclusive of hypertension, diabetes, asthma, obesity, etc. I think it was upwards of two-thirds. And so, we do know that these chronic conditions do predispose to poor outcomes at deliver. Certainly, these are all examined in a process of the review and these also appear in the reports.

So, in the last report and in the upcoming report as Ms. Raboni stated that data should be in there.

CHAIRPERSON LEVINE: Right, I understand but can you tell us for example, so far in 2020 whether there have been disparate rates of such underlying conditions in all women giving birth across various racial and ethnic and demographic groups?

DR. WENDY WILCOX: I am not able to give that data.

CHAIRPERSON LEVINE: Right, that would be the kind of close to real time data that we could look at that I think would be a marker of our progress and if we did see that we were closing the disparity in those underlying factors, even independent of the tragic incidents of mortality. That would show that we are making progress at least on one front and I do want to move on but just lastly along those lines, do we have data and methods that we know help solve this problem?

For example, can we track our progress in increasing the number of mothers, birthing people who have Doula or other birthing assistance and again, track whether that the gap is closing amongst different groups?

DR. WENDY WILCOX: Again, I would have to refer that to my colleague Ms. Raboni to talk about citywide data. However, to tie back your question as to why we thought the Maternal Medical Home was so crucial is because and that model was based off of the medical home that was created in internal medicine for chronic diseased patients such as HIV care or diabetic care.

So, the Maternal Medical Home really was fashioned over that model, which said that if we have patients who we realize may be a little bit more complex to care for, let's put an extra layer of support in there both for the patients sake, to make sure that that patient has someone to reach out to and to talk to and to make sure that she gets tied into Doula care.

But also, to all the other services she may need, such as enhanced nutrition, whether it is through SNAP or WIC. You know, housing, legal services, nutrition counseling, other forms of support. And so, that model of the Medical Home can be applied and is being applied currently to our prenatal patients specifically for that reason.

CHAIRPERSON LEVINE: Okay, I am going to wrap up because we have so many colleagues and advocates asking for questions but you know, the adage is that if you don't measure it, you can't fix it and I think we need to get transparent as close to real time data on not just mortality and morbidity rates but underlying conditions and the methods that we know can help solve this.

We need that as a city and we will certainly continue to advocate for that. Thank you and I will pass it back to you Chair Rosenthal.

CHAIRPERSON ROSENTHAL: Thank you so much Chair Levine. I will now ask the Moderator to call on my colleagues with questions for the Administration.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. The next Council Member with questions will be Council Member Barron.

SERGEANT AT ARMS: Starting time.

COUNCIL MEMBER BARRON: Good morning. How are you?

ESTELLE RABONI: Good, how are you?

COUNCIL MEMBER BARRON: I am well, thank you. Just a few questions. We talked about most recently in the questioning here about the lag, the delay from the time that we have when we get the data. Why is that — most recently Council Member Levine asked, why can't we get it sooner?

ESTELLE RABONI: Well, as I have mentioned before, there is a standard protocol that we are following from the CDC that suggests that there is a two year delay in order to track this data and to report on it responsibly. It takes time. As I

mentioned before, as tragic as maternal deaths are and they are tragic, they are rare and so, it is a relatively small sample size to be assessing.

Of course, you know, so we are trying to follow a particular protocol in order to assess accurately.

COUNCIL MEMBER BARRON: Thank you. I have lots of questions but I am going to be quick. I think I heard testimony that there were 3 out of 11 hospitals that have no midwifery services. Is that what you said? Is that what was reported on the record?

DR. WENDY WILCOX: [LOST AUDIO 2:03:33] Health + Hospitals facilities that do not have midwives.

COUNCIL MEMBER BARRON: And can you tell us what area of these 3 hospitals are located in?

DR. WENDY WILCOX: I do not have those 3 hospitals listed right now.

CHAIRPERSON ROSENTHAL: I am sorry, this doesn't need to eat into Council Member Barron's time. Then can you read the names of the hospitals that do have the midwifery service and we will figure it out from there.

DR. WENDY WILCOX: I am so sorry; I regret to say I do not have the specific hospitals that do or do

not. Perhaps we could provide that to you after. I don't have it in my information.

CHAIRPERSON ROSENTHAL: Okay, if you could please add Sergeant a minute to Council Member Barron's time.

COUNCIL MEMBER BARRON: Thank you Madam Chair and I did want to follow protocols and thank the Chairs for having this very important hearing, Levine, Rosenthal and Rivera.

I am suspect and it's not paranoia but I am suspect as to what the 3 hospitals are, why they don't have it because I don't believe that it just evolved. I think that there were factors at play in determining whether or not a particular hospital would have these kinds of services. It has been said that the problems are systemic and not necessarily individual and I think that as we try to address these issues, we have got to make it systemic.

When HIV became a real crisis, when the opioid crisis became touching other communities other than Black communities, the City put millions and millions of dollars into solving that problem. I understand that every life is valuable. Every life is important and I accept that and I have heard it said, well

there were only a few. There aren't a large number but the percentages by which Black and Latino women are disparately impacted in a negative way still needs to have the money put into address solving this issue. I think that the social determinant factors in these issues talk to the systemic racism that is prevalent and persistent to this day and I think that we have got to make sure that this City puts money in and not puts a cap on what we do based on what the feds and what the state does but based on what we see the areas are that need attention.

We are talking about a massive campaign to have people understand well, yes, historically we know we were given the guts of the hog for our sustenance but now we have got to help people understand that we can evolve and do better. We also understand that we have this so-called deserts that don't have the nutrition. We have got to make sure that we provide those kinds of forces and put the money in it. I think it's about money. I think it is also about social consciousness and this is the time for us to make sure that we do that.

We talk about preexisting conditions. Those conditions are reflection of this society

underplaying, undermining, undervaluing Black and Brown lives. Until we make investments large scale about social programs, about health, about education and about providing jobs to people, we are not going to get the results that we are looking at.

Someone else earlier in the testimony said that the health outcomes for Black women with higher degrees was worse than it was for White women with a basic high school degree. That's a reflection of racism. So, it doesn't matter that you continue to go on and get higher degrees and advance education. It is determined by your skin color and until we face that and say listen, we are going to bombard the media. We are going to bombard public announcements, public service announcements and help elevate people's understanding of what they themselves —

SERGEANT AT ARMS: Time expired.

COUNCIL MEMBER BARRON: Thank you. Until we can understand that that is what we have to do to really make sure of this and until we understand that this is so important that we must have real time data. We can't get data 4 or 5 years later and say, oh, well you know, 5 years ago this was happening and we should have done such and such and we didn't do that.

So, we have got to make that commitment. We have got to put money into this. We have got to make sure that all of these issues get the financial underpinning to make them successful and get the results that we need to let Black and Brown women know that this society, because they already know it in most degrees but that this society has got to address that and reflect that. Thank you so much, I appreciate it.

COMMITTEE COUNSEL: Thank you so much Council Member Barron. Council Member Cohen has his hand raised.

SERGEANT AT ARMS: Starting time.

COUNCIL MEMBER COHEN: Now, I am unmuted. Thank you Chair's. Thank you for the testimony. This has been really a fascinating hearing and highlighting you know, a just serious and tragic problem.

This may have been discussed and maybe I missed it but Doula and midwife services, are they Medicaid eligible? Anyone?

ESTELLE RABONI: Sorry, I am looking at my notes. I would like to defer to Dr. Wilcox, yes.

DR. WENDY WILCOX: Midwives are Medicaid eligible; I believe. They are part of our clinical

healthcare team. They are actually employees of many hospitals. There are private practices of midwives as well. I believe Doula services, there were two state trials going on to try to work out reimbursement for midwives. One in Buffalo and one here in Brooklyn and so, I am not sure that we can answer that but there was a program through New York State Medicaid that was trying to pay for Doula services. Those were two pilot programs is the wording I was looking for.

COUNCIL MEMBER COHEN: But you don't know if Health + Hospitals bills for Doula services?

DR. WENDY WILCOX: Oh, we do not. They are not employees of our hospital. We refer to CBO's and they handle the Doula employment.

COUNCIL MEMBER COHEN: So, you don't know if they get paid by — those expenses are reimbursable by —

DR. WENDY WILCOX: There were two pilot programs where New York State Medicaid was trying to work out how that could happen. I am not aware of the update on those programs.

COUNCIL MEMBER COHEN: I know this is an old fashion notion but this problem seems maybe particularly well suited for in-home visits. Like,

is there any problem and I see you nodding doctor, would you talk about what is available?

DR. WENDY WILCOX: Thank you for asking that question. So, we have through our Community Care provided at home services for our — I am looking for the information right now. Community Care was able to provide at home prenatal support, Doula services and also care for neonates or newborns who were at high risk.

I am looking for the actual numbers for that through Health + Hospitals. Oh, here it is. So, prenatal home visits since 2018, the grand total is 602, newborn visits 13,433 and postpartum visits 12,981 for a total of 27,016.

COUNCIL MEMBER COHEN: The prenatal number is pretty low.

DR. WENDY WILCOX: Yeah, we — I believe we send it to complement our existing structures. We also, I don't have the numbers here but we also enlisted some tele-visits but I am sure you realize that you know the gold standard is really —

COUNCIL MEMBER COHEN: But COVID aside, it seems like you know, prenatal visits are an ideal way to identify people in need of early intervention who

might need some handholding to get the services that they ultimately require. I mean, that seems like that's got be — that seems an easy way to expand and maybe make sure people who need care get it.

ESTELLE RABONI: So, Council Member Cohen, we do have that nurse family partnership at the Department of Health which does work with thousands of families at 26 weeks of pregnancy to up to 2 years, the 2-year-old birthday of the infant.

So, there is that program and has been continuing even despite the pandemic.

COUNCIL MEMBER COHEN: Who makes the visits for the Health Department?

ESTELLE RABONI: Excuse me?

COUNCIL MEMBER COHEN: Who makes the visits for the Health Department?

ESTELLE RABONI: Nurses, qualified nurses. So, we actually have nurses within the Health Department that conducts those visits. We also contract with other organizations like Public Health Solutions, Visiting Nurse Service and others to do that work as well.

COUNCIL MEMBER COHEN: Do you know how many prenatal visits by nurses the Health Department made?

ESTELLE RABONI: I mean considering that we visit thousands of women and families, I would say it is in the thousands. I don't have that number.

SERGEANT AT ARMS: Time expired.

COUNCIL MEMBER COHEN: I think that would be helpful and maybe tracking you know, outcomes for people who have gotten those visits versus people who didn't get those visits might be very helpful to.

ESTELLE RABONI: We have that information. It actually is a very positive outcome to have a nurse family partnership or a newborn home visiting type of visit, home visit in support of pregnant and parenting people.

COUNCIL MEMBER COHEN: Thank you very much Chair's. Thank you for your testimony.

COMMITTEE COUNSEL: This concludes Council Member questions. Are there any other Council Members that have questions with the Administration or would the Chair's like to ask additional questions? Chair's Rosenthal, Rivera and Levine?

CHAIRPERSON ROSENTHAL: Thank you. I would like to jump in with a few more and first start by thanking Council Member Cohen for his interest and asking questions at this hearing.

I want to reiterate that the point of this hearing is accountability. The Administration is in a position to address the disparity of mortality and morbidity between people of color and White women. And I understand that the numbers may be small. I understand that reimbursement is challenging but the impact of prevention. The impact of better communication is so clearly huge that it explains the reason why we're — you know, we have had a hearing on this topic in the City Council, at least one a year. I asked a couple of questions that I just want to see if you were able to get some information on. What are the hospitals that do not have midwifery services?

DR. WENDY WILCOX: I am sorry Chairperson Rosenthal I do not have that information.

CHAIRPERSON ROSENTHAL: Is it on the website to the hospitals? So, if I did some detective work and went to — where could I find this information online?

DR. WENDY WILCOX: We should be able to get this to you soon. I just, I don't have it.

CHAIRPERSON ROSENTHAL: Can the public access this information?

DR. WENDY WILCOX: I believe so. I believe on each hospital website it does describe the types of services each department has.

CHAIRPERSON ROSENTHAL: So, they would be able to see that midwife is not listed. If H+H is not planning on bringing midwifery services to those hospitals would it consider making a note on the websites where there are not midwifery services that explicitly they do not exist? Or do you plan on bringing midwifery services to all the hospitals?

DR. WENDY WILCOX: I am not able to answer that at the time. However, we will get a response to you.

CHAIRPERSON ROSENTHAL: Okay, thank you. I heard over and over you say that the lack of communication seems to be the main reason for maternal mortality and morbidity. Did I hear you right?

ESTELLE RABONI: Yes, that is a major factor.

CHAIRPERSON ROSENTHAL: Yeah, can you repeat the list that you identified? I just didn't get it in my notes of communication between who and who is problematic?

ESTELLE RABONI: Well, predominantly communication between providers and the patient as

well as institutions and patients are problematic or can be problematic.

CHAIRPERSON ROSENTHAL: Yeah sure. Why not institute a simple checklist like the ones that surgeons use in the operating room. For example, at the beginning of a surgery, they check to make sure that certain tools, equipment is there or people are in the room. Why not have a checklist like that, that could be part of the medical record in your database?

ESTELLE RABONI: I am sorry Chair Rosenthal is the question that there should be a checklist in providers databases or?

CHAIRPERSON ROSENTHAL: Yeah, I mean, why can't you have a checklist so that when anyone is in contact with the woman, with the pregnant person, there is a checklist of what needs to be communicated or —

ESTELLE RABONI: When we do implicit bias training, we don't necessarily provide a checklist but we do — because it is a very nuanced conversation each person is unique, we do have guidance and guidelines on how to access ones own implicit bias or personal bias and how to counteract that and to

recognize that prior to the conversation. So, it's not so much of a checklist to ensure you know, a particular equipment is there but rather to those biases and ensure that whatever the conversation that there is a really keen sense of listening to what the patient is asking about, responding respectfully, communicating to the patient that they have rights and that they should you know, be active decision makers in their care.

CHAIRPERSON ROSENTHAL: Okay, there is a kernel of something in my question but I don't quite have it yet. I am hearing what you are saying though and I appreciate it.

Let's see, is the funding for the maternal hospital quality improvement network in next years budget?

ESTELLE RABONI: It is still in discussion. Unfortunately I don't have additional information. I did ask my staff but the discussions are ongoing regarding future funds.

CHAIRPERSON ROSENTHAL: And just to be clear, the fact that it is an ongoing discussion, great. I am glad you guys are pushing for it but that means

definitionally it is not in the budget for the next fiscal year, is that accurate?

ESTELLE RABONI: I don't have that information unfortunately. I don't know for certain.

CHAIRPERSON ROSENTHAL: For the record, it is not in the budget for next year. You mentioned that you would give me the names of the three hospitals that were in the pilot program. Can you do that publicly?

ESTELLE RABONI: I was not able to get that information as well but I can get it to you.

CHAIRPERSON ROSENTHAL: Okay, is that information something you can share publicly or that I can share publicly after you send it over? You can say no or you can say you are going to tell me yes or no when you share it with me but I am just wanting to know.

ESTELLE RABONI: Let me share it with you either yes or no once I know for certain.

CHAIRPERSON ROSENTHAL: Gotcha. You mentioned I think two categories of pregnancy, of maternal deaths. Pregnancy related and then pregnancy associated, were you able to pull out those numbers for any of the prior years?

ESTELLE RABONI: No, I would have to follow-up with you on that. That requires some work.

CHAIRPERSON ROSENTHAL: Alright, thank you. I am turning it back to Moderator, thank you.

COMMITTEE COUNSEL: Thank you Chair Rosenthal. Chair Rivera or any other Council Members, do you have any questions? Chair Rivera.

CHAIRPERSON RIVERA: Oh, I would like to move on to hear from participants, thank you.

COMMITTEE COUNSEL: Thank you so much. So, I will do one last call for Council Member questions. If there are any other Council Members that have questions, if you can please use the raise hand function. We are not seeing any other Council Member questions.

So, Chair Rosenthal, we have concluded the Administrations testimony and we will turn to public testimony and Chair's Rivera and Levine.

CHAIRPERSON ROSENTHAL: If I could just jump in, if I could ask the Administration to stay on the Zoom. You can turn off your videos if you want and just have it as background something to listen to. I think the stories we are about to hear are riveting and important. So, I would ask you to stay on. Thank you.

COMMITTEE COUNSEL: Okay, thank you Chair's. So, with this, we will now move to the public testimony portion of our hearing. Thank you very much to the Administration.

First, I would like to remind everyone that individuals will be called up in panels. Council Members who have questions for a particular panelist should use the raise hand function in Zoom to be called on and they will be called on in that order that they have raised their hands after everyone on the panel has completed their testimony.

For panelists, please do not use the raise hand function, you will called up in panels. Once your name is called, a member of our staff will unmute you and you may begin your testimony once the Sergeant at Arms sets the clock and gives you the queue. All testimony will be limited to three minutes. Please note that there is a few second delay when you are unmuted before we can hear you and there is also a box that pops up and you need to accept the unmute option.

Please wait for the Sergeant to announce that you may begin and start the clock before starting your testimony. The first panel today in order of

speaking will be two individuals, Bruce McIntyre III and Nonkululeko Tyehemba. We will start with Mr. McIntyre. So, Mr. McIntyre, if you are ready to begin, you may begin once the Sergeant calls the clock. Thank you so much.

SERGEANT AT ARMS: Starting time.

BRUCE MCINTYRE III: Thank you for having me. This is not going to be a pleasant conversation. So, I just want to start off a little bit about Amber.

So, Amber had actually received her bachelor's degree in psychology of May 2018. She wanted to introduce art therapy to the youth as the youth to express themselves. Also, while pregnant, she was in a master's program for business development. She wanted to start an early life childhood program. She would be walking here and receiving her masters this month.

So, my spouse and the mother of my son Amber Rose Isaac passed away on April 21st at 12:36 a.m. at Montefiore Hospital in the Bronx. She received the same treatment from two different Montefiore facilities.

On September 21st, I am sorry 27th, we found out that we were having a baby at 7:44 in the morning

exactly. We were excited and ready to become a family and we planned this for months in advance. We were excited to have this baby but all of this excitement went out the window during our very first appointment with our OBGYN at Montefiore Moses and it was just, it was really unsettling and it drained the excitement out of the pregnancy.

I remember feeling judged after our first visit because we were two Black parents who were unmarried but we had plans for marriage. But yeah, I just remember feeling judged by the OBGYN and she was just being mistreated by not only the doctor, not only the OBGYN's but the staff of the facilities. Amber complained of the lack of communication between doctor's offices from the beginning of her pregnancy. Amber had actually to get her mother involved on numerous occasions because her mother had been a long-term employee with Montefiore for 25 years, 25 years. Amber is 26-years-old.

Amber's mother had called the doctors office more than once to speak on you know, the mistreatment of her daughter. You know, luckily my job was lenient enough for me to take Amber to her appointments. Whenever I would take her to some of her appointments

and we would get there, some of the appointments that she had scheduled were not appointments at all.

We would go and say that we have an appointment and they would tell us oh, you have no appointment set for today and then they would have to reschedule.

Amber was also an early life teacher. She taught in Harlem. She taught a group of young kids in Harlem. Whenever the pandemic started to arise, right you know, some of the schools were the last facilities to shutdown because they were trying to soak up as much money —

SERGEANT AT ARMS: Time expired.

CHAIRPERSON ROSENTHAL: This panelist can have as much time as he needs. Thank you Sergeant.

BRUCE MCINTYRE III: Thank you but yes, the schools were shutting down because of COVID. This was the last facility to shut down. Amber, who is pregnant right and she is feeling these changes in her body. She knows that her health is deteriorating. She is having troubles breathing as her platelet levels are deteriorating but we don't know this at this time.

She is constantly having to carry children up and down stairs in this condition. She has to travel up

and down stairs. She has to deal with children who are coming to school sick with no doctor's note and the school is allowing this, right. So, there are sick children who are rubbing their saliva on Amber, sneezing on Amber, coughing on Amber.

She voiced all of her concerns to her OBGYN because she felt like her safety and her health was at risk. She would express these to her OBGYN because she was trying to get early leave. She was due May 30th, May 30th was her due date. She wanted to leave in April. She wanted to have early dismissal for April because of her conditioning.

She expressed these concerns to her OBGYN. She didn't feel safe, she couldn't breathe, it was really hard for her to breathe whenever she walked for a while. She would have these pains in her legs and instead of the OBGYN being attentive to Amber, she tells Amber, well, there are pregnant women who are squatting and lifting in this office, why can't you do that at work?

So, on Amber's FMLA forms, the OBGYN stated that Amber wanted to leave for personal reasons, personal reasons. Amber was denied FMLA by HR at her job. We had to redo the whole process. We had to resubmit.

This time we got Amber's mother involved yet again and instead of the OBGYN then being attentive to her needs, she was more or less worried about who Amber's mother was and what her relationship is to Montefiore, right.

And she tells Amber, well the only way that you are going to get early leave from FMLA is if you see a high-risk doctor. That was the only time we were appointed to a high-risk doctor. Not because her platelet levels were decreasing. Not because her health was deteriorating. Just to get the FMLA forms filled out.

We also were trying to find her a new doctor as well. We had to seek a high-risk doctor to fill out the FMLA forms that she wanted to you know, she wanted to leave early and back in March, right when you know, the end of February, beginning of — I mean, end of March. I am sorry, the end of February coming into March right, telehealth was being introduced. When Amber needed to be seen clearly.

Telehealth was being introduced and before her last appointment, we spoke to another OBGYN at the same facility and she told Amber that Amber — her iron was really low. So, they prescribed her iron

pills, right. They prescribed her iron pills, a blood pressure monitor and told her to monitor herself. That they will follow-up with her every two weeks during the Zoom meetings right and after facing so much neglect and so much incompetence through the telehealth program we decided that we wanted to hire midwives and doula's instead. People that were going to be more attentive to Amber's needs and we found a group, right.

We sent over all of the information. We sent over all of Amber's health records, which took forever to get back because it wasn't on the My Chart. It wasn't on My Chart; it wasn't showing up. We finally get the records over to our midwife, right and on April 3rd is when our midwife views it and she is so confused to why Amber had not been receiving treatment and why she is being ignored and not being seen.

We were denied a home birth due to Amber becoming high risk. We tried to get into a birthing center because we don't want to go to a hospital now because we dealt with the negligence and these hospitals are being overwhelmed with COVID patients. So, we are

thinking okay, maybe we can get into a birthing center. We were also denied into a birthing center.

Even with Amber having exceptional insurance through the hospital, right. We were still going to have about $4,000 out of pocket for a home birth and we were willing to do it. We were willing to spend our hard earned money to get the care that Amber needed.

After previous visits, right, the OBGYN — Ambers visits with the OBGYN, Amber's platelets were dropping without her knowledge since December of 2019, since before COVID, since before COVID was announced.

Then we had to find another high risk doctor. This time, we went through Amber's mother's job. We went to the facility that she worked at because they had everything set up for us. They know about our situation; they were going to take good care of Amber. They assured her mother they were going to take good care of her. That was a lie.

Amber never even got to meet her high risk OBGYN due to the first appointment being cancelled. The doctor was, there was a subsequent appointment by phone and orders for blood were not given until April

10th. After receiving those results, right, the doctor calls Amber and they tell her, your platelet levels are dropping and that she was concerned about her liver enzymes as well and the doctor told Amber to go to the following appointment on April 17th, right.

We went in on April 17th to get blood work drawn for Amber. The orders weren't in the system from April 10th. Amber had to call the doctor's office to let them know that the staff tried to locate the OBGYN or another physician to call to input the order. Amber waited for over 2 hours and nothing was done. I took her back home, brought her back once they got everything collected and yet again, Amber's mother had to reach out to somebody to reach out to somebody to reach out to us.

The OBGYN's neglect as well as the high risk doctor, a few minutes after Amber had received the call from the high risk doctor apologizing, said that she didn't know why the orders weren't in the system and doesn't know why the lab staff didn't call her. She gave her Amber's personal cellphone number and instructed her to go back, right. That's when Amber left her last Tweet, that gained national attention

on April 17th, when she stated that she wanted to write a tell all about the incompetence and the negligence that she was facing from both Montefiore facilities. Montefiore Moses and Montefiore Einstein.

They called us the very next day, April 18th, told us that we have to go in immediately for treatment. We are thinking that we are going to be in there for treatment and that they were going to raise her platelets. That couple of hour visit turned into okay, she needs to be here for a day, okay she needs to be here all weekend.

On April 20th, Amber calls me after being in the hospital all weekend. She is telling me that they are going to induce her labor knowing that her platelet levels are at a dangerous level, they were going to induce her labor. She called me to the hospital, I was allowed to come up finally after taking my COVID test. She was tested for COVID twice, came back negative. They didn't understand what was going on with her and why her platelets were deteriorating.

They later found out that it was HELLP syndrome, H-E-L-L-P syndrome, which is a serious of high blood

pressure during pregnancy, Hemolysis Elevated Liver Enzymes, Low Platelet count, HELLP Syndrome. And HELLP syndrome usually develops in the third trimester but many women are diagnosed with preeclampsia beforehand, right.

One out of two women are developed to have HELLP syndrome out of 1,000 pregnancies. Mortality rate on that is 100 percent preventable. If treated early, they had plenty of time to treat this, they had plenty of time to catch this and they didn't until the day that they decided to induce her labor, right.

With her platelets being dangerously low, they came back to us with the options for a cesarean. Said that they needed to perform a C-section on her immediately. That the baby was not handling the contractions well and she was only dilated by 2 centimeters. They didn't give her enough time. I was supposed to be there for a day or two. I was with Amber in that room for maybe a couple of hours before they made that decision.

With her platelet levels being so low, they still decided that they wanted to perform a cesarean on her. Her blood at this point was like water. Her blood was unable to clot.

We were asking these doctors; do you have everything? Are you guys prepared? Are you guys ready for her? They are assuring us they have everything prepared for her in that room. That was a lie. The nurses are telling me not to come too close to Amber because of COVID. They don't know who has COVID at this point. They don't even know if the nurses have COVID because the nurses weren't being tested.

That was very unsettling for Amber and I. The last thing that Amber says to me is all three of us are going home. We are all three going home after this. That was the last time I seen Amber alive. As soon as they cut her open, her heart stopped immediately and she started to bleed out. I am asking nurses, what's going on because I am supposed to be waiting. They told me it was going to be quick. I will be waiting in the room for 20 minutes, she will right back. I was waiting for hours. No doctor was telling me what was going on. I asked numerous times.

It took a Black nurse, a Black head nurse to answer some of my questions and she didn't even want to. I am asking them; she has low platelets and you

guys cut her open. Did you guys at least sew her back up after the C-section? No, they didn't. They had to cut open her chest and message her heart manually. So, they cut her open twice with low platelets.

I asked them, well, did you sew her back up after that? No, they didn't. They didn't know or understand where the bleeding was coming from, so they performed a hysterectomy on Amber and they took out her uterus, which was very disheartening to me because Amber and I had plans to have another child in a year or two.

After everything said and done, the doctors are leaving the room. Black doctors are standing in the hallway with this look on their face, with this disgust on their face that they can't believe what just happened. And they are staring at me in the hallway and they look like they have to tell me something but they can't. Meanwhile, there are White doctors who are coming out and they are patting me on my back. You are going to be fine. You are going to be okay. You are going to be fine.

And if I can just double back to when Amber was trying to get her FMLA and early leave. Amber was

due May 30th. They induced her labor April 21st. She wanted to leave in April. There were White women who were due after Amber who were getting early FMLA but Amber was not and that's something that I cannot understand.

They didn't know Amber had HELLP syndrome this whole time since December. They had plenty of time to treat her condition, which they did not and you would think my trauma is going to stop there but no. My trauma doesn't stop there. As a COVID response, these hospitals were leaving death certificates blank. Blank as a COVID response they tell me. Under the section of the death certificate where Amber's mother's name is supposed to be, who had been a long term employee for 25 years, they left Amber's mothers name blank.

For the father of the child, which they knew who I was, which was the only reason why they let me upstairs during COVID times, they left my name blank. They left the location for Amber to go to Heart Island to be dumped with the rest of the COVID patients.

If I wouldn't have took affirmative action then, Amber's body would have been thrown in the back of an

ice truck and she would have been buried with COVID patients, even though she did not have COVID. You think my trauma ends there and it doesn't, unfortunately because also during these times, funeral homes aren't accepting patients for the next four to five months. I had to figure that out.

Do you think that this hospital that killed Amber paid a penny, a penny towards funeral expenses? I had to come up with funeral expenses during COVID times. I had to come up with funeral expenses through crowd funding. Then you would think my trauma is going to end there, no, no. The hospital was not trying to allow me to check my own son out because Amber and I were unmarried and by law, they could not release my son to me because Amber was no longer alive to contest that I was the father of my child. Even though she was before she was alive.

The hospital then told me to fill out these forms, send it to this address, you will be fine, you will be taken care of, your name will be on the birth certificate. I did, yet again, exactly what the hospital had asked me to do. I had received a letter two months ago denying my request. Saying that I have to take it to family court which was closed due

to COVID. And that's what I am still fighting for till this day. Till this day, I am still fighting for that.

I am sorry you all. In less than 8 months, this happened less than 8 months ago. I have had to become a doctor, I have had to become a birth worker, a maternal health activist, a community leader, a politician, all while father a son who will never get to see his mother. Why is it that I have to do all of this research. I don't even have time to grieve. Why is it that I have to do all of this research, right to help create bills on how our government should already be treating us. Why do we have to pass a bill for this?

From the collections of studying that I have done around the U.S. right, every year in the U.S. 700 to 900 women are dying due to pregnancy related complications. Our maternal mortality rate is higher than any higher income country but yet we are paying the most in healthcare today.

The maternal mortality rate has increased in the past decade while other countries have managed to reduce their rates but like I said, yet again, we are still paying the most in healthcare and I am pretty

sure that a good majority of you doctors in this room know what's killing these mothers. And if you don't it's cardiovascular disease, high blood pressure causing seizures or strokes, blood clots or infections, preeclampsia, HELLP Syndrome. These are some of the leading causes in maternal mortality, including incompetence, negligence, insubordination and lack of moral value, right.

So, that means for every death, for every death right, 100 women suffer from severe complication related to pregnancy and childbirth, resulting in over 60,000 women every year developing one of these conditions. Maternal mortality is still on the rise here in the U.S. and these are life altering changes. It is estimated that between 1.5 to 2 percent of 4 million deliveries that occur every single year in this country are associated with one of these events. So, that's 5 to 6 women every hour having a blood clot, a seizure, a stroke, receiving blood transfusion and organ damage such as kidney failure, right.

The most unforgivable part about this right, is over 60 percent of these complications are deemed to be preventable. That's more than half we are talking

about. I keep hearing all these talks about budgets and you don't need that. There are concrete steps and standard procedures that can be implemented, that can prevent these outcomes and save lives. You don't need new fancy machines or budget cuts to prevent these outcomes from happening. You just have to ensure equal standard of care between hospitals. You have to value the quality of care for pregnant women before, during, and after pregnancy which is what midwifery and doula associations are about. That's what they do.

The insurers should have more payout options, more home births. They should have more payout options for homebirths, just like they do for these hospitals. We need to make midwifery and doula services more accessible and more affordable to the people of our communities. And since that hasn't happened, we took the initiative ourselves, right and we created the Amber Rose Isaac Access to Homebirth Scholarship program which offsets the cost of insurance premiums and covers what insurance does not.

We have been able to help 16 families thus far with this program and most of these women do have government assisted insurance.

These women are scared to go into these institutionalizes hospitals with these doctors, so why not put them in the hands of the people who are going to be more attentive to our family's needs? I have been working with a collective on bringing a free standing midwifery led birthing center to the Bronx as well. I am a part of that effort. The reason why I jumped into that right, is because the Bronx has the highest C-section rate in New York City.

Mind you, over 60 percent of these women don't need cesareans. They don't need it and I think it is no secret that these hospitals within these underprivileged families, within these underprivileged communities are being underfunded, right. Giving me the reason to insinuate that these hospitals are putting profit over people. Securing an extra, let's say, I believe it is around $8,000 for a C-section versus a natural birth.

Over 60 percent of these women are getting C-sections. They are securing an extra $8,000 per C-

section to I guess substitute for these budget cuts, right.

So, this crisis has actually been going on long before me but I do believe that midwifery and doula associations are key solutions to better birthing outcomes, as they provide care before, during and after pregnancy. Meeting mothers and family tailored needs.

We need to redirect the course of birthing equity by passing the New York Health Act as the start of this change, right. After advocating and gaining national attention, Andrew Cuomo was very much aware of Amber's situation. He actually mentioned her situation without having to mention her name and said that his maternal task force was on it. Where are they at?

We have seen nothing. In fact, Mr. Cuomo's father was dealing with the same accusations when it came to turning a blind eye to maternal health. If this matter is going to continue being ignored further, then there needs to be a public service announcement stating while Black, Brown and indigenous families within our communities cannot be prioritized by our government elected officials whom

we are paying for their chair to protect us. This is a clear bias agenda that's infiltrating our civil and human rights and it needs to be addressed, not sooner than later but it needs to be addressed now.

That's all I have for you. Thank you guys so much.

CHAIRPERSON ROSENTHAL: Mr. McIntyre, I have no words. This Committee sees you; we hear you, respect you and we want to be with you. It is very difficult to move on but I fear we have to. You have answered every single question. You have hit on every single point that is worth talking about. You have become an expert when you shouldn't have to be but you have.

BRUCE MCINTYRE III: Thank you.

CHAIRPERSON ROSENTHAL: We are honored that you testified today. Thank you.

BRUCE MCINTYRE III: Thank you.

CHAIRPERSON ROSENTHAL: Oh and of course, I offer my condolences and I am so, so, sorry for your loss and my guess is that for litigious reasons the system doesn't apologize to you. It is ridiculous. I am so, so, sorry for your loss.

BRUCE MCINTYRE III: Thank you, thank you but I have started the Save a Rose Foundation in honor of

Amber and we have been dismantling the system that falls within the healthcare system and we have been redirecting the way birthing equity should be directed as well. I have worked with numerous offices including Kamala Harris's office and Underwood's office and plenty, plenty more politicians and been helping families within our communities all in her honor because she deserves — and she was an excellent woman who didn't deserve this at all. She had so much to offer the world and she was cut short.

CHAIRPERSON ROSENTHAL: You have carried on her memory so respectfully and beautifully. I see Council Member Barron has her hand raised. I want to recognize her. If the Moderator could — thank you.

COMMITTEE COUNSEL: Council Member Barron.

SERGEANT AT ARMS: Starting time.

COUNCIL MEMBER BARRON: Thank you and I am going to be brief. I just want to say we extend our condolences. You should not have had to endure what happened. We have our prayers for your family and for your beautiful child and I just want to commend you for the strength during this time of grieving to step forward and to step up and to say, I am going to

take action so that others don't suffer what it is that I have suffered. And that's all that I am going to be able to say but just to commend you and to support you as you go forward. Thank you.

CHAIRPERSON ROSENTHAL: I am going to turn it back to the Moderator.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. We have one other person on this panel and I will read that person's name now. It is Nonkululeko Tyehemba. Ms. Tyehemba, please accept my apologies for any pronunciation. When the Sergeant calls the clock, you may begin your testimony.

SERGEANT AT ARMS: Starting time.

COMMITTEE COUNSEL: The witness is still muted; it might take just a minute. Okay, you should be unmuted. Thank you so much.

NONKULULEKO TYEHEMBA: Thank you so much. Good afternoon to all. My name is Nonkululeko Tyehemba and I am a Certified Nurse Midwife who lives and works in the Harlem Birth Action Community.

I am also a laid off midwife who worked at one of the hospitals of the New York City Health and Hospital Corporation who no longer have midwives to service the women in our community. For my written

statement, I would like to state but I was one of the founders of the Harlem Committee, an organization that seeks to empower women and bare families through education and information.

In 1989, our organization was founded because of our concern with the high informality rates that existed in our community at that particular time. In the 1990's, we became an intimate part of the perinatal networks that lead to healthy start programs and other groups. We vigorously fought to reduce the health crisis to some success.

In the last 20 years though, the rate of maternal mortality and maternal morbidity have reached as we know, pronounced an egregious levels in our community, our city, in our nation. This year for example, at least 4 to 5 known healthy Black mothers have died before birth or shortly after birth due to pregnancy childbirth related complications. We can only guess though the number of unknown mothers who have died or developed some preventable complication.

From the tennis champion Serena Williams spoke out about the medical emergency she endured after the birth of her child in 2017, that could have led to her death and she suffered the psychological trauma

as she stated as a result and that led to a continued long overdue debate on dismal rate of maternal death and injury in our country.

As well as the ways that women and people of color bear the brunt of subpar care. Studies have indicated that over 60 percent of these tragedies did not have to occur. Many investigators are stating that some of these extremely harmful results happen because birthing mothers and their companions —

SERGEANT AT ARMS: Time expired.

NONKULULEKO TYEHEMBA: Are not being listened to. We need — and at the same time, I wanted to say and I will try and finish very quickly. At the same time, the rates of defensive obstetrical interventions that lead to a cascade of operative events have increased astronomically.

For example, one out of every three women are having unnecessary C-sections. Despite the guidelines by Rural Health Organization that the rates should be no more than 15 percent. Nationwide we read 35 percent, over 90 percent of first time mothers have episiotomies that a large number do not need to have. Don’t even mention the number of women

who are having epidurals, unnecessary sometimes inductions, that far exceed the need.

We need a revolution. Not of guns but of minds. We need a new paradigm of reproductive justice healthcare. We need it right now. We need to increase the number of midwives attending our mothers, our families. We need to demand more midwives in our hospitals. Particularly those three hospitals that do not have any midwives at all. Because I worked for one of them, so I do have an understanding of the situation.

We need to emphasize, prioritize and educate more midwives in our communities. Particular in hospital and community settings. We need to adopt a model of care with midwives to prioritize for low risk mothers and parents.

Midwives tend to focus on the physiological management of birthing and if midwives are good for the royal family of England, they are good for us in our community. Despite the governments task force on internal healthcare and this organization and that organization and the time that’s necessary to change, the tragedies are continuing. Women are dying, they are dying or they are having these pregnancy

complications that are overlooked because they are not listening. For some reason, is it racism? Is it bias? And how many trainings are we going to have to have to change the system? We are in the year 2021 now and you know, back in 1920, more than 100 years ago, which is even further than that, there was a definite campaign to get rid of midwives. They were called ignorant, they were called illiterate, they were called dirty. It was a structural campaign to get rid of them and they have. They blame midwives for everything.

We need more midwives in our communities and until we do get them, this is going to continue. We are going to continue to have these tragedies over and over again. And I feel for your brother Bruce McIntyre. I am in tears because I see it and I hear it. Not only that, the mothers, they are fearful of going to the hospitals. Some of them just the other day told me they are having free births. They are going to have their own, unassisted births at home because they are afraid to go to these hospitals. They are isolated and they are in fear. They have to submit to all types of unnatural physiological ways of giving birth. They are in bed, their IV's go on

the bed, nothing right and they are made to give birth in positions that are totally, totally not right. We need a change. We need a revolution and until we get it, we are going to have hearing after hearing, death after death. We are scared to death.

So, with that, I am going to end but I thank the Committee. I thank the Chair; I thank all of you and I am so impressed with the passion that I am listening to. We have to be honest. We have to really be honest and not say, oh, my job. Oh, I can't say this. Oh, I don't know that. Just say it. Let's make a change now. Thank you so much for listening to me.

CHAIRPERSON ROSENTHAL: You know, Ms. Tyehemba, thank you for your passion. I am going to say something explicitly that you alluded to. So, my guess is it's the association of obstetrical, gosh, I am so like blown away, my brain is dead. Physicians, obstetricians, that it's their association that has led to the demise of midwifery.

NONKULEKA TYEHEMBA: Yes, exactly so.

CHAIRPERSON ROSENTHAL: And —

NONKULEKA TYEHEMBA: I'm sorry.

CHAIRPERSON ROSENTHAL: No, no, you go.

NONKULEKA TYEHEMBA: That James Marion Simms who even became the first president of the American Medical Association. I mean, come on. Please, you know, for our parents. Our families, our communities are being separated. Some don't have mothers to take care of their babies and so forth. We need a change. I see it and there are women — I am in the community a lot more and when we are in company and we talk about it. They are scared to death and furthermore, studies have indicated to that some of these deaths that could be prevented are due to lack of information.

CHAIRPERSON ROSENTHAL: Yeah.

NONKULEKA TYEHEMBA: Lack of education. They don't know. They are not told. They don't know what their right are. They don't know what their options are as well.

CHAIRPERSON ROSENTHAL: Right, you can't ask the question if you don't know that there are options. That there is information out there and to that point, at our 2018 hearing, we were led to understand that there was a new pamphlet that was going to be distributed to every incoming pregnant person. You know, know your rights as a pregnant person. I am

guessing that Mr. McIntyre did not receive that pamphlet nor did his girlfriend. Am I right? Yeah and that was supposed to go to everyone. So, the pamphlets even exist and they are not distributed.

NONKULEKA TYEHEMBA: We need a new paradigm of not only birthing, we need a new paradigm of prenatal care. We need, yes, we do need centering. When people come to the clinic or so, I have food for them, provide nourishment for the mothers. Provide a block by block of B6 better birth block by block reproductive health model to directly reach our community block by block.

CHAIRPERSON ROSENTHAL: If there is additional information you would like to submit for your testimony, please feel free to do so.

NONKULEKA TYEHEMBA: Thank you.

CHAIRPERSON ROSENTHAL: Information about programs etc. You know, it is definitely the case that the medical institutions led by males intentionally want birth to happen at their convenience and you are right to mention, even the royals get a midwife. It is because in England they have the history and the confidence in midwives and of course there is the wonderful TV show called

Midwives that everyone should watch about women who are midwives in England and know and have the passion for their — I am not even going to say patients. For their pregnant people that they take care of.

I want to honor you for your work and I guess turn it back to the Moderator but thank you so much for being here, for testifying for your expertise and your passion for what you do for the community. I really bless you.

NONKULEKA TYEHEMBA: Thank you, thank you Chair Rosenthal.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal and to the panel. Before we move to our second panel, I just wanted to check if there are Council Members that have additional questions for this panel?

Not seeing any Council Members at this time, no raised hands. We will move to the next panel. So, the next panel, panel 2 I will read the names of the panelists and then call you individually. The first panelist is Lorraine Ryan followed by Emily Frankel followed by Maryam Mohammed-Miller.

Lorraine Ryan, when you are ready, you may begin once the Sergeant starts the clock. Thank you.

SERGEANT AT ARMS: Time begins now.

LORRAINE RYAN: Thank you. Good afternoon Chair's Rivera, Levine and Rosenthal and members of the Committee on Hospitals, the Committee on Health and the Committee on Women and Gender Equity. As you heard, my name is Lorraine Ryan, I am the Senior Vice President at the Greater New York Hospital Association and for more than a decade and a half, in my responsibility of hospital and healthcare quality improvement, I have focused very deliberatively on maternal health and equity and improvement efforts if you will.

I have comprehensive prepared remarks that you have in hand but I am going to go off script because I can't possible be considered credible without responding to some of what I have heard today. And I would also like to offer my sincere condolences to Mr. McIntyre. He is very courageous and I can't imagine what it took for you to speak to us today and also more importantly to endure what you have endured in terms of the tremendous loss and you will be an amazing parent because you have such compassion and wisdom and you are channeling your grief in all the

right directions, so I can't say enough about what I think about you and we just met and virtually.

I think I can best use my time and I am sorry but there is noise outside of my home, I hope you are not hearing that. Is that coming through? A little bit.

CHAIRPERSON ROSENTHAL: No worries. Keep going.

LORRAINE RYAN: I will try my best. To address some of the questions that were raised that I don't think were answered adequately. I am going to start with doula's because there has been outreach to Greater New York and to me personally several times since the beginning of the pandemic and I appreciate that outreach because it gives me as a representative of the hospitals an opportunity to address challenging issues and issues that might not be communicated effectively or totally or in a way that is leading to a constructive end.

But we know that there has been challenges to doula's access to patients and through Melissa DeRosa's, the Governor's Task Force on COVID maternal wellbeing and care and disparities in care. Back in April, doula's were added to the list of those who could visit and be present as a support person in

addition to a significant other in the hospital throughout labor, delivery and postpartum.

Apparently there is still some issues with that that we are trying to tackle and Greater New York has agreed to host a forum with all the New York City hospitals and the doula community to discuss those challenges.

There are things we can't fix. Two bedded rooms are two bedded rooms. Social distancing is not something that we can create overnight but we are working to find adequate space so that a patient who chooses to have a doula present as an important support through one of life's most challenging and yet rewarding and gives you an amazing feeling to become a parent —

SERGEANT AT ARMS: Time expired.

LORRAINE RYAN: So, we are working on that.

CHAIRPERSON ROSENTHAL: As a representative of the Greater New York Hospital Association, I would like you to continue on.

LORRAINE RYAN: Okay, I will.

CHAIRPERSON ROSENTHAL: Thank you.

LORRAINE RYAN: Related to the doula issues are testing and visitation and the New York State

Department of Health has been iterative in a very positive way about visitation policies. I can't believe I have been here all morning and now they decide to make noise outside. I am sorry, can you hear me okay? I don't want to be disruptive. Okay. So, with regard to visitation in the very early stages in March when COVID was presenting itself, all visitation was shutdown. Within days it was opened up to obstetrical patients because of the realization that you can't take away that once in a lifetime experience of becoming and parent for another significant other.

Shortly thereafter that in April, after deliberations of the task force on COVID related obstetrical care, visitation was expanded to allow not only the significant other or partner but a doula as well. So, I think we have been responsive maybe not always in the time that certain patients could have benefitted from that presents but the state has been responsive and I believe the hospital community has followed suit.

Another recommendation out of the task force on COVID and obstetrical care was testing and just last week, the Department of Health issued testing

guidance for all pregnant persons. In fact, they are very specific that universal testing of all pregnant individuals during pregnancy and within one week prior to the estimated due date or upon admission if the second test is not conducted, one week prior is to be undertaken.

There is a second recommendation, as increasing testing availability presents itself, support persons may also be tested. This could potentially also include a doula. So, we are responding and you know, it probably takes more to move an entire state in a different direction of public policy than any one of us would like, but I think we are getting there.

The other issue is visitation and as I mentioned, I actually have already covered that and even with visitation shutting down for all of the patients except for categories of patients with obstetrics visitation has always been permitted. There are a myriad of quality improvement initiatives that you have heard referenced today that Greater New York and its hospitals along with the State Department of Health and the City as well have been engaged in with our hospitals. Anything from reducing through the Save Motherhood Initiative, complications from

hemorrhage, hypertension, venous thromboembolism. A new focus on opioid use disorder and neonatal abstinence syndrome. There are a number of initiatives but none of them are getting where we want to go as fast as we want to get there but it takes time and I think we have to recognize the challenge of the day. We are still in a pandemic. We have hospitals that are shutting down visitation in high impactivity zones across the state except for obstetrics, pediatrics and two other categories of patients. So, we are sensitive where the need is the greatest to ensure that someone has a support person.

With regard to doula's, I just want to mention that there was a state pilot in Erie County as well as Brooklyn New York. The Erie County pilot and this was started as part of the governors task force recommendations from 2018. There hadn't been enough doula's signing up for the pilot in Brooklyn. A lot of it could have to do with reimbursement is not adequate. We are pushing for Medicaid reimbursement for doula's. We are also looking at how doula's through a managed care plan can be onboarded and become part of that insurance plan.

So, these are not solutions that are here today but they are solutions that are being contemplated and pushed forward. Health equity: We are all learning the difference between equality and equity.

CHAIRPERSON ROSENTHAL: Excuse me, Ms. Ryan, could you — someone just flagged something. Just real quickly, what did you just say about doula's?

LORRAINE RYAN: As part of the governor's task force from 208, one of the many recommendations was to expand doula programs.

CHAIRPERSON ROSENTHAL: Yes.

LORRAINE RYAN: It was a doula pilot program in both Erie County and Brooklyn.

CHAIRPERSON ROSENTHAL: Yes.

LORRAINE RYAN: To the best of my knowledge, the one in Brooklyn has not been as well subscribed if you will by doula's. I don't know why.

CHAIRPERSON ROSENTHAL: You said doula's didn't sign up.

LORRAINE RYAN: Not enough have signed up, yes exactly. And it could be because of the reimbursement rate, which I know in the early deliberations was not considered adequate by the doula's but it was a pilot and I see heads, they are

nodding. So, we are looking — or a way to sort of potentially address that is through Medicaid Manage Care Plans.

I can't say that it is going to be adequate but it could be something that could promote more doula interest, at least in that pilot. As you know, most doula's come to patients on their own. They are paid out of pocket by the patient. They don't come through insurance plans but that's something that potentially we need to contemplate as a state in terms of getting appropriate reimbursement.

CHAIRPERSON ROSENTHAL: I just wanted to clarify that, make sure for the record that you weren't blaming doula's for not signing up.

LORRAINE RYAN: I am not blaming anybody for anything. I am trying to just give you what I have been told are the facts.

CHAIRPERSON ROSENTHAL: Yeah, I guess listen, I hear your passion. I mean, if there is more that you want to share but I would like to get to the heart of this. I hear your passion Ms. Ryan but obviously we are nowhere and so, what I want to know is in your 15 years at the Greater New York Hospital Association, what have been the challenges you have faced?

Because I am sure you have pushed for this but what are the actual barriers to getting this done?

LORRAINE RYAN: I will tell you; I mean, I have a couple of answers to that. The science of quality improvement needs to be applied in all facets. You can't just you know, look at a problem and look at the outcomes you are getting without understanding the root causes and what are the root causes of those challenges that are leading to negative outcomes?

So, we have tried to do that and I mentioned earlier working with the State Department of Health, with the City, with ACOG. The clinicians need to be involved. We have looked at how do we identify the root causes and you have heard earlier in the maternal mortality review process, it's a long protracted process. It doesn't happen overnight.

CHAIRPERSON ROSENTHAL: [INAUDIBLE 3:25:33]

LORRAINE RYAN: I am getting there. Communication, communication is huge. We have heard it on this hearing from several different places.

CHAIRPERSON ROSENTHAL: But you knew that 15 years ago, so what's the problem with fixing the communication problem? You can't tell me that you are just learning from this hearing communication.

LORRAINE RYAN: No, no, I am not saying that at all. Please, you know, I am trying to be as —

CHAIRPERSON ROSENTHAL: We want to hear from the Greater New York Hospital Association.

LORRAINE RYAN: I think we learned a lot.

CHAIRPERSON ROSENTHAL: The hospitals throughout New York City which you know, if we want to hold people accountable, I want to hear about your association holding the hospitals accountable. So, what you have learned and I want to know from you with your passion what are the hurdles to getting this done? We are not talking about rocket science.

LORRAINE RYAN: I actually beg to differ. It is very complicated and I think you have heard about structural racism being a component. We as a hospital provide care in the outpatient setting and the inpatient setting. But there are other aspects of someone's life and how they live their lives —

CHAIRPERSON ROSENTHAL: The president of any hospital sets the tone, right for the hospital? The head of any institution does that. The guiding philosophy of the president of a hospital sets the tone. So, what kind of implicit and explicit bias training have we been doing for hospital presidents?

LORRAINE RYAN: This is an agenda item on our board. Almost every meeting we discuss this. Greater New York is supporting implicit bias training for hundreds of staff upwards of — I don't even want to say how many because I don't know the exact number. On its own, I started with communication and I got a little bit sidetracked. We heard from a listening tour that the State Commissioner of Health took about a year and a half ago, pre-COVID, around the state, listening to women in minority communities voice what they felt were the problems and the issues of not being heard and implicit bias was clearly one that came through. Through that, there are many different avenues now of implicit bias training, health equity conferences that are taking place. It doesn't happen overnight. It doesn't mean a CEO is not committed but one person can't change societal challenges. This is more than what's happening in a hospital. This is what is happening with regard to food insecurity. With insecure housing options.

CHAIRPERSON ROSENTHAL: I just — I need you to know that my blood is boiling. My blood is boiling.

LORRAINE RYAN: Well, I am sorry.

CHAIRPERSON ROSENTHAL: I just can't imagine. The people over the last decade who has had somebody in their life died because talking about and training hospital presidents on implicit and explicit bias is hard.

LORRAINE RYAN: That is not what I said. That is not what I said.

CHAIRPERSON ROSENTHAL: Oh, clarify because I got to tell you, it is not going well. I am very upset, so sorry, I will control my feelings but to hear that — please continue.

LORRAINE RYAN: What I said to you was, it is an agenda item because it is important for hospitals to address the needs and the challenges that implicit bias can present. I did not say that we are training hospital CEO's on implicit bias.

CHAIRPERSON ROSENTHAL: Why not.

LORRAINE RYAN: You know, I feel like I — whether I — I wanted to share the positives of what hospitals are trying to do and our great concern, our greatest concern with any morbidity and mortality related to obstetrical care and maternity services.

CHAIRPERSON ROSENTHAL: Well, I just want to share with you that its not enough. It is not even

close to being enough. The fact that it is an agenda item for years. So, it is an agenda item —

LORRAINE RYAN: I think you are using — you know, I kind of wish you wouldn't take such offense to maybe language that isn't communicating effectively on my part. That this is a very serious issue. It is taken very seriously. We have president of hospitals who are minorities themselves. Who are a big part of us attempting to dissect in a meaningful way what we can to as a healthcare community but we are part of the healthcare community. The hospitals isn't the sole provider of services or can't impact all of the other life events if you will or as I mentioned earlier, societal issues.

We believe healthcare is a human right. That everyone should benefit from all that that can bring in a positive way and we need to do better. I agreed with that from the get go. Every death is a tragedy, every preventable death is just unspeakable and hospitals are working to get us to a better place that we all need to go to as a society. We also have to fund the care appropriately.

CHAIRPERSON ROSENTHAL: It is to lower your cesarean rates. To intentionally bring in midwives

and doula's and we're just from this hearing, we are seeing that's not happening. You know and then to blame it on reimbursement rates is a reflection of racism. You either believe in doula's and midwives changing outcomes or you don't. You either you know, as Mr. McIntyre said, you know, a reimbursement rate, I understand about hospitals and living on the edge. I mean, my goodness, you know, why not you know, if I — gosh.

LORRAINE RYAN: I mean, I wish you wouldn't take everything I said as an attack.

CHAIRPERSON ROSENTHAL: The concept of doula is spitting money compared to what hospital presidents are paid. You know, if the hospital presidents across the city would agree to reduce their salaries by $50,000 and put that money to having doula's attend births or a midwife at every hospital to attend a birth, those obstetricians need to step out of the room.

If we believe in this. If we believe that every death is a problem, show it. Show it personally. I want to see the hospital president announce that they are reducing their own salary and putting that money toward midwives and doula's. Because we know the

cost of midwives and doula's in the context of a hospital is spitting money and the impact it will have on all the future Mr. McIntyre's is life and death.

LORRAINE RYAN: Yeah, I would like to sort of end and I am sure you want to move on with on a positive note that we look forward to working with the doula's and bringing them together with the city hospitals and midwives as well.

CHAIRPERSON ROSENTHAL: When you say City hospitals, you don't just mean H —

LORRAINE RYAN: Those in New York City. Those in New York City, all hospitals in New York City.

CHAIRPERSON ROSENTHAL: Like including Mount Sinai that just closed its —

LORRAINE RYAN: All hospitals in New York City. They are all our members. They will all be invited to participate and have a dialogue and get to a more constructive relationship that promotes what a patient might choose for their birth experience.

CHAIRPERSON ROSENTHAL: As a hospital Association, did you put out a state when Mount Sinai closed the Mount Sinai West Birthing Center?

LORRAINE RYAN: We did not and you have to — no, we did not.

CHAIRPERSON ROSENTHAL: I am going to turn it back to the Moderator.

COMMITTEE COUNSEL: Thank you Chair Rosenthal. We will move to the next panelist at this time. We have Emily Frankel. Ms. Frankel, you may begin once the Sergeant sets the clock.

SERGEANT AT ARMS: Time begins now.

EMILY FRANKEL: Before I begin my testimony, I would just like to say that my heart goes out to Bruce McIntyre and his entire family for the loss of Amber Rose Isaac. I am so sorry for your loss. I was personally moved by your words and thank you for your advocacy and I look forward to potentially working with you in the best way I can.

My name is Emily Frankel and I am the Government Affairs Manager for Nurse Family Partnership. Thank you for this opportunity. Since I have a limited amount of time, I am just going to try to summarize my testimony as best I can.

Our nurses are on the frontlines of prevention efforts aimed at reducing maternal mortality and achieving better pregnancy and birth outcomes. Nurse

Family Partnership is an evidence-based community health program that helps transform the lives of low-income mothers who are pregnant with their first child.

Each first time mother is partnered with a specially trained registered nurse early in her pregnancy and receives regular ongoing nurse home visits that continue through her child's second birthday. Our nurses help clients achieve healthier pregnancies and birth, stronger child development and a path towards economic self-sufficiency. This is accomplished through the provision of health education and guidance, care coordination as well as preventive services to NFP moms and their children.

Family served by NFP experience the following improvements in maternal health. 35 percent fewer cases of pregnancy induced hypertension and 31 percent reduction in very closely spaced subsequent pregnancies, as well as a reduction in pre-term births.

Since 2003, NFP has served over 16,400 families across all five boroughs through its five network partners. The New York City Department of Health and Mental Hygiene, Montefiore Home Care, Public Health

Solutions, SCO Family of Services and the Visiting Nurse Service of New York.

New York City NFP is currently funded to serve 2,985 families annually. A portion of this funding is baselined in the New York City budget. We thank the City Council, the Office of the Mayor and DOHMH for their support. NFP plays a vital role in identifying and mitigating the risk factors that can lead to maternal mortality and morbidity. NFP nurses use their clinical expertise and assessment skills to understand the strengths and risks that mothers have experienced in their lifetime that may impact their health and their children's health.

NFP nurses identify early warning signs of health problems during pregnancy, postpartum infancy and early childhood that can lead to adverse outcomes, even death. For example, during her last in-person home visit prior to the pandemic, a 17-year-old Bronx mom was complaining of some preeclamptic systems. The NFP nurse took her blood pressure and noted that it was in the severe range. The nurse urged the mom to go to the hospital to be evaluated and consulted her obstetrician who agreed.

The mom went to the hospital —

SERGEANT AT ARMS: Expired.

EMILY FRANKEL: And was found preeclamptic. May I continue?

CHAIRPERSON ROSENTHAL: Another minute, sure.

EMILY FRANKEL: Thank you. Was found to be preeclamptic and her labor was induced. Following her discharge from the hospital, the mom received a telehealth visit from the NFP nurse. While conducting her assessment, the nurse identified symptoms consistent with postpartum preeclampsia. The nurse encouraged the mom to contact her obstetrician. As a result, the mom was able to get a blood pressure machine that same day.

Once the machine was delivered the NFP nurse conducted a telehealth visit to teach the mom how to use the device and educated her about the signs and warning symptoms associated with elevated blood pressure. When the mom found that her blood pressure was too high, she was relucted to return to the hospital for treatment due to fear of COVID-19 exposure, so the nurse encouraged the mom to see her doctor and she did. The NFP nurse was with the mom every step of the way. The life of this mom and her baby were saved because she had an NFP nurse with the

experience, clinical reasoning and specialized training to assist her at critical moments during her pregnancy and in the postpartum period.

Our nurses provide guidance and support to the mother as she learns how to navigate the healthcare system for herself and her child. This is really important considering what we have discussed today and the institutional racism and structural racism we all have seen in our healthcare system.

NFP nurses empower mothers to advocate for themselves to be seen and heard by their healthcare providers and to have their health assessed when they know that something isn't right.

A 20-year follow up study of the program shows that NFP's effective at reducing all-cause mortality among mothers living in highly disadvantage settings. This study showed that mothers who did not receive nurse home visits were three times more likely to die from all causes of death than nurse visited moms. We need our partners in government to invest in evidence based programs like NFP brining nurse family partnership to scale in New York City who do a lot to prevent adverse pregnancy outcomes and maternal mortality. With existing state and city funding, NFP

can only serve 5 percent of the eligible population in the City. Every dollar invested in NFP saves New York City $8.30 in future costs for high risk families served.

With that, I will end to say we urge that the New York City Council expands its funding for NFP, as well as invest in other policies that deal with social determinates of health. We support doula's as well as midwives in conjunction with working with our NFP nurses and thank you so much for allowing us to present testimony today.

COMMITTEE COUNSEL: Thank you so much. The final panelist for this panel before we go to Council Member questions will be Maryam Mohammed-Miller. You may begin —

SERGEANT AT ARMS: Time begins.

COMMITTEE COUNSEL: Sorry, go ahead.

MARYAM MOHAMMED-MILLER: Thank you, thank you so much. I also want to start by sending my condolences and positive vibes to Mr. McIntyre and your family. Thank you so much for sharing Amber's story and your story today.

Good afternoon. My name is Maryam Mohammed-Miller and I am the Government Relations Manager at

Planned Parenthood of Greater New York. I want to thank the Chairs of the Health, Hospitals and Women and Gender Equity Committee's for holding this important hearing on maternal mortality and morbidity and advancing legislation that moves us closer to achieving reproductive justice.

Planned Parenthood has been a trusted provider of sexual and reproductive health service for over 100 years and provides care to all New Yorkers no matter their background. We also recognize the important role doula's and birth support workers play in ensuring safe births before all people but specifically Black women and stand alongside them and in their work.

The COVID-19 pandemic reveal that there are many inequities in our public health system. However, this has been the reality for marginalized communities that communities continue to face.

For Black and Brown people, specifically Black women, the compounded identities of race, gender and often economic status, makes seeking maternal healthcare increasingly difficult. Studies show the racial, the major racial disparities in maternal healthcare with Black women being 4 times as likely

to die in childbirth than White women in New York State. And in New York City Black women are 12 times more likely to die from pregnancy related causes than White women.

These outcomes are a result of institutionalized medical racism and implicit bias within our healthcare system that leads to the unique needs of Black women being ignored. Studies show that Black women are more likely to have their health issues ignored by their doctor and are treated differently than White patients when they present the same symptoms.

Studies also indicate the presence of support in individuals, including doula's, midwives and other birth support workers and Black women are giving birth lead to positive health outcomes for both mother and baby.

Doula and midwifery care is a right that should be afforded to all pregnant people to ensure safe births and today, PBGNY supports the legislation that moves us further to a goal of providing holistic care for those most in need.

We support Resolution 1408 that calls on the state to pass A10440 and state bill, the senate bill

S8307 that works to remove the barriers to create independent birthing centers in New York State. We have seen a steady decline in birthing centers. This legislation will move us closer to the creation of more birthing centers and provide alternatives places for individuals to give birth safely.

We also support Introduction 2017.

SERGEANT AT ARMS: Time expired.

MARYAM MOHAMMED-MILLER: Sorry, can I continue?

CHAIRPERSON ROSENTHAL: Yeah, yeah for just a bit longer. Thank you, thank you Ms. Miller.

MARYAM MOHAMMED-MILLER: We support Introduction 2017 that clarifies visitation policies within our hospital systems. We saw that inconsistent policies led to a lot of confusion for patients, a lot of confusion for families, doula's and other birth support individuals. This introduction will allow folks to have more clarity on who they can have in their room while they are giving birth. We also support all legislative measures that grows accessibility to doula care and supports legislation that will provide more information publicly on how individuals can access midwifery care.

We applaud the legislation today that meaningfully addresses the issue of maternal mortality in New York City and we look forward to working with the Council to making maternal mortality a thing of the past. Thank you.

COMMITTEE COUNSEL: Thank you so much. I will now move to Chair Rosenthal.

CHAIRPERSON ROSENTHAL: Great, thank you so much. Thank you all for being here today and for testifying. We really appreciate your time and your passion. I am very familiar with the work, the amazing work of the nurses and of planned parenthood and really am grateful to your taking the time to testify and of course, all your hard work.

Ms. Ryan, I want to start by apologizing to you for losing my temper and maybe I didn't give you really a chance to answer to this question. It is hard to hear about something that — hear when someone says that there is a lot of talk on a topic at a board meeting. That's it is on the agenda at meetings but not hear about tangible actions that are taken. Can we start there please? I think we're going to have to unmute Ms. Ryan or does she have to unmute herself?

COMMITTEE COUNSEL: We are sending the request. It should just take a second, apologies there is a delay.

CHAIRPERSON ROSENTHAL: Got it.

COMMITTEE COUNSEL: One moment, apologies, we are having a technical difficulty.

CHAIRPERSON ROSENTHAL: No problems. I want to thank; I see many other panelists who are waiting to testify. I want to thank you for your patients and I appreciate your being here.

COMMITTEE COUNSEL: Ms. Ryan, a box might pop up that asks you to accept the unmute. There you go.

LORRAINE RYAN: Okay, I didn't quite take the time to focus on the improvement projects that we have been engaged with. Maybe that would help strike a better tone to understand that there is a lot going on where it is more than talk.

In addition to promoting health equity through a couple of different channels is we have worked at the New York Academy of Medicine before; we will be hosting our second summit in January. We are not hosting; we are just contributing to the summit and there will be doula's and midwives and physicians and those that study the data and understand the root

causes of outcomes that are skewed very negatively towards minority communities, so we look forward to that. We are also working as I mentioned with the State Health Department on an improvement collaborative because we find that if we can change processes, those that are not working then we can hard wire what is working that we see improvement, then we see the data that reflects that.

We have collaborated in our hospitals in the City. When I say City, I don't mean NYC H+H, I mean all the hospitals in the City participated in a maternal depression screening program that is continuing to identify depression typically postpartum in pregnant persons and getting them into treatment earlier on. We are also working on a statewide improvement collaborative to reduce opioid use disorder in pregnancy and Neonatal Absence Syndrome, which is a syndrome where the infant is demonstrating exposure to elicit substances.

CHAIRPERSON ROSENTHAL: Ms. Ryan, hang on one second. I just want to make sure we can hear you. Is it the background noise?

LORRAINE RYAN: It is.

CHAIRPERSON ROSENTHAL: An earlier panelist just had to re- call in but keep going, no problem.

LORRAINE RYAN: You know what, I could probably change rooms, hold on and I will do that. I will take you with me and I will go to another room.

CHAIRPERSON ROSENTHAL: We are all coming to realize how much construction work happens during the work day now that we are home.

LORRAINE RYAN: Right. How is this? Is this better?

CHAIRPERSON ROSENTHAL: Yes.

LORRAINE RYAN: Okay, sitting on the floor of my daughters room, so.

CHAIRPERSON ROSENTHAL: Thank you.

LORRAINE RYAN: We are engaged in opioid admission, opioid use disorder, neonatal absence syndrome program. This is something that with the Department of Health was piloted in about 20 hospitals across the state and we are hoping to engage and recruit all birthing centers that have any found issues with this condition which are all of them and the goal is again to identify, treat and to reduce stigma with regard to drug substance use disorders.

I quickly mentioned that with ACOG and the Department of Health are focused on obstetric hemorrhage project where we seen improvement in outcomes by preparing for a potential hemorrhage situation. Avoiding it of course at all cost but if it should arise to be able to respond appropriately.

Similarly there then in programs with ACOG, the State Department of Health and others on reducing hypertension in pregnancy and venous thromboembolism.

And lastly, what we call the 4th trimester looking at postpartum care to ensure that the pregnant person has the necessary follow up. There is also a Medicaid component to this. We would like to see Medicaid reimbursement extend beyond that which it does now, so that birthing people can get treatment well after the delivery of the child. But clearly and based on all that we have heard today, we must do more and what I was trying to say earlier is the hospital certainly has its responsibilities but as a society, we have responsibility because of food insecurity, housing insecurity, lack of appropriate childcare, education etc.

You are shaking your head but I will finish my remarks by saying that you know, we have a fraying

social safety net that has been further imperiled by the pandemic and we are fighting in Washington for substantial relief for New York State in particular in this case but that will benefit in minority communities. Black and Latino women who rely heavily on social service programs. I thank you for the opportunity to participate today and I hope that my remarks were instructive and not insightful.

So, thank you very much for the opportunity to complete.

CHAIRPERSON ROSENTHAL: And you know that the reason that I was shaking my head is because you know, it's — we know about the societal problems. It is not for the greater New York Hospital Association to remind us of that. I mean, you are here as a representative of an association and we want to hear what the association has done about this. I have two more questions for you. One is, do you know which hospitals, in which Health + Hospitals don't have midwifery services?

LORRAINE RYAN: I do not know that. I believe that Health + Hospitals was asked that question so, but I don't know that.

CHAIRPERSON ROSENTHAL: Do you know which of the private hospitals do not have midwifery services?

LORRAINE RYAN: Not off the top of my head. I have surveyed hospitals on that. I probably have that information but —

CHAIRPERSON ROSENTHAL: Do you have guess?

LORRAINE RYAN: Pardon me?

CHAIRPERSON ROSENTHAL: If you were hazarding a guess, what percentage of the private hospitals in New York City do you think —

LORRAINE RYAN: I am not going to guess. I am not going to hazard a guess.

CHAIRPERSON ROSENTHAL: Would Greater New York Hospital Association consider funding the DOH Maternal Hospital Quality Improvement Network?

LORRAINE RYAN: I don't know enough about it or what would entail. I think you mentioned earlier, you asked a couple of times of the City, the Administrative staff if that was in the next city budget. Is that what you are talking about?

CHAIRPERSON ROSENTHAL: So, you are not familiar with the Maternal Hospital Quality Improvement Network? Are the affiliate hospitals just not involved?

LORRAINE RYAN: I am familiar with many of the initiatives that the city is undertaking. I am not familiar with the details of this. The one that you are referencing right now.

CHAIRPERSON ROSENTHAL: I have no further questions. Thank you.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. At this point, we do not have any other Council Members who have raised their hands, including from the other Chair.

CHAIRPERSON RIVERA: I did have a question.

COMMITTEE COUNSEL: Oh, sorry Chair Rivera, go ahead.

CHAIRPERSON RIVERA: Thank you so much. Ms. Ryan, I just wanted to ask about just one thing in your testimony. I am very surprised that no one seems to know where there is a lack of midwifery programs considering there are only 11 acute facilities.

I think I know which ones they are. I think it's Lincoln, Harlem and Queens. I don't know why no one else seems to know those answers besides. I got that information from fellow midwives and doula's and what concerns me and I am trying not to make a connection

is that those hospitals exist in historically underserved Black and Brown low-income immigrant communities where these rates, these statistics have hit disproportionately with COVID on top. That wasn't my question.

My question is on something that you mentioned in your testimony which was, let me make sure I get it right here. When discussing the state pilot program, you stated you don't know why it was not well received and in the steps, you mentioned that Greater New York is taking to address implicit bias and how is doula feedback and expertise included in that?

LORRAINE RYAN: I am confused by the first part of what you said. You referenced the pilot in Brooklyn and then you went to a comment. I am not sure I am connecting the dots.

CHAIRPERSON RIVERA: I will repeat it, it is not a problem. When discussing the state pilot program in Brooklyn you stated you don't know why it was not well received and I know we mentioned —

LORRAINE RYAN: I didn't use the term well received. What I said is that there were two county's in New York State, approximately a year and a half, it could have been slightly longer when the

Governor's recommendations came out that were awarded as pilot test sites for doula programs.

CHAIRPERSON RIVERA: I'm just going to — and the quotes weren't around well received. There was you said, you don't know why. My question is —

LORRAINE RYAN: No, I did, well, if I could just finish. The one upstate —

CHAIRPERSON RIVERA: I want to finish my question and then you can finish your answer.

LORRAINE RYAN: Okay.

CHAIRPERSON RIVERA: In the steps you mentioned that Greater New York is taking to address implicit bias and I want to know, as you are addressing implicit bias, how is doula feedback and expertise included in addressing that issue? And I believe that the doula community in New York City has been extremely clear about many specific concerns is why I asked.

How are you incorporating doula expertise and feedback as you address implicit bias within your greater New York Hospital Association facilities?

LORRAINE RYAN: What I did mention that Greater New York was supporting was an implicit bias training program. We are working with an outside organization

that is focused purely on obstetrics and how patients are communicated with. Whether or not the workforce is sensitive to the needs of their patients if they are different than the patients that they are serving. Doula's wouldn't necessarily be excluded from that but I don't know that that has a particular focus on doula's. What I did mention is that the doula community through its advocates and community-based organizations has approached Greater New York about having a forum with hospitals, so that they could speak for themselves in expressing the benefits of the doula's presence and how they could work more cooperatively hospitals and doula's together in welcoming doula's and ensuring that doula's have access and in understanding some of the limitations that might be because of space considerations in the era of COVID. That was my reference to hospitals and doula's having a forum. It starts with communication and I am happy to bring the parties together, so that they can have the direct one on one with one another to understand, for the hospitals to understand the role of doula as a non-clinician support person and for the doula's to understand what some of the restriction might be because we are in the middle of

a pandemic and the numbers are just going up again. They are not unfortunately leveling off.

CHAIRPERSON RIVERA: Understood and considering the pandemic, the state has provided guidance indicating that doula's and other support persons are able to accompany a person giving birth. However, we have heard from advocates that different hospitals are interpreting this guidance differently leading to access issues.

So, can you please restate the policy for allowing doula's to be present at births during the pandemic?

LORRAINE RYAN: I read it the way you read it. That is a patient chooses to have the doula as a support person, they can be present during labor, delivery and in the postpartum phase.

One thing hospitals may have some specific need to restrict because as I mentioned earlier, we don't have private rooms in all of our safety net hospitals. So, you have a doula and a significant other and a patient times two. Six feet of distancing isn't going to work.

So, there might be some situations that have presented challenges. That by and large, you and I

understand the state policy the same way. That doula's are permitted at the request of the patient as a nonclinical support person.

CHAIRPERSON RIVERA: Does a doula have to how paperwork in order to enter the facility?

LORRAINE RYAN: You know that has come up a lot. I don't know that they even ask for paperwork. The noise is moving, so I am moving but what I have heard is that doula's have been asked if they are certified. They don't have to be certified. I think some hospitals have asked what their training is. I don't know if there is a hesitation to speak to the training but as far as the states policy, they should not be required to be certified.

CHAIRPERSON RIVERA: Well, I mean, it's just concerning because doula's need to know ahead of time that they need to show any sort of paperwork and this needs to be across the board the same.

LORRAINE RYAN: Yeah, one of the things on our conversation with the doula community last week, I recommended that it would be useful to communicate previously to the hospitalization. The patient can communicate it or if the doula attends prenatal

visits that they plan on being present in the hospital for the delivery.

So, and they actually embraced that concept. That information is you know, knowledge is helpful. So that the expectation that there will be a doula present with the patient and potentially another support person is useful information for a hospital for planning.

But these are the kinds of things that I think would come out when we host this conference call, forum, Zoom meeting, whatever it turns out to be.

CHAIRPERSON RIVERA: I think bringing the parties together seems like a very needed and simple first step. When is that forum scheduled?

LORRAINE RYAN: It isn't scheduled yet.

CHAIRPERSON RIVERA: Okay but there is a forum in the works?

LORRAINE RYAN: We spoke last week, yeah, I am working on it.

CHAIRPERSON RIVERA: Okay, well, we would be thrilled to know when that happens and to be able to make sure as many people are participating as possible, relevant stakeholders. Well, thank you very much.

LORRAINE RYAN: You are welcome.

CHAIRPERSON RIVERA: I just want to be clear is you know, the last thing that someone needs to worry about in a pandemic is showing up and being told they can't access or can't help or can't support. That's why we have been so consistent about having some sort of standards. Considering there is no standard certification for doula's right now, so the lack of consistency around requirements is troubling. But I thank you for your answers and for being here and for testifying and thank you Chair for allowing the questions.

LORRAINE RYAN: Thank you.

COMMITTEE COUNSEL: Thank you so much Chair Rivera. I am going to check if there is any other Council Members that would like to ask a question or if Chair Rosenthal or another Chair would like to ask any other questions. Okay, thank you. We will move to the next panel.

So, panel three, I will read the names and then call on you individually. The next panel will be Danielle Castaldi-Micca, Denise Bolds and Debra Lesane. So, the next panelist will be Danielle

Castaldi-Micca. You may begin when the Sergeant calls the clock, thank you.

SERGEANT AT ARMS: Starting time.

DANIELLE CASTALDI-MICCA: Hi, thank you so much for having me. Thank you to all the Chair's and in particular, I want to thank Council Member's Rivera and Rosenthal for staying. I know that that's not like visible on the livestream, but I think for all of the presenters, it is really valuable to see you and to know that you are here. So, thank you very much. It is hard to speak into the void.

So, again, my name is Danielle Castaldi-Micca, I am the Vice President of Political and Government Affairs at the National Institute for Reproductive Health. At NIRH, we work to secure access to reproductive healthcare, protect reproductive freedom and ensure reproductive justice at the state and local level across the country. We are based here in New York.

While NIRH is a reproductive rights organization that most frequently would be speaking with the Council about abortion or contraceptive access, it was important for us to be here today because the

ability to have safe and healthy births is the other side of that same coin.

The principle of reproductive justice, which is a phrase we have used a lot here today, is most frequently — I think people use the sister song definition which is the human right to maintain personal bodily autonomy, have children, not have children and parent the children we have in safe and sustainable communities. And it feels very clear before this but certainly from the testimony we have heard here today that we are failing on nearly every piece of that definition in New York City and the racial disparity component of that is so stark and shameful.

I am really happy the Council is taking up this issue and given the bills and resolutions that are being considered, taking a broad view of ways to address it. We cannot accept that maternal deaths are just a part of birthing.

I don't think I need to say this to the members who are here but to the rest of the Council, I hope that our elected officials are listening closely to the birth workers and providers and parents

testifying here today and that we use every tool at our disposal as a city to help address this.

As someone who lobbies on reproductive right issues a lot, the one thing I often say is there are a lot of structural things that we can change. It is much harder to legislate racism out of healthcare. If we could pass a law, that would be amazing.

So, I am not going to go through the statistics, we have had plenty of public health experts do that. We know what is at stake here. What I am going to say is that I urge the City Council and the Administrative agencies that are here today to work together to shape a city where childbirth does not have to be a high risk activity. That is a city where everyone has access to range of birthing options.

SERGEANT AT ARMS: Time expired.

DANIELLE CASTALDI-MICCA: I will be quick, thank you. Where everyone has access to a range of birthing options that includes not just hospitals but also home births, midwifery led birthing centers and everything in between regardless of their income or neighborhood. It is a city where the health and safety of those giving birth and their children is of

the utmost priority over convenience procedure or profit. It is a city where those giving birth have access to affordable prenatal midwifery, doula and postpartum care in their own communities and where those providers are fairly compensated. And it has to be a city where healthcare providers are held responsible for rooting out their own biases and racism and our institutions are required to do the same. And I appreciate the vigor with which Chair's Rosenthal and Rivera are trying to do that today.

So, NIRH supports Intro. 2017, 2042 and Reso.'s 1239 and 1408 but we emphatically urge you to continue to do more. While 2020 has been a year defined in New York City by a singular public health crisis of COVID, maternal mortality and morbidity has been a crisis for decades and we owe it to the families of all whom have been lost to keep doing this work. And I want to add I think to everyone's condolences and thanks to you Bruce. I know again, I am a live city feed, you can't see it but I know you are here watching and I am exhausted and heartbroken. And so, I can only imagine what this day is like for you and thank you for being so brave and so open.

And the last thing I will say, which I also said at the rally in the morning, my job, I get paid full-time to be a government affairs professional that talks about reproductive health. We all need to be working towards a day when I can do that for my full-time job but you don't have to be out here doing it. That's not your job and that all of the parents get to just be parents and all of the birth workers get to just be birth workers and usher in health, happy families.

So, thank you so much for having me and again, to the Council Members who are here and who have stayed, thank you for showing your faces. It is really important.

COMMITTEE COUNSEL: Thank you so much for your testimony. We will move to the next panelist now, Denise Bolds.

SERGEANT AT ARMS: Starting time.

DENISE BOLDS: Hi, good afternoon everyone. My name is Denise Bolds and I am a Native New Yorker. I was born in Harlem Hospital where my mom had an unassisted birth because as a Black woman who was ill at the time during her pregnancy, the clinical staff did not want to come in and help her deliver me, so

she basically had an unassisted birth in the hospital. That's how Black birth starts. That's how my birth started back in 1964.

I just want to say also to that I am a donor certified birth doula past six years, over 173 family supported. I am a hospital Doula. I am known for high risk births because of my prior careers, where I was a trauma technologist at Bellevue Hospital where I learned a lot in the ER and the OR. That was two of my favorite places in the world to be back in the early 80's and I also then became later on; I became one of the first medical social workers with a master's degree in social work to be hired here in New York State to do case management for managed care organizations back in the 90's.

So, I did medical case management for insurance companies and I did it for high risk pregnancies and I can tell you that the one entity that we are all trying to get around here in this room is money. Money controls just about everything when it comes to healthcare and it is the money that we have to look at. For these for profit hospitals that are complaining about, they don't know what to do, if they put on their budget line a budget for doula

care, for doula support services, I can promise you that there are statistics in customer satisfaction as well as their birth outcomes will change.

Insurance companies as well as hospitals, they have to answer to quality assurance regulations and we all know that doula's make a difference, okay. For Lorraine Ryan, please if you can think consciously to stop using the word minority. It makes me flinch. It is an outdated term. It is up there with negro and I can't stand it.

At this point, we are people of color or we are BIPOC but I am no one's minority, thank you.

The way I feel about this is very, very personal near and dear to me because of the work that I have been called to do. As a doula, I have been called to do this work and as a high risk doula who is in the hospitals a lot, I see many, many, many things that are happening here when it comes to birth that can be avoided. I see a lot of fear. I see a lot of intimidation. I see a lot of lack of communication. I see a lot of miseducation that's happening to families, good people, good hard working degree earning, tax paying law abiding people and they are pushed into this vacuum and treated like it is an

assembly line. Where you don't know that patients name. You didn't look at their chart. You don't know their background. You don't know what it took for them to get here. You don't know anything other than the diagnosis code. Because that's the way the medical model has shifted now.

SERGEANT AT ARMS: Time expired.

DENISE BOLDS: We have begun to treat pregnancy like it is more of a clinical situation, more of a disease, more of a code, more of a reimbursement. And what we have to understand here is that this is a three legged stool that we have to hold hospitals accountable as well as the insurance company and the community.

I have written doula proposals for major hospitals. As a medical case manager for Emblem, MVP and Oxford Health, I know the intricacies of what insurance companies do and how they impact hospitals and how that impacts the care of a community. I have written doula proposals for hospitals. Whereas Chair Rosenthal said, just a couple thousand dollars to start a doula program, you will see a difference but the resistance that you see here today in the way Lorraine Ryan has communicated, that is the same

bureaucratic communication that the upper echelon of the medical model, the CFO's and the CEO's, that's exactly the way they speak and that's exactly the way they think. Okay, they are on the defensive, they don't want to be corrected, they are putting something on an agenda for ten years and you better like it because that's the way its got to be. And I am saying that that's no longer acceptable anymore. It is just not acceptable.

This is a crisis against humanity. When Black and Brown women are dying. I can go and have a triple bypass or quadruple bypass and come out faster than I would giving birth. Think about that. I can come out very well in cardiology but I am taking a huge risk when it comes to labor and delivery. And these women are coming to me and they are asking me to do something that puts them at more risk. Unassisted birth, they don't want to go to a hospital. They are afraid and not every woman is a candidate for a birth center birth. We have many, many moms who do need the support of the hospitals and it is the hospitals responsibility to do that well.

The last thing I would like to say here also is that we need to look at the midwives who are here in New York practicing at hospitals. What do they look like? They are White. They don't even have enough representation of diversity for midwives who are allowed to practice here in New York hospitals because the White, there is an influx of White midwives but it is very, very hard to get a Spanish speaking or a Black midwife into these hospitals to serve for people that look like me.

So, I am really, really keen Lorraine and whoever else is possible. Please, this doula forum, I would love to speak there because of my prior history, because of my prior career and because of the work that I am doing. I am taking COVID tests like you wouldn't believe because I am trying to appease every single hospital and each hospital is a personal silo. I went to Montefiore, the two Montefiore's in the Bronx Einstein and the other one. Einstein said, you got to have the COVID test. You got to walk in with the COVID test. You can't come in here and support this birth unless you have a COVID test.

My client went to Einstein to give birth. It was too crowded. They sent her over to the other

Montefiore hospital, okay. She went there, went into labor and labor in the triage room for 8 hours because there wasn't a room for her. I couldn't come and support her until they got her into a room, right. I understand that. I understand, no problem. I went and showed the nurse my doula certification, my medical malpractice insurance and my negative COVID test, you know what that nurse told me? Oh, you don't need to have that here.

Do you know what I went through to navigate getting the COVID test within the 72, you know the 2 day, the 72- hour period to make sure that I am not reinfecting. Do you know the stress and strain of this family? This poor mom is huffing and puffing. Denise, did you get a COVID test? Can you come?

The stress and strain that we are putting on our families and the essential workers who are on the frontline. Why? A lot of this is avoidable but I do want to say, I would love to participate in this doula forum that's coming up because I do have a lot of exposure being a hospital doula. That's what I do. I work as a hospital doula and I have seen all of these hospitals, including the one out on Long Island, Northwell, where they don't want doula's.

Even with an executive order, they are allowed to exclude themselves from the executive order and ban doula's from their hospitals.

Okay, so let's talk about the amount of autonomy and the amount of power that these hospitals give and it is not benefiting the communities. It is not. It is not helping communities at all. When you can override an executive order from the governor of the State of New York, that's a lot of power. That's a lot of power and that's a lot of money and we have to call it as we see it. These for profit hospitals can no longer broke. Oh, we don't have money for a doula support but if you want to come in and do it for free. No and to answer Lorraine Ryan, yes, we had a doula pilot program here in Brooklyn. I was one of the first doula's to get my NPI and do everything to sign up to be a Medicaid Doula because that's what I was called to do.

But you know what happened? The reimbursement rate. There is no way I can live on $600 before taxes and there is no way that I can do 6 prenatal visits and 6 postpartum visits and support a birth on average that lasts about 27 hours. It is punitive what New York State did when it came to the Medicaid

reimbursement for doula programs. It was punitive what you did.

Other states, they are paying $800, $900, $1,200, $1,500 up in Massachusetts for a doula reimbursement program. But here in New York, all we could negate was $600 and told, you better like it because that's all you are going to get. And then you are going to sit here and say, well, gee I don't know why the doula's in Brooklyn didn't sign up. Because you can't survive off of that and it doesn't make sense. 6 prenatal visits and 6 postpartum visits, how are you going to fit all of that in? It is almost virtually impossible, especially being on call to support the birth as well.

So, that's why the medical model failed when it came to Medicaid for doula's in Brooklyn. Because you did not set this up, you did not listen to the doula's. You picked one doula to speak for all doula's and that's a big mistake. We have very intelligent doula's here in New York State and you cannot just pick one doula and one doula organization to speak for all doula's. That's plantation mentality. That's racist and its got to stop.

That's all I have to say because I am losing my temper. Thank you very much.

COMMITTEE COUNSEL: Chair Rosenthal.

CHAIRPERSON ROSENTHAL: I want to continue with the panel but I really want to thank you.

DENISE BOLDS: It breaks my heart. It absolutely breaks my heart. Why women were treated better as slaves when they were pregnant because they were somebody else's property. When we were no longer slaves, then we had a problem here called maternal health disparities. This model was never for us. The AMA banned Black doctors when we were emancipated. This medical model was never for Black people. It was never for people of color. So, you are trying to build something on a very unstable foundation.

CHAIRPERSON ROSENTHAL: Thank you for your anger and expressing it. Really appreciate you, very, very much. We still have the rest of the panel, is that right?

COMMITTEE COUNSEL: Chair Rosenthal, so we have one more panelist on this panel and that panelist is Debra Lesane.

CHAIRPERSON ROSENTHAL: Thank you.

COMMITTEE COUNSEL: Ms. Lesane, you may begin when the Sergeant calls the clock. Thank you so much.

SERGEANT AT ARMS: Starting time.

CHAIRPERSON ROSENTHAL: I think Ms. Lesane needs to be unmuted. There you go.

DEBRA LESANE: Thank you. Thank you so much. Thank you Chair Rosenthal, Chair Rivera, Chair Levine. Thank you for the opportunity. My name is Debra Lesane, I am the Director of Programs at Career of Young Women's Health Association and we provide a range of services for our community but I guess I am here today because we coordinate a doula program. We provide doula services in actually four boroughs. Brooklyn, Manhattan, Bronx and Queens and I just submitted written testimony but I wanted to use my time to some of the issues that came up and I wanted to speak before but I wasn't able to.

So, I want to respond first to an issue brought up by Chairperson Rivera. I want to say that our doula program, Healthy Women, Healthy Futures is funded by New York City Council. So, we thank you very much for the opportunity to serve our community. This is our seventh year of funding and the funding

for our doula program allows us to provide doula support to the women from the four boroughs at no cost to the women but it also allows us to recruit and train people from the community to become doula's.

So, that's something in response to Chairperson Rivera that something that we do every year. We recruit a cohort of [LOST AUDIO 4:22:22] trained upwards of 75 new doula's across all five boroughs. Okay and that's something we have been doing every year for the last seven years.

In response to Chairperson Rosenthal, your suggestion of Greater New York Hospital Association supporting the MHQUIN project. That is an excellent idea [LOST AUDIO 4:22:49;22:54] some components of the MHQUIN. One component that I have worked very closely with them is promoting doula access and specifically I work very closely with promoting doula access at Montefiore Hospital and Metropolitan hospitals. And in promoting doula access there are number of steps that we have taken in working with those hospital and one of the steps is to help the hospital develop a doula policy for that hospital.

So, that everyone at the hospital is clear on what the doula policy is and people outside, including doula's can know before they come to the hospital. What is that hospitals policy in terms of doula access.

And so far, we have developed a really nice policy and procedure with Metropolitan Hospital. I believe they are the first hospital to complete the doula policy and we are working with Montefiore Hospital at this time for them to complete their doula policy.

So, even though as Chairperson Rivera noted, even though we have a mandate from the governor on doula access—

SERGEANT AT ARMS: Time expired.

DEBRA LESANE: Even though we have a mandate from the governor's office, every hospital was developing their own policy and procedure and it was often times individual depending on who was meeting the doula at the door.

I have had to — on a personal note, I had to actually go to my office at 9 p.m. one night and write a letter for doula to be able to have access to be able to support her client. Mount Sinai Hospital

would not allow a doula to [LOST AUDIO 4:24:40-4:24:44] and women don't deliver on any schedule, so this was an emergency and she was unable to go in unless I was able to provide a letter on letterhead at 9 p.m. Okay, so these are things that are happening but with the development of each hospital having a doula policy, hopefully we will be able to get rid of these issues.

So, what Ms. — the lady from Greater New York mentioned about working with individual hospitals, it is something that MHQUIN is already doing and they already have a template and a format. Okay, so you know, as much as they can contribute to that process, I think it would be helpful and that process should continue.

I want to What Ms. [INAUDIBLE 4:25:37] said about the Medicaid Doula Pilot for Brooklyn is correct. It is not that the doula's didn't want to sign up. The doula's were not able to participate because of the reimbursement. It was prohibitive.

So, what that means is that women on Medicaid in Brooklyn did not have the ability to have a doula paid for by Medicaid and I think that's a travesty at this point. It is just really a travesty.

Early on communication was mentioned as an issue that basically lack of communication is contributing to an ongoing problem with maternal mortality and morbidity and that communication [LOST AUDIO 4:26:19-4:26:28] client and the providers are important but we are seeing women from the time they know they are pregnant, actually before they know they are pregnant, throughout their pregnancy up until a year after they give birth. Because maternal mortality is defined as any pregnancy or delivery related that's up until a year after the child is born. So, during that time, communication with community-based providers is very important and needs to be supported. Hospitals have to be open and recognized. That community-based providers provide support to women before they go to the hospital and after they get out of the hospital.

So, yes, we should be working with hospitals but we should also provide adequate resources to community-based organizations so that we can provide the necessary level of services that are required.

And the last thing I want to say is we know that the COVID pandemic has heightened the disparities that exist. We serve upward of 600 women per year

pregnant and postpartum and we seen a real increase in women who need housing. We have many women who are now in shelters who are pregnant and going through pregnancy in shelters. We have women who also have food insecurity and women who have heightened mental health needs.

So, I would recommend that New York City develop some system so that pregnant women have priority [LOST AUDIO 4:28:09-4:28:12] should just have to go through the shelter system while she is pregnant or with a newborn baby. There has to be some priority given to serving pregnant people in New York City.

And that completes my testimony. Thank you very much and I just wanted to give my condolences to Mr. McIntyre. As much as we do, it is not enough as long as women are dying. It is just not enough and we have to do more. Thank you all.

COMMITTEE COUNSEL: Thank you so much. Chair's Rosenthal and Rivera.

CHAIRPERSON ROSENTHAL: Yeah, well first of all Ms. Lesane, thank you for everything that you do. It is pretty remarkable and really appreciate your comments. You know, Ms. Bolds, halfway through your testimony or about a quarter of the way through,

interestingly Greater New York Hospital Association Representative hopped off.

So, Greater New York was not able to hear. Their representative was not able to hear both your and Ms. Lesane's really good suggestions for them and it was noteworthy.

DEBRA LESANE: Predictable.

CHAIRPERSON ROSENTHAL: Yeah and let's see, so I had a question for both of you. Are either of you on the city's M3RC?

DEBRA LESANE: I was a member for the first two years. So, my position expired in December of 2019.

DENISE BOLDS: No, I am not on but I would certainly make every effort to contribute any way that I can.

CHAIRPERSON ROSENTHAL: Do you work, Ms. Bolds are you in touch? Is DOHMH in touch with you on your work?

DENISE BOLDS: No, no, this is my work. I have a full-time doula business, full-time doula practice. This is what I do for a living. That and I am a CLC, so I also work with breastfeeding women and no, I have not heard from the Department of Health with that.

CHAIRPERSON ROSENTHAL: So, they are required to do an analysis of the doula services that are provided in New York City now and come up with a plan of action to increase the number, increase access to doula's. You are telling me they have never reached out? You have never heard from anyone at the Department of Health?

DENISE BOLDS: No.

CHAIRPERSON ROSENTHAL: That's concerning.

DENISE BOLDS: It is. I mean, I have an LLC. I am an MWBE. I have done everything the right way when it comes to my business, so my information is out there. I also have an NPI number. I am out there. I am accessible.

CHAIRPERSON ROSENTHAL: Clearly. Thank you. Ms. Lesane, you talked about a doula access plan that you came up with for Metropolitan. You are working on one now for what was it Montefiore or Mount Sinai?

DEBRA LESANE: Yes, Montefiore.

CHAIRPERSON ROSENTHAL: And again, do you work in collaboration with the city on that, Department of Health?

DEBRA LESANE: Right, that's one aspect of the MHQUIN project is to improve doula access at the

MHQUIN member hospitals. So, we have gone to both Montefiore and Metropolitan many times to speak with the staff to engage the staff around doula access. Educate the staff [LOST AUDIO 4:31:39-4:31:42] appreciate the role of the doula. So, and also to get them as I mentioned policy that is an official hospital policy on doula access, so that all of the hospital staff is following the same policy and that policy can also be publicized to the public and to the doula community. And doula's are involved in the development of the doula policies at the hospitals.

CHAIRPERSON ROSENTHAL: That's great, that's great. Two quick questions. How much money does your organization receive from the network project? In other words, if the project is not funded for next year, how much money will your organization lose?

DEBRA LESANE: We don't receive any funding to participate on the MHQUIN. So, we you know, receive funding to provide our doula program and coordinate our doula program in four boroughs but we —

CHAIRPERSON ROSENTHAL: But you are doing the work.

DEBRA LESANE: Yes.

CHAIRPERSON ROSENTHAL: The bill requires on coming up with doula access plans. You are doing that work and not getting reimbursed by the city?

DEBRA LESANE: No.

CHAIRPERSON ROSENTHAL: The City Council funding?

DEBRA LESANE: No. Our City Council funding is only to coordinate Healthy Women Healthy Futures Doula Program. So, we take it as [LOST AUDIO 4:33:19-4:33:24] Health and Mental Hygiene because doula access is important for us to be able to do what we do but we don't get funded for that specifically.

CHAIRPERSON ROSENTHAL: Would you have liked to have continued on the M3RC? And I know your screen is occasionally frozen, so —

DENISE BOLDS: And once again, that's the mentality when it comes to community doula work, when it comes to serving your community. It is the BIPOC. It is the women of color who step up and do this work.

DEBRA LESANE: I missed your question. Chair Rosenthal?

CHAIRPERSON ROSENTHAL: Yeah, got you. One second, one second please. Please continue Ms. Bolds. I agree with you 100 percent.

DENISE BOLDS: Yeah, so we don't get reimbursed. Debra was saying in Healthy Women Healthy Futures, along with several other organizations have been working very hard and look at all this wonderful work that she is talking about and she is not being reimbursed in any way. This is going to impact a lot of families and a lot of the community and that's the pattern when it comes for community doula work when it comes to Black women.

You will do the work but you will not be adequately compensated for your expertise and for your intellect. That's intellectual property. That's theft.

DEBRA LESANE: I didn't hear your question Chair Rosenthal.

CHAIRPERSON ROSENTHAL: I was wondering. Thank you Ms. Bolds for that comment. Ms. Lesane, I was asking whether or not you would have liked to have continued on the M3RC and if knew the name of the doula organization that continued the work after you left.

DEBRA LESANE: I am not sure. I just received a letter stating that my term was over. So, I am not sure that [LOST AUDIO 4:35:11-4:35:14] decision. I was not informed. I was just informed that my two year term was expired.

CHAIRPERSON ROSENTHAL: While you were on during those two years, do you feel like your voice was heard during the Committee meetings? Ms. Lesane, while you were a Committee Member, do you feel like your voice was heard on the M3RC?

DEBRA LESANE: Definitely, it was and I was thinking that the information that I gained from being a member of that Committee has helped me to be able to improve the level of support that our doula's are providing. As we are going through cases, we hear about gaps in services and care, so that when we receive doula referrals, you know, I can know for example you know, I will say a women you is an immigrant who has recently arrived here is at greater risk. And so, we pay special attention to cases like that.

Women who are in shelters, you know, we try to give them additional support because we know they are

at greater risk. Women who may not speak English are at greater risk.

CHAIRPERSON ROSENTHAL: And you learned all of that by being a member of the M3RC.

DEBRA LESANE: Participation on that Committee.

CHAIRPERSON ROSENTHAL: Great, thank you all so much. I could talk to you all day long. There is another panel waiting and you have important work, so thank you so much for your time. It is really valuable for us to be able to push the ball forward. I just so appreciate everyone. Thank you.

COMMITTEE COUNSEL: Before we move forward Chair Rivera, did you have any questions?

CHAIRPERSON RIVERA: I just want to thank you all so much. This is, I think Ms. Bolds, you kind of laid it all out. We are built on an unstable foundation. So, we are trying to essentially build something new and no one is giving us the tools.

DENISE BOLDS: And it hurts. It cuts so deeply for me. It really does. It is something that keeps me up at night. I hear the terror; I see my peers working alongside me so hard. I hear stories like Mr. McIntyre. This is not what I had anticipated when I stepped into this role of being a doula. I

had no idea the enormity and like I said, it is because of the cellphone that we are able to stay connected and it has really opened up the enormity of this maternal crisis that we are in because the cellphone is able to connect millions of people at once and document something that has happened. If it didn't document, it didn't happen and that's why we fell into this abyss for so long. But it is just, it is devastating for me.

CHAIRPERSON RIVERA: Thank you. Thank you for all you do. Thank you Chair.

COMMITTEE COUNSEL: Thank you so much to our panelists and also to the Chair's. I don't see any other Council Member hands for this panel. We will just do one check for Council Member questions using the raise hand function in Zoom. We don't see any hands, so we will move to the next panel. This next panel will be our final panel. There will be five panelists, so we will call the panel and then each individual by name followed by a check after this panel, for any panelist that we may have missed.

So, we know some people have logged out and may log back in. So, we will do a check after this panel but for right now, it is our final panel.

Panel Four will be Eugenia Montesinos, Neelu Shruti, Annette Perel, Patricia Loftman and Tricia Shimamura. So, again, we will start with Ms. Eugenia Montesinos. You may begin when the Sergeant calls the clock. Thank you.

SERGEANT AT ARMS: Starting time.

EUGENIA MONTESINOS: Can I start now?

COMMITTEE COUNSEL: Yes, please begin. Thank you.

EUGENIA MONTESINOS: Hi, good afternoon. My name is Eugenia Montesinos, I am a Midwife at Metropolitan Hospital. I have been working for 20 years here and it is a hospital that serves a minority of Brown and Black mothers. And so, I just want to talk a little bit about what is going on.

Like plenty of the previous people on that were saying how much maternal mortality is a pandemic that was happening way before COVID. It has been happening way before and I have been witnessing, I mean, it was happening but with COVID that increased, it surfaced more what is really happening, especially with our Black and Brown mothers.

I just want to start how even that much people notice it even more why maternal care was so

important in the city and why it makes more news, not because they weren't paying attention to our Black and Brown mothers. It was because our White mothers, they got hit. They never got hit in a way that now your partner cannot go in with you and that make it big news.

So, it was not — if it wasn't that, I don't think they would pay attention to that. It is not on the news, the newspaper, the media, everybody was paying attention to now. Because of White mothers being hit for the first time with these big disparities that is happening.

So, on one of the teams said it was very disheartening with me that would happen. They were able to look for options. They were able to look for having a home, I mean a birth home, you know they can have it at home. They can pay for that or they can pay to be going out of the city where [INAUDIBLE 4:42:18] is not in there. So, they can go to their country houses which you are not getting infected but our Black and Brown people, they have no options whatsoever. They have to be there. They lose jobs, their partner losing jobs and there is no way to get communicated with us because we were not prepared.

We didn't have anything — how are we going to find out like what is it. There is no phone.

SERGEANT AT ARMS: Time expired.

EUGENIA MONTESINOS: For them also there was no way to be communicating to us because we — when you went into the hospital, you are not assigned to a specific provider. It's a group and there is a number our clinic chose and they were calling and there is no way to get in touch with us.

So, it was really more and the whole problem got really very bad for us also and for the mothers and for every people who was taking care of them. Doula's could no longer come in. Mothers can be having the babies alone. I mean, no one in there, no one. Not even [INAUDIBLE 4:43:44] we couldn't even go too much to the room because we don't want to be exposed. Because we have to take care of another mother.

So, it was very sad and traumatic for everyone. It was not only traumatic for the mother, it was traumatic for us, traumatic for the partner and it was really bad. And when you are a White person, you can scream, you can get and sometimes you can get your way but when you are a minority, when you are

Black or Brown, they are not going to listen to you or you are not aware of your rights. That is one other thing.

So, doula's are not advocates and they are not there. We are advocates yet we can't cover everything. So, it was a big thing on the maternal mortality and morbidity. With this one, we really, really see how Black and Brown women suffer and there were the consequences for that. You know, they lost their job. Sometimes the traumatic — it's just all alone and some people, some of the mothers, the domestic violence got higher.

CHAIRPERSON ROSENTHAL: Yeah.

EUGENIA MONTESINOS: And also, they were not on call. They got pregnant while they were in quarantine and nobody can leave and they got pregnant. Unwanted pregnancies, they can't get in touch with us to have their contraception or if they become pregnant, they can't have an abortion.

So, it got completely chaos on everything and we wanted to do our best to but there is no way how we can get in touch. As I said before, we lost a lot of mothers and we just saw them when they were coming to have a baby and we didn't see them for months. And

we were talking to them, what happened? They said, I don't have a phone. I don't know how to get in touch with you. My husband died because he got infected, the whole family got infected and it is just very sad.

So, for me, we need to implement. As midwives we try to do very holistic care and that is not what it is and we have to change that and if we want to decrease the maternal mortality, we have got to get very serious about it and change how we approach women care period. Not in a way how it is right now.

Right now, all our mothers who suffer during the pandemic who had a baby like that including now, they are trauma and it is going to be a big trauma not only the parent and also the child because when you were born and you don't have skin to skin, there is not such a connection. It is separated and its going to be a big trauma. We are going to see that in 15, 18 years from now, it is going to be a big mental pandemic and it is going to hit us. We are not thinking about that.

We will not see the whole picture and we try to see the whole picture and that is why it is so important to have that option for women. The

midwifery option. If they want to chose that, this option should exist for them but we don't have that.

Plenty hospitals don't have that. So, we should implement it, if the woman chooses, good. If she doesn't chose, good because we have to offer options and that is for me one of the things that, when I think about mothers in general, maternal care have to be changing. Look at we have in England, Netherlands, Denmark, they have a very good outcome because why? The fist line of midwives and when they have a problem they go to a doctor. So, they do have high risk, low risk and that is what we have to do.

United States paid billions and billions of money for prematurity. We spent so much money and it is just enormous and that we can fix it. And just that alone, why are we having premature babies? Premature babies they have problems. They have delayed in learning. It costs us amounts of money and there is no need to go through this. If we are serious to change our lives, the new generation life and I think that's the most I can say.

There is times that I can keep talking but I think I am going to give a chance to the next ones. Thank you for listening.

CHAIRPERSON ROSENTHAL: Thank you and thank you for sharing what you witnessed all these months.

EUGENIA MONTESINOS: Thank you.

COMMITTEE COUNSEL: Thank you so much and thank you Chair. We will move to the next panelist who will be Neelu Shruti.

SERGEANT AT ARMS: Starting time.

COMMITTEE COUNSEL: Ms. Shruti, you may begin your testimony. You are still on mute; you probably have to accept. A little box will pop up asking you to unmute. You need to be unmuted. There is a delay. We are working on a technical issue, one moment.

NEELU SHRUTI: There it is. Thank you.

COMMITTEE COUNSEL: You may begin when the Sergeant calls the clock. Thank you so much.

SERGEANT AT ARMS: Starting time.

NEELU SHRUTI: Hi everyone, my name is Neelu Shruti. I am a Birth Advocate here in New York City. I am a student midwife. I run a support space for expecting a new parents and I am also part of a group opening a midwifery led birthing center in New York City.

I would like to start by pointing out and speaking to the specific bills and resolutions that we are talking about today, in the context of reducing racial disparities in maternal mortality. In terms of the first one which talks about I believe it is number 2017 as it applies to visitation policy guidelines. In order for this bill to truly address racial disparities in maternal mortality, it needs to include that doula's are allowed to visit birthing clients in all hospitals without any certification barriers and for the doula's presence not to be counted as a visitor as they are essential workers.

For pregnant and birthing people to have a companion at prenatal visits during birth ensure no separation from baby unless medically necessary and in case the patient is readmitted for postpartum that the baby is not considered a visitor and allowed to room in.

For the second, which is number 2042, which pertains to posting information about midwives on line on the DOHMH website, in order for this bill to truly address racial disparities in maternal mortality, it would be necessary to include the benefits of using midwives, include nationally

available data and statistics of C-section rates, maternal and infant disparities, in mortality and choosing to use midwives as well as links to resources to help pay for midwifery services.

For Resolution number 1239, which relates to making doula's more accessible to individuals with Medicaid and those without health insurance. Yes, of course, doula's should be more accessible; however, in order for this Resolution to truly address the racial disparities in maternal mortality, this Resolution must focus on midwives. Yes, access to doula's should be increased but doula's do not solve the racial disparities in maternal mortality as they have no role in providing healthcare or not healthcare professionals. We should be relying on healthcare professionals that are trained and have proven time and time again to have better outcomes for birthing people of color.

And finally, in terms of this Resolution 1408, calling on the New York State legislation to pass a related accreditation approval for a midwifery led birth centers. To clarify all birth centers in New York, even if they are the two emergency birth

centers are all physician led. To this day, we have zero midwife led birth centers in New York.

SERGEANT AT ARMS: Time expired.

NEELU SHRUTI: There remains zero midwifery led birth centers in New York despite the governor's executive order. Despite the recommendations of the New York Maternity Task Force. There is a stark difference between the two. In addition to the language for this bill for it to be truly effective, all midwife led birth centers must receive deemed status for this certificate of need process, which is onerous, expensive and prohibited, which is why we do not have a community birth center facility.

I would also ask the Council to support Resolutions to pass an executive order for this deemed status to happen because it might take a while for this bill to get passed. We also need a Resolution to allow certified professional midwives to have permanent full scope of practice and immediately make funding accessible for any group that is trying to open a midwife led birth center in New York City. Thank you.

CHAIRPERSON ROSENTHAL: Yeah, thank you and thank you for your attention to the bills in particular and

sharing those thoughts on the record. I really appreciate that. Is there anything else you wanted to add? I don't want you to feel — I mean, that was, you really just helped us.

So, if there is anything, one or two more sentences that you want to add, you are so knowledgeable about this. I really appreciate you.

NEELU SHRUTI: This is the first time that I have been included in a gathering such as this and so, I appreciate that. I do think that voices such as mine for folks who are doing this actual work and have policy related issues and policy related ideas need to be taken into consideration.

I do think we need a midwifery school in New York City that is a direct entry program, that is publicly funded to offer and expand midwifery services in this City. That would make a huge difference in the maternal mortality, the disparities in short and there are lot more ideas but I wanted to focus on the specific things that we are talking about today and would love to continue this conversation as many times as you need but hopefully not to many more.

CHAIRPERSON RIVERA: I just wanted to ask —

CHAIRPERSON ROSENTHAL: I just want to continue, oh, I am sorry Council Member. We are going to continue with questions after the whole panelists finished. I just wanted to jump in on that. Council Member?

CHAIRPERSON RIVERA: Yeah, I just wanted to yeah, just jump in and say, I am looking forward to working with you Neelu. I appreciate your edits and your expertise, I really do.

NEELU SHRUTI: Thank you.

COMMITTEE COUNSEL: Alright, thank you so much Chair's. We will move to the next panelist Annette Perel. Thank you. You may begin, Ms. Perel, you may begin when the Sergeant calls the clock.

SERGEANT AT ARMS: Starting time.

ANNETTE PEREL: Hi all, can you hear me okay? My name is Myla Floris[SP?], I am working with Annette Perel. I am a community member of the birth doula's and birth workers out here. I have been a birth worker for 14 years. One of the things that I work with is with Uptown Village Cooperative, which is a multicultural group of perinatal professionals that are based in and serving upper Manhattan in the Bronx.

I have worked with Neelu a ton recently and Bruce a ton recently on advocacy efforts towards our missions and the different levels of the different points that have been made. Thank you Neelu so much for all of that detail and your sharpness and dedication and I just want to also thank everyone here for your commitment. Our leaders, the birth workers who have been tirelessly dedicated to improving birth justice and those who have been most deeply impacted by issues that we are speaking of and those who have been neglected, who have been left behind and we are here for all of them and for all birthing people. And so, I just want to appreciate that we are here in the effort to bring things forward and consider these wonderful creative ideas.

We all know and have a whole bunch of data, a whole bunch of solutions. We even have protocols, like lots of specifics and I just want to again echo many of the recommendations that have already been made and for now, I am going to focus on the last point that Neelu just touched on and it is really, really driving home this ask for Governor Cuomo to use his executive authority to allow midwife led

birth centers deemed status so that we are granted certificate of need.

If we meet the rigorous standards that CABC lays out in their free standing birth center accreditation process, this should be sufficient to exist in New York and this should be sufficient for providers who are working in this setting to have reimbursements and for the facilities to be reimbursed. This would be a tangible action towards the intent that the task force made to create safe alternatives for out of hospital birthing sites. As she stated, there are none. We have zero midwifery led birth centers and during this COVID-19 pandemic and the pandemic that existed prior with the maternal mortality, this is a crisis on top of a crisis and it is not being properly addressed.

So, birthing options remain unavailable to New Yorkers and this is a key birthing option. We should have access to birth centers. We should have access to midwife led birth centers and we want creative approaches to collaborative care in a model cognizant of the complexities around what our communities face. A lot of these birth workers —

SERGEANT AT ARMS: Time expired.

MYLA FLORIS: Can attest to the different stories that we faced in supporting our birthing families. My most recent and I am only going to name just the most recent things. My most recent lactation client, she, 19-years-old, birthing in a New York City hospital saying wow, my doctor, I didn't even know he was my doctor. He just came in and would occasionally talk to the nurse and then leave and afterwards I found out he was my doctor but exchanged zero words with me. I wish I had one of my nurses was a person of color, you know, and she describes this experience that she had a healthy outcome but she is traumatized.

And so, you know, that's a lactation client. From like the birth perspective, I have two people back to back at a private hospital in you know, the parts that I serve, upper Manhattan and the Bronx but the one was White, one was Black and the same circumstance happened induction and the way that the Black person had to advocate for herself in order to still be provided substandard care and still have outcomes that were negative and pushed on her in comparison to what the White person had to do when she just set her mind and didn't make it an argument

and I was just like, wow, okay, she is just being listened off the bat. And this is all stuff we know of.

You know, I don't have to name case after case of what we see all the time but I just wanted to just go ahead and illustrate, these are the common things and as a birth doula in the birth field with a whole group of 17, 18 mentees that are speaking to me about their issues on a regular, I am noticing the same things and I just want to speak also to the doula program, the pilot.

You know, Uptown Village Cooperative had to secure funding from a private grant source in order to provide the care that we wanted to in the way that we wanted without the whole 6 prenatal's and 6 postpartum's and so we were able to pay our doula's in that way and that's a model that we wanted to continue to do but we ran out of funding.

We have community-based, community-led initiatives from organizations like birthing services like Bronx Rebirth, that are able to get communities to help fund them to support people in their communities, right.

So, that we can reflect the care so that we can reflect culturally and energetically the type of people that we are serving and they have been successful at that. And so, there are community led initiatives that I believe we should be aware of and in support of and oh, my gosh, Debra Lesane and all the work that you are doing with Healthy Woman, Healthy Futures, just like what you have to manage in order to keep that program floating and you know, thriving and you know, I am in touch with the doula's.

Some of the many doula's who pass through that program and you know, we still remain appreciative in knowing you know what's out there and the barriers that we are all facing in being like some of the primary stakeholders in improving maternal health for our communities. And we all recognize how important it is, how time sensitive it is and we don't want to be going through these slow boiling, slow grind of you know, getting these bills passed especially for something as simple as a public statement that has been we need midwifery birth centers to exist.

So, now can we get those steps taken. And so, I hope that anyone here and the circles of influence

you have — influences that you have can really consider putting a press towards the Governor Cuomo because those offices who we have also been in touch with Neelu and I with the Department of Health and basically, you know, those are under the executive authority and therefore, like if he were to go ahead and push forth this commitment, it can change.

The last thing I wanted to mention, was just you know, it's been known that we have resources here in this state. I know it is a complex year but truly we need to put our money where our commitment is. There are other states, Eugenia had just mentioned countries that are doing things successfully. Right here in the United States there are places, there are jurisdictions that are doing things gorgeously. I have been following and just wanted to mention a jurisdiction in Seattle that has the office of planning and community development.

They have an economic development initiative there. It is a fund created to respond to the needs of marginalized populations, reduced disparities and support access to opportunity in health vibrant communities and it was championed by the community organizations concerned about the you know, pressures

and the lack of investments in the communities of color. And so, the Mayor proposed a sustained funding source and awarded a bunch of organizations led by and serving people of color that would basically allow for capacity building, property acquisition and capital expenses.

And so, we know again, midwifery led birth centers are necessary among other things. I am just driving that one home because I really want us to consider creative ways to use every resources available to us and every tool possible to help make change. And that's all I want to say for now.

COMMITTEE COUNSEL: Thank you so much for your testimony. We will move to the next panelist and then we will take questions at the end of the panel. If that's okay with the Chair's. Okay, the next panelist is Patricia Loftman.

SERGEANT AT ARMS: Starting time.

PATRICIA LOFTMAN: Hi, good afternoon and greetings. I would like to thank you for this opportunity to provide testimony before the Hospitals Committee on Maternal Morbidity and Mortality.

But before I start, I would like to comment that one of the limitations of committee's such as yours

is that you don't have the benefit of individuals like myself who have been doing this work for about 40 years and so, you don't have the benefit of our historical memory and information.

So, for example, Neelu referenced the bill that would provide information on the number of midwives etc. That already exists. This bill is redundant. There is a New York State Maternity Information Law that dates back to the 1990's that provides information on childbirth practices and policies including whether a hospital has a midwife. The number of midwifery births, the C-section rate, the VBAC rate, Vaginal Birth After Cesarean. This information is packed with a lot of information that families such as Mr. McIntyre could have used in making an informed decision of where to go for maternity care. The problem is, is that because this emanated in the 90's, there are few people who remain who even know that this New York State Law exists and consequently it is not enforced.

So, you have a bill now that is recreating what already exists but no one knows that it is not enforced. So, why don't we, before we continue this bill, research the maternity information law and

enforce it. Make certain that it works. So, that's number one.

So, I am sorry, my name is Patricia Loftman, I am a Certified Nurse Midwife, Fellow of the American College of Nurse Midwives and Former Hospital Center Midwifery Services Director from 1984 to 1999. I practiced full scope midwifery for three decades, I retired from clinical midwifery in 2010 but clearly I am still around, so I have not left the field.

When I retired in 2010, I was attending the births of infants that I had brought into this world, which means I had taken care of over two generations of families. And what that attests to was the satisfaction of having someone cared for by someone who looked like you.

The American Public Health Association identified racism as a public health issue and described how racism effected public health and health disparities. Racism is the power to control the distribution of money, power and resources and the differential access to good services and opportunities based on race at the global, national and local level.

So, for example, when COVID occurred —

SERGEANT AT ARMS: Time expired.

PATRICIA LOFTMAN: And women were — thank you and women were afraid to go into the hospital, a midwifery led birth center was actually open in Manhattan. Except the problem is, is that COVID rates in Manhattan were the lowest. Where that birth center should have opened, would have been in the Bronx or Queens or Brooklyn where the COVID rates were high.

So the resource was placed in the area that needed the resource the least, rather than the area that needed the resource the most. Structural racism is the foundation from which social determinates of health and health emanate an account for persistent health inequities.

You know, we throw these terms around without really understanding what these terms mean. Social determinants of health are the condition in which people are born, grow, work, live, age and the wider set of forces and systems shaping the conditions of their daily life. Which means this happens from the time you are in utero in your mom's belly.

Maternal mortality is a direct consequence of social determinants of health more than health behaviors and clinical care. So, if a woman didn't

go for prenatal care at all, it is the condition in which she lives that would impact her outcome more than anything else. Historically, women at risk for a poor pregnancy outcome were characterized as those with no prenatal care, low income, low literacy, engaging in unhealthy behaviors such as tobacco, alcohol and/or illegal drug us, exposed to intimate partner violence and having mental health challenges.

However, as early as 1992, a centennial study published in the New England Journal of Medicine demonstrated that being a college educated middle class African American woman was not protected against poor birth outcomes. And this disparity was reaffirmed in 2019. So, we have known about this for a long time. We just have not put a name to what was the condition that created disparity for African American women and we now know that it is structural and institutional racism.

What's important for the Committee to understand is that maternal mortality is a process that begins long before a woman becomes pregnant. The vascular changes that contribute to the maternal mortality begins in utero. Traveling a life course that builds

and accumulates with each experience of stress and daily living of being Black, Latinx or indigenous.

The COVID pandemic only exacerbated these inequities. Strategies to address maternal mortality for Black and indigenous women require a systemwide approach to address factors related access to care and the quality of that care.

For example, evidence documents that Black and Latinx women in New York City experience a higher risk for sever maternal morbidity compared with White women within the same hospital. Even after controlling for patient insurance and hospital characteristics.

So, if I choose a hospital because I think there are more White women in that hospital so I will get better care. The answer is no. One strategy to promote access to care is supporting increased racial and ethnic diversity in the maternity health workforce. Delivery in care encompasses two elements. I always taught the students that what I preached at their students. The first element centers on the relationship between the provider and the woman. The second element centers on the provider quality. Does the provider present the most

current medical information and technical skill to render high quality, evidence-based healthcare.

While both elements are critical, the more important of the two is the provider woman relationship. Women must be motivated to enter and remain in the healthcare system to avail herself of the available medical. It makes absolutely no difference if you have all the technology in the building if the woman won't come in. It makes no difference. She will not access those wonderful services that you think that she needs. Race concordant care has been associated with strengthen patient provider relationship. Further a growing body of evidence suggests better outcomes for individuals cared for by race concordant providers.

What is the value and significance of race concordant care? Race concordant providers usually reside in the community and posses shared experiences of daily life, language, values, customs and cultural norms. Individuals report feeling more connected and comfortable, respected and trusted, satisfaction and confidence with race concordant providers.

As a result, individuals demonstrate increased adherence with appointment and treatment plans and

increased retention in the healthcare system. Individuals report negative attitudes from providers from other racial and ethnic groups reflect internalization of broader issues around societal racism.

Evidence-based outcome data is lacking about race concordant care provided by Black, Latinx and indigenous midwives to Black, Latinx and indigenous women. The sparce evidence that does exist however, documented that 13 percent of Black women reported that they were treated poorly in hospitals during their last childbirth because of race, ethnicity, language or cultural background.

As a result, 23 percent of Black women reported that they would be willing to consider a home birth for their next pregnancy. That is unbelievable. According to the American College of Nurse Midwives, there are approximately 12,907 certified nurse midwives and 117 certified midwives as of August 2020. Black, Latinx and indigenous midwives represent 13 percent of this number for a national total of 1,660 midwives.

That means BIPOC midwives across the entire United States are less than 2,000 and in New York

City, in New York State there are approximately 1,000 licensed midwives, the bulk of whom are in New York City but are not midwives of color. This statistic provide that both Black, Latinx and indigenous women including pregnant and childbearing women never be cared for by a race concordant midwife. I was privileged during my 30 years practicing midwifery at Harlem Hospital Center to participate in two clinical projects rendering women's healthcare. One was in Harlem Hospital focusing on pregnant drug using women.

The second was located outside of Harlem Hospital in a community-based health center that focused on women's healthcare across a lifespan. However, the unique characteristic of both clinical sites was that they were completely staffed by Black and Latinx providers in all of the disciplines. Internal Medicine, OBGYN and Pediatrics. And the community was able to see the relationships that occurred between us. So, what was reinforced was the importance of remaining in the health system because that's where they would be cared for and have their health maximized.

Both sites experienced high attendance rates with low no show rates demonstrating high patient satisfaction as a recurring scene.

In conclusion, the conventional strategy to address maternal mortality has been to focus on the maternity cycle from preconception care to one year postpartum. That's very short sided. The most effective strategy would be to focus on rendering preventive women's healthcare long before pregnancy. Ideally women should enter the maternity cycle healthy.

This results from health promotion and maintenance activities that begins in adolescents and continues throughout the reproductive years. Healthy women have healthy babies. Post pregnancy women should return to their health promotion and health maintenance providers focusing solely on the maternity cycle precludes the opportunity to stabilize and control chronic conditions that are associated with poor outcomes.

In the end however, only by intentionally addressing structural and institutional racism which I said is the distribution of resources can health

equity be achieved and maternal mortality be eliminated.

You know, for Mr. McIntyre, as I listened to you I said oh, my God, you know, Amber should not have died just because she wanted to experience motherhood. That is something that we all look forward to and we should enjoy our pregnancies, not be fearful of becoming pregnant, which a lot of Black and Latinx women now they can't enjoy their pregnancy because they are now internalizing the data that if they are Black and Latinx, they are going to die.

So, they are focusing now on, am I going to die before I can see my baby. Before I can experience their first Thanksgiving or their first Christmas and that should not happen. And I just want to go back to two questions that Council Member Rosenthal and Rivera asked about. Which are the institutions that no longer have midwifery services.

The answer are of course, Harlem Hospital. You might recall that earlier this year in January, I testified the Harlem Hospital was the second oldest midwifery service. So, Harlem Hospital no longer has a midwifery service. Lincoln Hospital no longer has a midwifery service.

There are midwives at Kings County Hospital and Coney Island but we call them place holders because you are asking the wrong question. If you ask which hospitals don't have midwives, that's the wrong question because in these hospitals there are midwives but they are not a midwifery service. They are not providing midwifery care. They are not practicing the midwifery model.

And Council Member Rosenthal asked about the affiliation contracts and what could the private institutions, you know, should they be shouldering more of the responsibility. Just to kind of bring you up to date, that affiliation contract ended in 2010. So, there are no longer any affiliations between the privates and the public institutions but what is important is that at the state level, the privates get considerable tax benefit without having to shoulder their burden of poor, you know, financially challenged individuals.

So, on one hand they get significant tax breaks that H+H hospitals don't get and H+H hospitals are then burdened with all the patients that the privates don't have to take.

CHAIRPERSON ROSENTHAL: Thank you.

COMMITTEE COUNSEL: Thank you so much. Chair's, I am going to go to the final panelist for this panel and then we will move to questions. The final panelist on this panel is Tricia Shimamura and I have noticed that some people are raising their hands. So, we will ask for anybody that we have missed after this panel. Since you raised your hands, we will be doing questions after this panel but thank you and I see you raising your hands for testimony after this panel.

So, the final witness again is Tricia Shimamura. Thank you.

SERGEANT AT ARMS: Starting time.

TRICIA SHIMAMURA: Hi everybody. I just want to say to Sir Bruce, thank you so much. My heart and my families heart are with you and I just want to thank you so much for your bravery. It is really an honor to add my voice to the incredible chorus of advocates who has spoken today and I agree so much with everything that has been said.

I am going to be very, very brief. Again, my name is Tricia Shimamura and I am a proud woman of color. I am a Social Worker, a wife and most importantly today and every day, I am a mom. Just 18

months ago when my son entered the world, he became my entire world and my packed motherhood was anything but easy.

Midway through my pregnancy, I was diagnosed with gestational hypertension which progressed to preeclampsia, a condition which we have spoken a lot about today but that one is characterized by high blood pressure and possible damage one's liver, kidneys or other organs.

For months leading up to my delivery, I spent hours in waiting rooms and hospital beds being monitored for the health of my baby and myself. I was fortunate enough to have the work flexibility to attend these appointments and was supported when I was hospitalized on the three occasions prior to my delivery.

When my blood pressure finally continued to rise, my doctors decided that the best course of action was to induce early. It was during my induction that an on call attending performed an invasive and painful examination. He dismissed my pain and incorrectly diagnosed me. It was only because in that moment, my husband ran out into the hallway and found my actual doctor that my blood pressure was able to be lowered

from the dangerously high levels that it was at and I was scared from receiving the wrong drug and the wrong treatment for an incorrect diagnosis.

Later, days after giving birth to my son and being sent home, my blood pressure again spiked. As is often the case of preeclampsia. A doctor friend of mine urged me to go to the ER and when I arrived, with systolic blood pressure readings of well over 190, I was told that I was lucky that I didn't have a stroke while holding my newborn.

I am one of the lucky ones. Along my path towards motherhood, I experienced several luxuries that undoubtedly saved me and my child. I had access to a medical professional whom I trusted and who took my insurance. I lived near a hospital and I had a job that supported my health needs and all of the visits that were required. I had a support person and my husband who was able to go with me to all of my prenatal appointments and be with me in delivery and who new when to get help.

And finally, I had a friend with a medical background who saved my life after I left the hospital with my baby. There are far too many women that we have heard about today who are not as lucky

as I was and the luxuries that I had should not be luxuries at all. They should be part of the basic level of care that we give all mothers and families.

We know that increased access to midwives, doula's and support persons —

SERGEANT AT ARMS: Time expired.

TRICIA SHIMAMURA: Health outcomes for both mother and baby and studies show all the time that integrating midwives into our healthcare system could significantly reduce maternal and infant death, with some studies suggesting by 80 percent or more.

Still more phase area showing that access to doula's lowers rates of maternal and infant health complications, preterm birth, cesarean sections and other medical interventions.

Our mothers deserve better and we need timely data from our hospitals, expanded communication between our hospitals and universal access to doula's. We need to diversify our maternal healthcare workers and we need to stop treating postpartum care as an optional recovery period and instead, really mandate and expand the support for new mothers through 12 weeks after delivery.

And one additional note, in my advocacy working with doula's, we have continued to hear heartbreaking stories, not just of doula's being denied access to patients during delivery but in the prenatal screenings leading up to delivery. There have been too many instances of women who have been alone when they find terrible heartbreaking news or when they are forced to make challenging decisions by themselves in a prenatal visit.

So, taking every safety precaution into consideration, I am particularly supportive of increasing access to doula's and support persons at every stage of pregnancy, including the prenatal screenings for the health of mother and baby.

So, I urge the City Council to pass Intro. 217, Intro. 2042, Reso. 1239 and Reso. 1408 and I urge you also to continue the fight for our mothers and families. Thank you so much.

CHAIRPERSON ROSENTHAL: Ms. Shimamura, thank you so much for your testimony for the record. Other people on this panel are applauding you. You have been a terrific advocate and since the birth of your son, you have mobilized and created a community of activists around you. Particularly as it relates to

the next City Council and I really appreciate you for that. Making sure that a year from now, those who walk in the door, keep their eyes on the prize with this issue. It is incredibly important and I want to thank you for that.

TRICIA SHIMAMURA: Thank you so much Council Member Rosenthal and Council Member Rivera and Council Member Levine for holding today's panel. It is so incredibly important and I swear to you that I am going to ensure that whoever is in our next City Council prioritizes this issue.

COMMITTEE COUNSEL: Thank you. We don't have any Council Members with raised hands but if there are questions for this panel, we will go to the Chair's first. Chair Rosenthal, Chair Rivera and Chair Levine.

CHAIRPERSON ROSENTHAL: Yeah, I just, I noticed a few people were raising their hands during it and just Eugenia, I saw you raised your hands a couple of times. So, if you could start and if there are others of these panelists that wanted to add something, please feel free to do so.

COMMITTEE COUNSEL: Excellent and Chair Rosenthal, we will also go after this, there will be

additional panelists that we have missed or that have come back on line. So, we will have additional witnesses after this panel.

CHAIRPERSON ROSENTHAL: Okay and I see Ms. Bolds putting up her hand.

COMMITTEE COUNSEL: Yeah, if we could please unmute Eugenia Montesinos, excuse my pronunciation. Thank you, you are unmuted.

EUGENIA MONTESINOS: Thank you, thank you. Thank you for allowing me to add a few things that I have been thinking about how to improve maternal care. One of the things is we would love to see all the hospitals in the city offer midwifery care. And of course, we are not going to have enough midwives. What we should do is also we have to maybe, I don't know if you can help us, have to push for more for midwifery school. That they can have more midwives but we want midwives of color and that is what we ask.

All the schools that we have and especially those private schools, they are all White midwives. Columbia and NYU is practically White New Yorkers. So we want to increase the number of color midwives. Every kind — that reflects of community. We have a

lot of, even in my hospital we have a lot of Arabic patients and we should have that to. We should have every kind of midwives that will reflect the community that we serve and that is one of the things I would like to add and if you can recommend. And also, one of the things that we have a problem is about a clinical sites. A clinical site means when you becomes a midwife, you need to go and learn apprentice hands on and we don't have that.

The School of Medicine, they do have a residency program and they pay for that and that is what midwifery should have. Should have like a kind of a residency program for midwives of training, so they can go and they can get you know, the places where they can go, they can be paid for that. And that would be an incentive for the hospitals who offer that to get.

So, that's is another thing and I another recommendation is that we should not only have birthing centers, we should have community centers that it would reflect and work in that community. Not everybody is going to be for a birthing center but we would like to have a community center with midwives, with doula's and they can choose where they

are going to go to have a baby. Either the birth center, the hospital but we should offer better care outside the hospital.

Another issue that I would like to address is that the postpartum care should be covered by a visit by a midwife or the one who deliver. We should have that. A community midwife that once a mom had a baby, should have postpartum care in their home because being a mom is very hard and if we can go like that, we can check in the place how they are doing. What is happening. We have support or not, so that way we can help.

[PHONE RINGING] Sorry about that. So, that it will be one of the other good things that we should have. Another thing that I think we should, a lot of people are not aware about that, even if we want to work as a midwife. I am going to give you my point of view as a midwife.

If I want to work in community and I want to put my place as a midwife and I want to give the best care I can give to a community that I wanted, I can't do it because that insurance is super expensive and I cannot pay for that. So, that, also we have to be

thinking about even though we want it but malpractice insurance is prohibited. We cannot do it.

So, that is why many midwives, they are not working in communities on their own even if they want because we can't afford that. So, that is that and another thing that we should get paid equal pay for equal job. Equity and pay and that is one of the things that we have to have that. You know, we are women, we work and we care for women and that is what we should do. And really, truly, frankly, people don't realize how important it is when you are pregnant only. Before that, nobody knows that.

Once you become pregnant, you are aware of all the things that you have no idea. I say to my clients, when you go to a restaurant, you look before. You check what is the rating, we don't have ratings about that. We don't have any ratings about what kind of obstetrical care you are going to have. There is nothing of that. We should have availability of that. If you go and chose a restaurant and say okay, let me see the rating and that's where you go. When it is something super important that is a life of your baby, you are lost. There is no rating, there is nothing where to go.

So, all those things we should teach, we should put in there. It should be transparent. The Department of Health should put that. Those are the things that I recommend and if we can just come up with something, some kind of bills that we have to fix that. This is the care of our future of our women of a new generation and we have to already be mindful about these things.

One other thing is, you know, as midwives we have really, we are into the whole environmental care and we are actually, our care is environmental. We are less invasive. We use less things that will be against environment.

So, it's just a win-win and that is what we should be doing. We are winning as a woman, we are winning as a new generation and we are winning you know, the environmental is coming and that should be part of that.

CHAIRPERSON ROSENTHAL: Thank you. I want to thank you for all these suggestions. You know, you reminded me a friend at once suggested to me that we should put the — for each hospital, there should be a billboard up. Just a giant billboard, those ones that you see when you are driving on the highway that

reports for that hospital. What is the maternal mortality rate. So, thank you for that.

EUGENIA MONTESINOS: Thank you.

COMMITTEE COUNSEL: And Chair Rosenthal, I think Chair Rivera might have a statement. Chair Rivera? We might come back to her, apologies for jumping in.

CHAIRPERSON ROSENTHAL: No, that's fine and I think while we wait, Ms. Bolds, I think wanted to make a comment. Can we go back to past panelists, is that alright?

DENISE BOLDS: Thank you so much Chair Rosenthal. I just want to say that we have to be very mindful of the environment that we are in. Here in New York City, the hospitals and the medical physicians have really, have a very strong toll when it comes to midwifery. It is almost a bad word to say and 30 years ago, I gave birth utilizing a midwife because my insurance was downgraded to precap and as punishment from leaving private medical insurance, going to Precap, they assigned me a midwife. Well, that was the best thing that could have done. Paula Duran delivered my son up at the Allen Pavilion and I had the best traumatic birth experience that a Black

woman could ever get even though you know, it was harsh but it was still something there.

I want to also address something really quickly with Neelu Shruti said. Neelu and I have worked on several committee's and then Neelu ghosted and I was always wondering what happened. So, it is always good to see you back here Neelu. But I do want to talk about the fact that we cannot separate doula's from midwives. Doulas are there when sometimes a midwife can't be there and for the number of times that I have gone to that prenatal visit and that postpartum visit, in my intuition, invoke the conversation to my client to say, something doesn't look right. I would like for you to call your clinical staff support person and I would like you to talk it out.

It is because the doula was there that we were able to support the midwife or that OB. So, we cannot say that doulas don't do this and doulas don't do that. Yes, we do have a scope of practice. We do have boundaries, yes that we are to adhere to but as a doula, I am here to tell you, I am in 100 percent support of supporting midwives and I will never try to exchange or replace one for the other.

This community should not have to say either/or when it comes to a doula or a midwife. They both work together and they work together well and I would like to see that continue to grow. So, that is a very important factor that we have to keep in place. We are not here to play politics. We are not here to substitute and we are not here to drink the westernized medicine of Kool-Aid okay. I am a Black person, I am a woman of color and I am not going to embrace the system because the system is not working and Neelu, I suggest you reconsider your statements as well but thank you.

CHAIRPERSON ROSENTHAL: You know what's so interesting. I was looking during some of this and you know, the United States ranks 46th in the world. And the rate that's listed by the CDC, which is back to the data's from 2015, so a rank of 46 with the R number being 14 deaths for every 100,000 but the same year for Black women, it was 41 deaths per 100,000.

So, if you can imagine the average was 14 and that ranked us 46th but for Black women, so many more preventable deaths. It speaks to the power of this hearing and all the testimony that's given today and how incredibly helpful it is.

I am going to, sorry, I just had to get that off my chest. Did someone else want to, any of the panelists feel free to speak.

COMMITTEE COUNSEL: So, Patricia Loftman had her hand up and then we do have at least one other witness after this panel.

CHAIRPERSON ROSENTHAL: Right, we should hear from Neelu and I think Annette had her hand up as well.

COMMITTEE COUNSEL: Ms. Loftman.

PATRICIA LOFTMAN: Yeah, I just wanted to speak on two things on doula's. I think for Neelu to recognize that years ago at the turn of the century when all women were giving birth at home, they were surrounded by all the women in their family. Their moms, their aunties, their grandmothers, their sisters, friends and the role they provided was the supportive one. Because as we know, labor and birth is a very hard process.

And so, to make certain that women were never left alone, we had all the women in the family surrounding them. Well, now the families are not close together in terms of proximity, doula's have really taken that role. That role that their aunties

and moms took in terms of providing physical and emotional support.

So, it's really important that we understand the role that doula's play now. They have replaced our moms and our aunties and our sisters and our grandmothers and our friends and so, they are just as important to the process in terms of advocacy as the midwife is in terms of rendering direct patient care.

The other thing that I wanted to talk about is the role that the Chair's of OBGYN Departments play in terms of the ability of midwifery services to exist and thrive because the power for a midwifery service to thrive rests with the individual who sits in that role, who is the Chair of the department.

When you look at the data where midwives are well integrated, those hospitals are the ones that have the best data in terms of outcomes but those are also the services where the OBGYN Chair truly believes in midwives and midwifery services and have embraced and allowed midwives and services to not just survive but to thrive as part of the Department as colleagues. And so, where you don't have midwifery services or where you have midwives who are present but are not providing continuous care, who are not doing birth.

Those will be the institutions where you will not see outcomes that are as good as they could be.

CHAIRPERSON ROSENTHAL: I so appreciate your bringing that up because we are just repeating what we all said to the Greater New York Hospital Association. It can't just be an agenda item. We want to see that your heads of hospitals are you know leading by example. So, thank you for brining that up again. I appreciate that.

I mean, you were talking about heads of departments but they report to the president of hospitals.

PATRICIA LOFTMAN: You are absolutely correct. It is also the institution because I can remember you know, Harlem Hospital was the first baby friendly hospital in New York but when I took that information to the executive director of the hospital, he embraced it, he championed it and it became — it went into effect.

So, it's both the Chair but it is also the executive director of the hospital. Whether they see midwifery services as valuable and an integrate part of the institution.

CHAIRPERSON ROSENTHAL: Yeah, thank you.

COMMITTEE COUNSEL: Chair Rosenthal, should we move to the next panel and then come back to comments? Move to the next panelist or move to other questions.

CHAIRPERSON ROSENTHAL: I think you gently guiding me to an answer there. There is one more panelist and then we will come back. If anyone from this panel wants to chime in. Okay, to the two people who have their hands raised. We see you.

COMMITTEE COUNSEL: Apologies, thank you so much. So, there are some people that have been here and come back that we have skipped over on panels that have logged out and logged back in due to conflicts and parents and things. So, that's the other Council Member offices have asked that we also make sure that they are heard today before they have to leave again.

So, we are going to do a check for other panelists now and anybody that we missed and then we can come back. Also, just as a reminder, the Sergeant said it at the top of the hearing but the deadline for written testimony, which can be as long as you would like is 72 hours after the hearing and so, you can send that to us and we will help make sure it is in the right place. But you should email

it to testimony@council.nyc.gov. Again, written testimony, testimony for the record can be as long as you would like, you can also amend what you have if there is additional information you would like to add due to the hearing and it should be submitted to testimony@council.nyc.gov.

So, we will do a check now for the panelists and then Neelu Shruti, I saw your hand raised, we will come back after the next testimony. There was another panelist that had her hand raised to go next after the request for that and please use the raise hand function in Zoom.

So, with this, we have heard from everyone that has signed up to testify that was on panels. So, again, we will come back for additional comments but if we inadvertently missed anyone that would like to testify, please, use the raise hand function in Zoom. Excellent and I will call on you in the order of hands raised.

So, Thamar Innocent you will be next. We will call on you next. So, as with previous panels, you may begin your testimony when the Sergeant calls the clock. The next witness is Thamar Innocent. Thank you.

SERGEANT AT ARMS: Starting time.

THAMAR INNOCENT: Thank you. Good afternoon everyone. I am a Birth Worker. I have been a Birth Worker for a couple of years now but I also want to speak in the capacity of I used to work in a New York City hospital, so I got to see hands on in an administrative capacity. So, I got to see hands on what was going on for you know, potential clients that I would have had in the future.

So, what I am noticing is that when I first started, when I became a doula and trained as a doula and I trained as a doula and I trained with Ancient Song, there was this piece that I didn't know about. That I inadvertently became an advocate when I just wanted to you know, care for families and love on families and be there for them but inadvertently I became this birth justice warrior. I became someone that was fighting, that was protecting women in hospitals.

And, although that is beautiful in itself, that is something that we are focusing on a lot more. I would love to focus on childbirth education but my prenatal appointments have turned into, let me teach you how to navigate the healthcare system. Let me

teach you the right words to say, so that they don't try to take your baby away. Let me you know, fight for you. Instead of, let me hold your back. Let me help you with the baby. Let me help you breastfeed.

A lot of these things have been pushed to the side for me or put on the back burner to be done at a later time because I am so busy fighting for this woman's rights.

In the hospitals, I believe there is a lack of cultural competency. There is a lack of bedside manner. There is a need for healthcare professionals and staff. The need to want to intervene when it is unnecessary medically. There are continuously disrupting the pregnant person ability to have a normal physiological birth and they do that so much so that the pregnant person doesn't feel safe anymore. And it is my job on top of my doula job to help them to feel safe, to feel comfortable enough to want to give birth.

So, again, I feel there is a big lack of education in terms of the hospitals and the staff but also the pregnant person. A lot of times there is no money put into education to help women with advocacy, understanding common hospital practices,

understanding childbirth education and their bodies and women's health.

I would like to see money go towards helping women prenatally or way before they are even thinking about having a baby and that takes me to family planning. Family planning for me when I gave birth 10 years ago, was what contraception do you want and that was it.

There was nothing about understanding my body. There was nothing about advocacy. There was nothing else about anything.

SERGEANT AT ARMS: Time expired.

THAMAR INNOCENT: So, I want us to focus more on educating people from way before they enter the hospital. Yes, that's all I have today.

COMMITTEE COUNSEL: Thank you so much. Are there any — Chair Rosenthal or Chair's, are there any Council Member questions?

CHAIRPERSON ROSENTHAL: I just want to say Ms. Innocent, when you said, you inadvertently became a woman warrior, is that what you said?

THAMAR INNOCENT: Yes.

CHAIRPERSON ROSENTHAL: Yeah, I will say, I understand the larger point you are making, which is

so very powerful but all I could think of when you said that is how at Ancient Song, a lot of the sessions begin by giving this deep throated scream and that's how sort of everyone in the room becomes a woman warrior.

THAMAR INNOCENT: Right.

CHAIRPERSON ROSENTHAL: Boy do I relate that.

THAMAR INNOCENT: Absolutely and I have been doing it ever since and it doesn't look like it is going to end. So, that's something that we have to do and be mindful of for a long time to come.

CHAIRPERSON ROSENTHAL: You are doing it all. So, thank you for that. I have no further questions. Just thanking everyone.

COMMITTEE COUNSEL: Okay, thank you so much. If there are any other witnesses, if you can please use the raise hand function in Zoom. Okay and Neelu Shruti also had her hand up. Chair, is that okay to return to Ms. Shruti? Excellent.

NEELU SHRUTI: Hi all, I just wanted to clarify because I think that maybe some of my comments were a misunderstood. I was not at all saying that doula's were not important. I just wanted to point out that

within these four Resolutions that expanding access to midwives has not happened.

So, I would encourage for access to midwives to be as important and included as doulas are. So, that's my first point. So, I wanted to make sure that I am clear and that I am not putting doula's and midwives against each other by any means. I think that they are both incredibly important solutions to this problem and we do need focus on both.

The second point that I wanted to talk about was regarding the bill and the data. I am aware of course of the information act and that data is available. This bill specifically relates to incorporating information about midwives on the DOHMH website, which is great because it includes like a lot of information about 311 and a lot of great — and so, I think including those same statistics within the access to midwives is important, so that people understand why midwives are being listed on this rather public website.

So, I just wanted to clarify those two points. Thank you.

CHAIRPERSON ROSENTHAL: Thank you and you know, it is interesting, I appreciate you bringing that up,

both points really but on the first one. Let me tell you why I am just sensitive to it because after the hearing that I Co-Chaired in 2018, we passed two pieces of legislation regarding doula's, increasing access and talking about doula's and also the M3RC and similarly, quite a few midwives reached out to me and said, you need to be talking more about midwives.

So, you know, noting the powerfulness of both professions. I really appreciate you for that. Thank you and thanks for clarifying.

NEELU SHRUTI: Yes, of course.

CHAIRPERSON ROSENTHAL: I turn it back to the Moderator.

COMMITTEE COUNSEL: Thank you so much Chair Rosenthal. Ms. Patricia Loftman also has her hand up and just to comment. So, we are unmuting now but if you have other comments and testimony, if you can please add it to your written testimony and again, you can amend it and just submit it to, it will be part of the record but if you would like to add it to your written testimony, you can send that to testimony@council.nyc.gov up to 72 hours after the hearing. Thank you so much.

PATRICIA LOFTMAN: I know that I mentioned in Maternity Information Law that comes out of the State of New York. That really provides a wealth of information about what happens in an institution.

So, for example, let me just read a couple of the data that's included in this. The percentage of birth that are C-sections. The percentage of primary C-Sections. The percentage of repeat C-Sections. Whether there is continuous monitoring in labor. How many, you know, whether there is rooming in. What is the percentage of infants that are breastfed. Whether you get an episiotomy. In other words, this provides information that families could use to determine where they would want to give birth, so that they could get the best outcome and this really is a report card on all of the hospitals in New York and this is — now, where does this information come from?

According to the state, the hospitals are supposed to provide this information to the state. The state then generates this, it populates this information and this information is then available to the public by hospitals.

So, again, this information exists. I don't think its been updated for years because nobody knows the follow up and insists that hospitals provide this information to the state and that the state fulfills their obligation to populate and generate this information.

This would be invaluable if it were released tomorrow and this is something that we could certainly work on today.

CHAIRPERSON ROSENTHAL: Thank you.

COMMITTEE COUNSEL: Thank you so much. If there are any other panelists or questions or if Chair's have any other questions. We will do one last call. If we inadvertently missed anyone that would like to testify, please use the raise hand function in Zoom and we will call on you.

Okay, Chair's Rosenthal, Rivera and Levine, if there are no other questions and we do not see any hands raised. Oh, Nonkululeko Tyehemba has her hand raised, not in the Zoom function but she is waving, if it is okay to unmute her.

CHAIRPERSON ROSENTHAL: Absolutely. Thank you and then that will be — then we will wrap it up from there.

NONKULELEKO TYEHEMBA: Can I speak now?

COMMITTEE COUNSEL: Yeah, you should be unmuted. We can hear you. Thank you so much.

NONKULELEKO TYEHEMBA: Oh, good, okay. I just want to make a comment in reference to the free standing birth centers. Back in the maybe 1993 our organization did a research analysis about how to start a birth center here in Harlem. We researched and learned that the guidelines for birth centers, it's almost prohibited. The application process alone deemed that they had to have a college industry to help group even to start an organization. Besides the enormous amount of money that it took to get that started.

So, I am hoping that at this point and time, almost 25 years later, that this would not be the case for any midwifery led birth centers. The other thing I do want to say though is, I did a birth in April, a home birth in April with an insurance company and I have yet not to receive any reimbursement for that. It is almost like it is a nightmare of colds and un-colds, in network out network. It is unbelievable in terms of how women and how midwives are or not reimbursed.

Finally, they said to the family that they will see me as an in network provider but I would be paid out of network services which amounted to $2400. It's atrocious, so I hope that something and I am so glad to hear all the views and I have learned so much. So, I thank all the birth workers and advocates and activists and thank you so much to the Chair's. This is such an important, important step forward. So, I have been invigorated. Thank you so much again.

CHAIRPERSON ROSENTHAL: What a great way to end it. It is true, it's a great group looking around this Zoom. Pretty impressive group of people and I, you know, actually I too was about 20 years ago, part of a group of people trying to open a birth center. We had property given to us. We had you know, everything lined up except for state approval. And so, story after story after story. It is so disheartening; we have to change this now.

I will pass it back to the Moderator I think.

COMMITTEE COUNSEL: Okay, thank you so much Chair Rosenthal. We are just doing one more check for raised hands.

ANNETTE PEREL: I have been unmuted and it might have been from a hand raised 20 minutes ago but I just wanted to echo that nothing is separate from each other in the uplifting of midwifery and doula's in the uplifting up hospital systems and midwifery led birth centers. Physician led birth centers, home births, like, we want access to all of these things. We want our birthing people to be cared for and we are all in different lanes. Some of our work overlaps with other people, organizations and you know, just kind of coming from that place of unity and coming from that place of just that frame of mind of like, the inspiration that we get from one another who are doing this work.

And when I also look around this room and I think of the interactions I have had with different individuals as well as the people's names I have heard of. As well as the history lessons offered and just like, you know, wanting to really challenges us to like put down any of our own biases about you know, how we can sometimes feel like there is some competition between like hospital and home and midwife led, physician led, all of those things need to get shutdown because ultimately like, we want

what's best for the birthing people of New York and so, just thank you for the opportunity to again chime in that thought.

CHAIRPERSON ROSENTHAL: Thank you.

COMMITTEE COUNSEL: Thank you so much. We are just dealing with a technical issue but we will be ending the hearing if there are no other witnesses, this would conclude public testimony. I am just checking, one second please. Please stand by. Okay, and then one other comment by Patricia Loftman please. If we can unmute her, thank you.

PATRICIA LOFTMAN: Thank you. To Chairperson Rivera and Rosenthal, I don't know how to thank you for remaining constant on this call since 10 a.m. this morning. You both sat there and listened to all of us and I can't tell you how inspiring that is to know that our public servants listen to us and regardless of how long this meeting has taken place, you just have remained steadfast and listened to everyone and that's important and we just thank you. We are appreciative and just thank you.

CHAIRPERSON ROSENTHAL: Thank you. That's very kind. We have a lot to say.

COMMITTEE COUNSEL: Thank you so much Chair and thank you to our panelists. So, Chair's Rosenthal, Rivera and Levine, this concludes public testimony for this hearing. We have no other witnesses that have raised their hands, so I will return to Chair Rosenthal for closing remarks. Thank you.

CHAIRPERSON ROSENTHAL: Great, thank you so much. What have we heard today, big picture. It is time to dismantle the current perinatal care system in New York City right now. COVID has made this glaringly clear and implement the model that we have really all been talking about and it's a model that other developed nations use. It is why their rates of maternal mortality are far lower than those in New York City and it has I think four components. We have to integrate midwifery services. Every birth should be attended by a midwife and an OBGYN involved when needed. We have to increase access to out of hospital births. It is shameful that there are only two birthing centers in New York because it is estimated that at least 70 percent of births could occur outside of the hospital at birthing centers and home births.

We have to third, establish a pipeline for Black and others, people of color as midwives to attend midwifery school. And of course, there should be a similar pipeline for doula's. There are excellent doula training centers and we need to increase access to those for people of color.

And lastly, we have to make doula's available to all birthing people who want one. We of course have to assure appropriate reimbursement whether it be through Medicaid reimbursement rates, which require advocacy at the state level or through a payment from a hospital that wants to ensure good birth outcomes for the patients that they see.

So, one more time, I really want to thank all the advocates that have shared their lived experience today. Thank you for your expertise. As the Chair of the Committee on Women and Gender Equity, I want to especially thank those of you that have articulated the connection to birth control, domestic violence, equal pay for equal jobs and the reverberating impacts on mental health from things like lack of skin to skin contact immediately following birth.

Thank you. I will now turn it to Chair Rivera.

CHAIRPERSON RIVERA: Thank you so much everyone. I have worked with many of you over the years but I continue to learn so much and I will continue to look to your guidance and your experiences. As the Chair of the Committee on Hospitals, I really tried my best to use this Committee to address the root causes of maternal mortality and morbidity in Black and Brown patients specifically. In three years, I have held several hearings on maternal mortality and prenatal care and implicit bias.

We even held a hearing that would eventually overturn the arbitrary drug testing on pregnant mothers disproportionately testing Black and Brown mothers assuming drug use. All of that, all of that to say, we have a very, very long way to go and I thank you for staying in this movement and in this fight when it is so physically, mentally, spiritually draining. Thank you to all that have been with me since 9 a.m. this morning when we rallied almost 100 individuals and of course, to Chairwoman Rosenthal for being here and for being so engaged.

So, thank you all. I look forward to working with you and I do hope that this was a productive

space and we do expect solutions and answers and transparency most of all. Thank you so much.

Thank you Chair Levine, would you like to give some closing remarks? I think he needs to be unmuted.

CHAIRPERSON LEVINE: Thank you so much Chair Rosenthal and Chair Rivera for your outstanding leadership. Years of leadership on this and for convening this hearing today which has been simultaneously gut wrenching but also uplifting. Obviously wrenching to hear the first hand accounts of loss and I am just so grateful to you Mr. McIntyre for the bravery to speak out on behalf of this cause. I know that's not easy but it is impactful but also just uplifting to hear from so many of you who have devoted your lives to this work.

Midwives, doula's, nurses, physicians and I feel that our role is to life you up, to amplify your voices. To amplify the voices of Black women in particular who are on the front lines of this fight and as allies, myself as Chair of the Health Committee, I want you to know that I support you 1,000 percent and that I will stand with you as we make something very clear. This problem is solvable.

It is a question of resources. It is a question of transparency and reporting. Ultimately, this is a question of will. We can solve this if we have the will to do it and the movement that is pushing to make this happen is absolutely inspiring and I will stand with you and in support of you as long as it takes until we end these egregious disparities in New York City and I thank you all for your leadership. And again, I thank Chair's Rosenthal and Rivera for incredible work today and beyond. Thank you everybody.

CHAIRPERSON ROSENTHAL: Thank you Chair Levine. This hearing is now closed. [GAVEL].

CHAIRPERSON RIVERA: Thanks everyone.

C E R T I F I C A T E

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

Date December 28, 2020