New York City Council

Committee on Hospitals

Hearing Testimony: "Oversight - Prenatal Care in New York City Hospitals"

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GREATER NEW YORK HOSPITAL ASSOCIATION

Chair Rivera and members of the Hospitals Committee, my name is Lorraine Ryan, Senior Vice President, Legal, Regulatory, and Professional Affairs at the Greater New York Hospital Association (GNYHA). GNYHA proudly represents all the hospitals in New York City, both not-for-profit and public, as well as hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

Thank you for the opportunity to speak with you today about prenatal care in New York City and the broader issue of maternal mortality and morbidity. These are extremely important topic. I have been actively engaged in clinical care improvement initiatives as a nurse and for over a decade as director of quality improvement (QI) and patient safety programs at GNYHA. During this period, I have worked directly with the New York State Department of Health (DOH), the American College of Obstetrics and Gynecologists, District II and our member hospitals on improving perinatal care and outcomes for pregnant women. I currently serve as a member of Governor Andrew Cuomo's Taskforce on Maternal Mortality and Disparate Racial Outcomes and the New York City Department of Health and Mental Hygiene's (DOHMH) Maternal Mortality Steering Committee.

GNYHA and our member hospitals believe health care is a human right—that is why we have campaigned, with 1199SEIU United Healthcare Workers East, to create and defend the Affordable Care Act and Medicaid expansion.[1] While for-profit hospitals are becoming the norm in other states, New York institutions continue to pursue their not-for-profit and public mission: caring for the most vulnerable. We view addressing racial disparities in maternal mortality and morbidity as part of that mission.

Today I plan to discuss the following topics: the challenges facing New York City hospitals; prenatal care in New York City; disparities in maternal mortality and morbidity; responses by New York City, State, and GNYHA to the problem; and additional steps we must take to improve maternal care.

A Time of Peril for New York Hospitals

New York City hospitals, both public and voluntary, serve huge numbers of Medicaid patients and provide the same quality of care to all. They have maintained major ambulatory networks for years that focus on providing care to Medicaid beneficiaries and other vulnerable New Yorkers, including the uninsured.[2] New York City hospitals are also proud of the maternal care services they provide. In 2018, they delivered around 103,000 babies. 57% were Medicaid beneficiaries, 40% had private insurance, and 2% were uninsured.[3]

[1] As a result, the uninsured rate in New York State is 5%—about half the national average. However, that leaves about 1 million uninsured New Yorkers, and we have a plan to get them covered. We know that about a third are already eligible for Medicaid but not enrolled; a third are eligible to purchase private coverage through the State health exchange but find it unaffordable; and the remaining third are low-income undocumented immigrants ineligible for any form of subsidized coverage other than emergency Medicaid. GNYHA supports policies to expand access to care for each of these groups, including: streamlining Medicaid enrollment and renewal, State-funded tax credits to supplement available Federal tax credits so coverage is more affordable for individuals, and expanding the Essential Plan to wrap around emergency Medicaid for low-income undocumented immigrants (as proposed in A.5974/S.3900 and supported in Council resolution 918-2019).

[2] In 2017, New York State hospitals provided over 8.5 million clinic and ambulatory care services to Medicaid and uninsured patients, $3.4 billion in Medicaid services, $600 million in financial assistance, and $988 million in subsidized health services. (Sources: GNYHA Analysis of New York State Institutional Cost Reports, 2017; Internal Revenue Service Form 990 reports.)

[3] Source: 2018 Institutional Cost Reports (newborn discharges).

Despite unprecedented threats to the survival of New York hospitals—including looming cuts to the Federal Disproportionate Share Hospital Program in May, and Medicaid and Medicare payments that don't keep up with costs—they are open 24 hours per day, 365 days per year, committed to treating everyone regardless of ability to pay or insurance status. Our hospitals are also the economic anchors of their communities: they are the largest non–public sector employers in the City and employ hundreds of thousands of hard-working caregivers, the majority of whom are union members.

Prenatal Care in New York City Hospitals

New York City hospitals strive to provide excellent prenatal care to every patient who walks through their doors. They deliver maternal care in inpatient units and hospital-based outpatient clinics, regardless of insurance status. New York City hospitals have made, and continue to make, significant investments in the resources necessary to serve their patients.

The general goal of prenatal care in hospital clinics is monitoring the health of expectant mothers and the fetus and making sure that specialty services are provided as necessary. Hospitals provide both routine out-patient pregnancy monitoring as well as inpatient care for individuals experiencing high-risk pregnancies (which could be because of a woman's age, pre-existing medical conditions that can increase the risk to the pregnancy, or prior history of complicated pregnancies). Other hospital-affiliated clinics, including federally qualified health centers and diagnostic and treatment centers, generally provide more routine obstetrical monitoring and care.

Typically, pregnant women are seen by their obstetric provider monthly in the first and into the second trimester of pregnancy when the frequency of visits increases as the due date approaches or if other medical issues arise. Some of the services provided at these visits could include monitoring weight, diet, the need for vitamin supplements, mental health and promoting healthy eating habits and exercise; assessing the growth and development of the fetus; and sonograms and/or ultrasounds to monitor growth and development. Prenatal care is highly personalized; physicians deliver tailored and appropriate care based on the needs of mother and fetus.

A number of New York City (and State) hospitals have also started evidence-based "centering" programs for expectant mothers in obstetric clinics, through a DOH pilot. Centering combines the individual prenatal physician visit with group educational-support sessions (where women can ask questions about their care, health, labor and delivery, infant care, and learn from both their clinicians and peers). This program helps to fill a void many pregnant women report, which is that they lack emotional and community support during this challenging period. According to DOH, centering is "associated with reduced incidence of preterm birth and low birth weight, lower incidence of gestational diabetes and postnatal depression, higher breastfeeding rates and better inter-pregnancy spacing."[4] GNYHA is optimistic about this initiative and our members are already reporting positive, although anecdotal, outcomes based on data and feedback from mothers.

[4] New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, "Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities," March 2019, p. 9, available at https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf.

Hospitals welcome doulas and midwives in all aspects of maternal care, including the prenatal space. These dedicated health professionals play an invaluable role, and a State pilot is underway in Erie County and Brooklyn hospitals to better incorporate them in the care team. Initial results from a GNYHA survey show that of 15 hospitals, including a number of large systems, 14 credential midwives and 15 allow doulas to be present for birth. GNYHA also supported the recently enacted Midwifery Birth Center (MBC) regulations, which allow midwives to operate MBCs.

Disparities in Maternal Mortality and Morbidity

The facts are clear: there are stark racial disparities in maternal mortality and morbidity. More black and Latina women die or experience severe complications than white women during and after pregnancy. Overall rates of maternal mortality and morbidity have also been increasing. A recent study (based on data from 2010–2014) found that severe maternal morbidity among black and Latina women was higher than among white women—even when they delivered at the same New York City hospital—regardless of socioeconomic or insurance status.[5] In 2019, New York State ranked 23rd in the nation with 25.5 pregnancy-related deaths per 100,000 live births.[6]

We must do more. New York's hospitals and providers are committed to reducing maternal mortality and morbidity and its associated racial disparities. We also acknowledge the reasons for these disparities: systemic racism, poverty, and discrimination.

Responding to the Problem

Below is an overview of New York State hospital efforts to address maternal mortality and morbidity and associated racial disparities. The responses can be divided into two groups: legislation and government policy, and QI programs. This list is intended as an overview of efforts; it is not exhaustive.

Legislation and Government Policy

Taskforce on Maternal Mortality and Disparate Racial Outcomes. In 2018, Governor Cuomo created this multidisciplinary group of clinical experts, medical practitioners, policymakers, and community members to inform State policy on maternal mortality and morbidity. Its co-chairs are DOH Commissioner Howard Zucker, New York State Association of Licensed Midwives President Sascha James Conterelli, former SUNY Upstate President Danielle Laraque-Arena, and Wendy Wilcox, chair of the Department of Obstetrics and Gynecology at NYC Health + Hospitals/Kings County. The taskforce released a report in 2019 recommending 10 steps to address maternal mortality and continues to advise policymakers.[7]

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[5] Howell, Elizabeth A., MD, MPP; Egorova, Natalia N., PhD, MPH; Janevic, Teresa, PhD, MPH; Brodman, Michael, MD; Balbierz, Amy, MPH; Zeitlin, Jennifer, DSc, MA; Hebert, Paul L., PhD, "Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities," *Obstetrics and Gynecology* (February 2020).

[6] United Health Foundation, America's Health Rankings, "Maternal Mortality." Available at https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/NY.

[7] See Taskforce on Maternal Mortality, "Recommendations to the Governor," March 2019, pp. 6-7. The recommendations are as follows: 1) establish a statewide MMRB, 2) design and implement a training program for hospitals on implicit racial bias, 3) establish a perinatal data warehouse, 4) provide equitable reimbursement to midwives, 5) expand and enhance community health worker services, 6) create a SUNY scholarship for midwives to promote diversity, 7) create competency-based curricula for providers and medical and nursing schools, 8) establish a loan forgiveness program for underrepresented providers that intend to practice women's health care services, 9)

Maternal Mortality Review Boards (MMRB). One of the keys to improving birth outcomes and racial disparities is examining cases of maternal mortality and morbidity and using them as opportunities to improve care. Last year, Governor Cuomo signed legislation (A.2376/S.1819) sponsored by Assembly Member Latoya Joyner (D-Bronx) and Senator Gustavo Rivera (D-Bronx) to create a group of experts for this purpose. It is comprised of a multidisciplinary team tasked with reviewing data on maternal deaths, identifying the root causes of the poor outcomes, and disseminating evidence-based best practices to prevent them in the future. The board's focus is on QI rather than punishment, reviewing outcomes of care, conducting peer reviews, and collaborating on process improvements.

New York City has its own MMRB, a right that is specified in State law. DOHMH also operates the previously mentioned Maternal Mortality and Morbidity Steering Committee, which is focused on addressing the root causes of death and morbidity in pregnancy. GNYHA supported the State legislation, advocated for its passage in Albany, and coordinates with DOH and DOHMH on these efforts.

2019-20 State Budget Initiatives. Last year's State budget included $8 million over two fiscal years to fund initiatives addressing maternal mortality, including the MMRB. Components of the plan include:

- more community health workers
- implicit bias training and post-birth training for medical professionals
- building a perinatal data warehouse to shape QI efforts and State policy
- a program to increase the ratio of minority perinatal health care providers
- pilots in Erie County and Brooklyn to increase the use of doulas, currently underway

Quality Improvement Programs

New York City, New York State, and hospitals are working hard to implement clinical and community health interventions to reduce maternal mortality and associated racial disparities. GNYHA QI staff, which includes physicians, nurses, and data specialists, assist our member hospitals on these initiatives. Below is an overview.

Prenatal QI Programs

- DOH is in the process of designing an **implicit bias training** pilot for medical providers in hospitals across the State. Funding will come from the $8 million approved in last year's State budget. GNYHA made recommendations to DOH on the training, which we believe should help members of the birthing team, including physicians and nurses, understand their patients' circumstances and use that knowledge to deliver equitable, culturally competent maternal care to all women through activities like live simulations.
- Led by DOHMH, New York City has implemented a **maternal depression screening program** as part of the wider Thrive NYC initiative. GNYHA has assisted with the implementation of the program, which involves screening for depression before delivery and post-partum, as well as connecting women to proper services if necessary.

convene a statewide work group to improve postpartum care, and 10) promote universal birth preparedness and postpartum continuity of care.

- New York State is leading a statewide improvement collaborative to reduce **opioid use disorder and neonatal abstinence syndrome** in pregnancy. This effort (the Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project) consists of training maternal care providers to screen for this condition in pregnant women and referring them to appropriate services, including substance use counselors and treatment. It also includes training emergency department and labor and delivery staff to destigmatize the use of these services. The aim is to teach practitioners to ask questions in nonjudgmental ways and screen all patients—not a subset of people. GNYHA, our member hospitals, the Healthcare Association of New York State (HANYS), and American ACOG, collaborate on this project.

Perinatal QI Programs

Through the **New York State Perinatal Quality Collaborative (NYSPQC)**,[8] led by DOH, hospitals are working with government, maternal care providers, and others to improve care for women and babies by promoting evidence-based care. NYSPQC projects are outlined below.

- The **Obstetric Hemorrhage Project** aims to implement obstetric hemorrhage protocols in hospitals and reduce mortality and morbidity from hemorrhage. GNYHA, our member hospitals, HANYS, and ACOG are working on a voluntary basis to actively engage all birthing hospitals across the State in implementing ACOG's Safe Motherhood Initiative bundle of best practices. To date, 100% of the regional perinatal centers and over 70% of all other birthing hospitals across the State have been actively engaged in bundle implementation.
- The **Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project**, previously mentioned, is also part of the NYSPQC
- New York State hospitals are working with maternal health providers, DOHMH, and DOH to promote **safe sleep practices** in order to reduce infant mortality
- Providers are working with hospital neonatal intensive care units to optimize **newborn early enteral (intestinal) nutrition** to improve their health

New York State providers are working to manage **hypertension** (high blood pressure) and **venous thromboembolism** (blood clots) during all stages of pregnancy to reduce complications related to these conditions, which are associated with maternal mortality and morbidity.

Postpartum Care Expert Workgroup

DOH recently convened the first meeting of its Postpartum Care Expert Workgroup which will identify and address barriers and challenges to providing comprehensive post-partum care to women across New York State. GNYHA is an active participant.

We Can (and Must) Do More

New York City hospitals, in concert with government and other health care stakeholders, are working hard to improve prenatal care, as well as to address maternal mortality and morbidity and associated disparities. They deliver high-quality care to all who walk through their doors, run programs to combat bias and promote culturally competent and equitable care,[9] support legislation to improve birth outcomes, work to

[8] SUNY University at Albany, School of Public Health, "New York State Perinatal Quality Collaborative." Available at https://www.albany.edu/cphce/mch_nyspqc.shtml.

[9] GNYHA continues to support hospitals as they seek to improve the cultural competence of the care they deliver. Efforts include cultural competence training provided to almost 2,000 frontline staff (mostly from New York City

forge ties with community-based organizations, and participate in robust clinical QI programs. Together with New York State, they are working to implement the Governor's taskforce recommendations, which GNYHA wholeheartedly supports (some have already been implemented). Hospitals are constantly looking for ways to improve the care they deliver.

However, as evidenced by the statistics, we still aren't where we need to be. Everyone in the health care community, including hospitals, must work even harder to address racial disparities. While we believe that the availability of prenatal care at New York City hospitals is sufficient, it's just one piece of a larger puzzle on maternal and child health. The factors that shape birth outcomes affect women well before their first hospital visit.

More focus should be on these social determinants of health, which contribute to the maternal mortality disparities we see: structural racism, food and housing insecurity, inaccessible primary care, lack of access to education, poor transportation options, language barriers, health literacy, lack of emotional support, and many others. While hospitals absolutely have a duty to do better, they can ultimately only control what happens inside their four walls.

GNYHA supports investing in interventions that will strengthen marginalized communities and the social safety net, which is fraying: community care coordinators that can connect pregnant women with services and serve as trusted advocates, the Medicaid program (especially maternity services), education, housing, and transportation. Social services and social justice should be our guiding principles.

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Thank you for the opportunity to speak with you about this important subject. I am happy to answer any questions you may have.

hospitals) under a DOH grant, sharing best practices and challenges on language access, and helping hospitals to identify and share best practices in LGBTQ+ care. See GNYHA testimony on "The Delivery of Culturally Competent & Equitable Health Care Services in New York City Hospitals," submitted for the Hospitals Committee hearing on September 18, 2019, for more information.