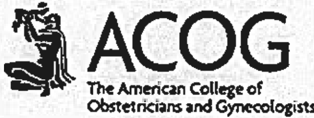

District II

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Testimony on Behalf of the
American College of Obstetricians and Gynecologists (ACOG), District II
Joint Senate Committee Hearing: State of Maternal Health:
An Examination of Maternal Mortality and Morbidity Rates in New York State
February 24, 2025

The American College of Obstetricians and Gynecologists (ACOG), District II represents New York State physicians providing comprehensive obstetric and gynecologic services, and supports policies that are evidence-based, enhance access to comprehensive reproductive health care, reduce administrative burdens, and prohibit interference in the physician-patient relationship. ACOG District II partners closely with the Legislature, Executive, and State agencies to provide clinical guidance and expertise on key reproductive health issues.

ACOG District II appreciates the invitation to provide testimony at this important forum on maternal health, and we thank the Senate for their commitment to enhancing care during pregnancy and beyond. Persistent rates of preventable maternal mortality are unacceptable and despite making progress in our state ranking, the loss of even one mother is devastating. There is a significant opportunity for the Legislature to advance efforts to improve maternal and reproductive health outcomes by engaging with clinical experts to develop thoughtful and effective policies. It is through this lens that we respectfully submit the following testimony.

- **New York must continue to focus on the ongoing maternal health crisis as federal actions devalue evidence-based care and clinical judgment.**

New York faces unprecedented challenges to address the maternal mortality crisis in light of troubling federal policy actions which seek to devalue clinical expertise and evidence-based care, jeopardize access to critical public health programs and information[1], and threaten ongoing federal funding for vital clinical research.[2] As New York contends with persistent racial disparities in maternal health outcomes, it is more important than ever for the state to uplift the ongoing quality improvement work of New York's clinical community and stand as a leader in supporting evidence-based programs to drive meaningful change. As New York's ob-gyns deliver care amidst the devastating confluence of the maternal mortality crisis with the national abortion access crisis, it is essential that state health care policies are designed to reduce health and socioeconomic inequities in access to pregnancy care and outcomes. It will take all of us working together to provide the nurturing support that people need to thrive during their pregnancies and beyond.

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[1] ACOG Urges Uncensored Access to Scientific Research and Clinical Data | ACOG
[2] Health Research Could Face Severe Cuts and Changes under Trump | Scientific American

- **New York State has put important systems in place to prevent maternal mortality and reduce persistent racial disparities through data-driven quality improvement programs.**

MATERNAL MORTALITY REVIEWS

New York has made significant progress to create the quality improvement and data infrastructure necessary to improve maternal health outcomes and develop sustainable systems to optimize care during pregnancy and the postpartum period. Passage of legislation to establish New York State and New York City Maternal Mortality Review Boards (MMRBs) has been a critical component of advancing data-driven maternal mortality prevention efforts. These boards host regular meetings to review maternal deaths occurring within the state and city. MMRBs are important structural components necessary to understand the causes of maternal deaths, to assess the preventability of each death and to propose actionable strategies for prevention. In addition to authorizing legislation, New York State has also prioritized the inclusion of consistent funding for the state to administer the board and staff maternal health quality improvement programs.

SAFE MOTHERHOOD INITIATIVE

New York State has also provided funding to support ACOG District II's Safe Motherhood Initiative (SMI) which develops evidence-based bundles to equip obstetric teams with best practices for managing emergencies in pregnancy, labor, and the postpartum period. Centering equity and dignity, the SMI unites maternal health partners statewide, using data from New York's Maternal Mortality Review Board (MMRB) committees to combat maternal mortality and address racial disparities. When the SMI was established in 2013, New York ranked 48 out of 50 states. Since that time that ranking has improved to 15th out of the 37 states reporting nationwide on maternal mortality.[3] Sustained investment is necessary to continue to improve our state ranking.

Through the state's financial support for the SMI, the program has offered obstetric teams easily accessible tools through the SMI app, including checklists and algorithms used at the bedside, and assisted hospitals in implementing the bundles through education and ongoing implementation support. The SMI is a critical component of ongoing maternal mortality prevention work which enables clinical experts to respond to recommendations of the MMRB, such as developing a Cardiac Conditions in Pregnancy bundle and leading an effort to educate emergency department physicians to respond to obstetric emergencies in the emergency room.

Recognizing that principles of health equity and respectful care are vital components of positive birth experiences, the SMI clinical bundles include specific focus on incorporating these principles and recommendations throughout. SMI meetings include presentations and

[3] https://www.kff.org/other/stateindicator/maternal-deaths-and-mortality-rates-per-100000-live-births/

opportunities to share learning on best practices on optimizing the birth experience and centering respectful care in the birthing process.

PERINATAL QUALITY COLLABORATIVES

The SMI has partnered with the Department of Health on the implementation of its perinatal quality collaboratives. The current effort is designed to enable birthing facilities to safely reduce the Nulliparous, Term, Singleton, Vertex (NTSV) cesarean birth rate specifically among Black birthing people.

➢ **The MMRB's findings have informed critical policy initiatives and quality improvement efforts.**

ACOG District II and the SMI have taken action to implement recommendations of the maternal mortality review board, including:

- **Medicaid coverage one year postpartum**: ACOG District II's successfully advocated for Medicaid coverage for one full year following the end of pregnancy, including for undocumented patients, to address the significant health challenges and maternal deaths which occur in the postpartum period up to one year.
- **Telehealth:** ACOG District II's successfully advocated for increased flexibility for patients to access health services through telehealth following the end of the COVID-19 pandemic.
- **MMRB Issue Briefs:** ACOG District II and SMI clinical experts partnered with the NYS Department of Health's MMRB to create clinical resources through Issue Briefs on Maternal Mental Health[4] and Perinatal Substance Use Disorder.[5]
- **Cardiac Bundle:** SMI created a clinical bundle to address cardiac conditions in obstetric care - a leading cause of maternal death in New York State.
- **Emergency Department Education**: SMI created emergency department education in partnership with the American College of Emergency Physicians' New York Chapter and the Department of Health to address obstetric emergencies occurring in non-obstetric settings.

➢ **Long-term undervaluing of maternal health requires sustained state investment and partnership to address the ongoing drivers of maternal mortality and morbidity and systemic issues which perpetuate health disparities**

As obstetric teams continue their work to improve clinical systems and patients' birth experiences, New York must be prepared to address the systemic issues which perpetuate health inequities that have evaded meaningful state investment. Without foundational work to address continued health access barriers, inconsistent community resources, and lack of

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[4] New York State Department of Health Releases Issue Brief On Pregnancy Associated Deaths: #Maternalhealthmatters

[5] Spotlight on Perinatal Substance Use Disorder, November 2023

innovative maternal health care delivery models, efforts to further reduce maternal mortality and morbidity will have limited efficacy. Ongoing maternal mortality prevention work will require a partnership mindset which commits to engaging the many communities necessary to drive change. To ensure more equitable maternal health outcomes requires sustained attention and investment from multiple members of the health care team and community, including ob-gyns, midwives, other physicians, nurses, social workers, hospital systems, governmental partners, payers, advocacy groups, and community-based organizations.

New York must:

- Invest in New York's perinatal mental health clinical workforce to ensure that pregnant patients with mental health conditions, including substance use disorder, can access needed care during pregnancy and critically, during the postpartum period.
- Create systems to more effectively address health during the life-course, not only during pregnancy, to improve patient health holistically. Cardiac conditions, substance use disorder and mental health conditions are among the leading drivers of maternal mortality in the state[6], and efforts to address them must begin well before pregnancy. Other chronic conditions including diabetes, hypertension and obesity also contribute to worse health outcomes during pregnancy and must remain a focus of prevention efforts.
- Enhance linkages to community resources to create partnerships which support patients during the postpartum period[7].
- Guarantee safe stable housing for pregnant and postpartum people experiencing homelessness, prioritizing those with chronic health conditions (including mental health conditions)[8].
- Continue to fund the Safe Motherhood Initiative to equip obstetric teams with the tools needed to improve care.
- Continue to fund the state MMRB and perinatal quality improvement collaborative as critical systems to prevent maternal mortality and morbidity.

We deeply appreciate the Senate's continued efforts to augment maternal mortality prevention systems in New York State. While ob-gyns and clinical teams continue their efforts to enhance clinical processes and improve patients' birth experiences, the maternal crisis cannot be solved only through the efforts of our health care system. The ability to effectuate meaningful change will require the commitment of a broad community of partners. We look forward to continued work with the state Legislature as we work towards a future where no community suffers from a preventable, pregnancy-related death.

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[6] New York State Maternal Mortality Review Report, 2018-2020

[7] Ibid.

[8] https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2022.pdf