New York State Senate Standing Committee on Women's Issues
New York State Senate Standing Committee on Health
New York State Senate Standing Committee on Mental Health
New York State Senate Standing Committee on Social Services

Testimony of Patricia O. Loftman, CNM, LM, MS, FACNM
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Greetings Chairpersons Webb, Rivera, Brouk and Persaud. Thank you for this opportunity to provide testimony on the State of Maternal Health: An Examination of Maternal Mortality And Morbidity Rates in New York State.

My name is Patricia Loftman. I am a Certified Nurse Midwife and a Fellow of the American College of Nurse Midwives. I graduated from Columbia University Graduate School of Nursing with a specialty in midwifery in 1981. I practiced full scope midwifery caring for women as a midwife and am the former Director of Midwifery Service at Harlem Hospital in New York City. During my thirty years at Harlem, I cared for women whose pregnancies were complicated by substance use, for ten years, developing an expertise in this area.

Today, I speak as a representative of New York Midwives, the State Affiliate of The American College of Nurse Midwives, the Professional Organization that represents midwives across the United States. I also speak as a member of the New York City Department of Health and Mental Hygiene Maternal Mortality and Morbidity Review Committee (MMRC) since its inception in 2018. I am also a member of the newly created New York City Council Maternal Health Steering Committee.

The New York City Department of Health and Mental Hygiene reported that two hundred forty-one (241) pregnancy-associated deaths, deaths of a woman or birthing person from any cause during pregnancy or within one year from the end of pregnancy, regardless of the outcome of the pregnancy, occurred between 2016-2020 in New York City. Of these 241 deaths, 105 or 43.6% were among Black non-Hispanic women and birthing people. During this same period, there were 114 pregnancy-related deaths, death of a woman or birthing person during pregnancy or within one year from the end of pregnancy that is caused by a pregnancy complication, a chain of events initiated by pregnancy or the aggravation of an unrelated condition by the physiological effects of pregnancy. Fifty-four (54) or 47.4% were to Black non-Hispanic women and birthing people.

The MMRC determined that 62.7% of pregnancy-associated deaths and 74.6% of pregnancy-related deaths were preventable. Mental health conditions, substance use/ overdose and suicide emerged as the leading cause of pregnancy-associated deaths contributing to 18.3% of deaths while mental health conditions other than substance use disorder contributed to 25.3% of deaths. Over 90% of pregnancy-associated deaths due to mental health conditions were considered preventable by the MMRC. The top contributing factors or leading causes of preventable death due to mental health conditions were lack of continuity of care/care coordination.

MMRC record reviews demonstrated that the women who died because of mental illness, substance use/overdose and suicide were ill long before they became mothers. They experienced trauma in their lives at an early age, sometimes prior to adolescence, which was not recognized and/or not adequately addressed. The result is that when these women became pregnant the hormonal, emotional and life stressors that accompany pregnancy overwhelmed them resulting in their death.

Health: (231-233) New York State Health Services Corps. Title 2-B. Expiration Date 07/18/1996. 231- New York State Health Service Corp. Expiration Date 07/18/1996. 232 – Powers and Duties. Expiration Date 07/18/1996. 233- New York State Health Services Corps Scholarship and Fellowship Program. Expiration Date 07/18/1996.

Rather than reinventing the wheel, old solutions often possess merit and remain valid. The problem is that there is often no transfer of information from one administration to another so solutions that worked are sent to the graveyard for permanent burial.

Another **immediate, evidence-based solution to maternal mortality** is to expand the number of **Crisis Respite Centers** throughout the five boroughs by at least two per borough, prioritizing areas with high need and open by appointment, walk-in, or referral. **Crisis Respite Centers are Preventive and Supportive Services** developed for pregnant and postpartum women and women with children. Needed are more Peer Bridgers, persons with lived mental health experiences who are in recovery to help women and birthing people connect to services. A woman and/or birthing person with a mental health challenge is more likely to connect and develop a supportive relationship with such a person. Currently, there are Peer Specialists and Social Workers at the Crisis Respite Centers. This **evidence-based solution** is consistent with a MMRC recommendation that NYS governmental agencies should fund the creation of Respite Centers for parents, newborns, children, pregnant people, and postpartum people with mental health and substance use and misuse needs, or those without care for their children during and after childbirth, that begins with Respite Center care (independent of ACS) and segues into long-term supportive housing that includes customized, individual patient-specific evaluation, drug use or misuse treatment, and easy access to psychological care, as well as peer supports, parenting supports, and necessary resources.

My last **evidence-based solution to maternal mortality** is a recommendation that uplifts equity for Black and Brown women and birthing people. The literature documents that health care system is utilized when Black, Brown and poor women and birthing people to have the option and ability to access reproductive and obstetrical clinicians of their choice that facilitates their ability to have safe, satisfying and sacred care. I note that Public Health Article 28 – Hospitals 2803-J-Information for Maternity Patients; NY Public Health Law § 2803-J (2023) was passed. However, The New York State legislature created **The New York State Maternity Information Law** in the late 1980's or mid 1990's. It **required each hospital to provide the following information about its childbirth practices and procedures.** This goal of sharing information was to allow women and birthing people to make **informed choices** about where to obtain reproductive health care including prenatal care and birth. Hospitals were and are required to provide the information contained on the list to the New York State Department of Health (NYSDOH). NYSDOH would then publish the hospital specific data on their website. Additionally, each hospital was and is required to distribute this information to pregnant women who register for prenatal care on the first visit. Unfortunately, although it is a law, it has not been enforced. You will note that the document has not been updated on the NYSDOH website since 2018. **The legislature did not need to reinvent the wheel. It only needed and needs to enforce legislation that currently exists.** I would recommend, in addition, that the information is updated to include doula services and most important for women, the identification of hospitals where deaths occur. I maintain that with this information you would make choices to enhance the best birth outcomes for you or someone you love. Black, Brown and poor women should have the same opportunity. https://www.health.ny.gov/publications/2901/; https://www.health.ny.gov/publications/2901.pdf. A copy of the **Maternity Information Law** is attached.

In closing, while the intent of legislation is always laudable the impact must also be considered and an enforcement mechanism a necessary feature to be included.
Thank You.