New York State Senate Joint Hearing

Committee on Women's Issues, Committee on Health, Committee on Mental Health and Committee on Social Services

State of Maternal Health: An Examination of Maternal Mortality And Morbidity Rates in New York State

Testimony of the New York State Nurses Association Presented by Janna Walter, RN

The New York State Nurses Association represents more than 42,000 members for collective bargaining in New York State. We are New York's largest union and professional association for registered nurses. NYSNA is an affiliate of National Nurses United, AFL-CIO, with more than 225,000 members nationwide. NYSNA is a leading advocate for universal healthcare, addressing inequities in our healthcare system, and improving community health outcomes.

My name is Janna Walter, RN, and I have worked for 13 years as a public health nurse with the Sullivan County Department of Health. I supervise the County's Maternal and Child Health Programs, including the Maternal Child Nursing and the Healthy Families Sullivan home visitation and support programs. I am submitting this testimony as a public health nurse and member of NYSNA, and not in my official capacity as an employee of the Sullivan County Department of Health.

As a public health nurse focusing on pre- and post-partum maternal health care, my work focuses on ensuring that women have access to vital health care services before, during and after they give birth.

Background on Maternal Mortality and Morbidity

The problem of unacceptably high maternal morbidity rates in New York and nationally is well established and widely acknowledged. Maternal mortality rates (defined as maternal pregnancy related deaths per 100,000 live births) in the U.S. were 22.3 in 2022.[1] The U.S.

[1] See: CDC National Center for Health Statistics for 2022, available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.htm#table. It should be noted that maternal deaths spiked during the COVID pandemic, but have been declining and now approach pre-pandemic levels.

maternal mortality rate is more than double the average rate for comparable developed economies.[2]

Maternal mortality data also reveals serious racial and class inequities, with significantly higher mortality rates for poor and black mothers. Thus, while New York maternal mortality rates in total were slightly lower than the national average in 2018-2020 (19.3 versus 20.4), racial disparities were worse than the national average, with black women in New York dying at more than four times the rate of white mothers (55.8 versus 13.2).[3]

Women in New York and the U.S. also suffer, as would be expected in the context of the data on mortality, from extremely high rates of maternal morbidity (defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health).

Factors Causing and Contributing to High Maternal Mortality and Morbidity Rates

The main causes of maternal mortality and morbidity include the following conditions, many of which are undiagnosed or untreated:

- Mental health conditions (including deaths to suicide and overdose/poisoning related to substance use disorder) (23%);
- Excessive bleeding (hemorrhage) (14%);
- Cardiac and coronary conditions (relating to the heart) (13%);
- Infection (9%);
- Thrombotic embolism (a type of blood clot) (9%);
- Cardiomyopathy (a disease of the heart muscle) (9%); and,
- Hypertensive disorders of pregnancy (relating to high blood pressure) (7%).[4]

It should also be noted that according to the findings of the mortality review boards and the CDC, 70% to 80% of maternal deaths have been determined to be preventable.

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[2] In 2020 the US rate was 23.8, compared to an OECD developed nation average of 9.8. It should be noted that the OECD average masks even greater disparities between the US and other similarly developed countries. For example, the maternal mortality rate in Canada is only 8.4, in the UK 6.5 and in Japan 2.7. See: Commonwealth Fund, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (2023), available at https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

[3] See: New York State Maternal Mortality and Morbidity Advisory Council Report (2023), available at **https://www.health.ny.gov/press/releases/2024/2024-03-14_maternal_mortality.htm**.
(19.3 vs. 20.4 deaths per 100,000 live births) but with larger racial disparities: Black women in New York State died at over four times the rate of White women (55.8 vs. 13.2 deaths per 100,000 live births).

[4] See: CDC Press Release (Sep. 19, 2022), available at https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html. It should also be noted that unnecessary c-section deliveries are a contributing factor, as the NY DOH reports that mothers are more than 3 times more likely to die during a caesarian procedure than a normal vaginal birth.

Proposals to Address Maternal Mortality and Morbidity

New York has made some progress in addressing maternal mortality. The state has adopted uniform definitions and reporting requirements, established formal maternal mortality and morbidity review boards to collect and report accurate data, established an advisory council to identify trends and issue concrete recommendations, created or supported new programs to support pregnant women (such as supporting doula services, and creating or expanding home visitation programs, and other measures to improve the situation.

Despite these efforts, however, much more needs to be done to bring down excessive mortality and morbidity rates.

NYSNA recommends the following proposals to address maternal mortality and morbidity and note that many of these proposals will also address the issue of racial and class disparities that are reflected in the higher mortality rates faced by black mothers.

1. Increase the availability of perinatal primary care services

Regular access to care remains a significant factor in the ongoing crisis of maternal mortality and morbidity.

Early and regular access to pre-natal examinations, testing, and check-ups is critical to diagnosing and treating possible threats to the health and life of pregnant women and can significantly lower mortality and morbidity rates.

Regular post-partum care is also critical, as the data indicates that more than 63% of maternal deaths occur after childbirth.[5]

Despite the critical need for perinatal care to reduce maternal mortality and morbidity rates, too many women do not receive the services they need to stay healthy.

Many areas of New York are healthcare deserts or otherwise faced with insufficient access to healthcare services in general and to maternity care in particular.

Pregnant women should begin receiving perinatal care immediately upon becoming pregnant, but in many cases are unable to find providers or face long wait times for initial and follow-up appointments.

I have personally encountered increasing instances of women in Sullivan County, for example, who were not able to schedule their first perinatal care appointments until early in their third trimester. This is too late in the pregnancy and exposes women to much higher risk of death or other negative effects on their health and that of their babies.

[5] See: CDC Report, Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020 (2024), available at: https://www.cdc.gov/maternal-mortality/php/data-research/index.html.

2. Increase funding for and access to perinatal home visitation programs

One of the most effective ways to reduce maternal mortality and morbidity is to expand the availability of home visitation programs targeted at pregnant and post-partum patients.

The state has provided funding for Nurse-Family Partnership programs around the state and has recently established the Healthy Families New York program.

These programs provide home regular pre- and post-partum visitation services by RNs or other public health workers and are targeted to the low-income and minority communities that suffer the highest rates of mortality and morbidity. and are highly effective.

The legislature should increase funding to local health departments to expand these highly effective programs that have a proven track record in improving maternal health and outcomes.

3. Increase Medicaid reimbursement rates

Many physician and physician practice groups do not accept uninsured or Medicaid patients, particularly in rural parts of the state that have fewer available providers present.

This leaves low-income women who rely on Medicaid searching for appointments for perinatal services provided by hospital-affiliated programs or local FQHCs and clinics.

Safety-net hospitals and rural community hospitals that serve these patients are financially precarious and often unable to meet local demand for services or to maintain the quality of care. In addition, many hospital systems are closing or reducing their perinatal services to focus on more profitable services and higher income communities.

The legislature should address this issue by considering substantial increases in Medicaid reimbursement rates for perinatal care. This will support safety-net and rural hospitals, stabilize their finances and allow them to maintain or even improve their perinatal services.

Increased Medicaid rates for perinatal services will also provide incentives for larger hospitals system and primary care providers to keep existing services or to enter the field and offer new services.

4. Expand the availability of mental and substance use health services

The ongoing mental and substance use health crisis in New York is a major contributor to high mortality rates.

The state should consider targeting services, preferably through local health departments, to address the mental health needs of pregnant women.

5. Require private and for-profit providers to provide more services to Medicaid and uninsured perinatal patients

Many private for-profit physician groups refuse to accept uninsured or Medicaid patients (largely because reimbursement rates are too low).

NYSNA believes that all private healthcare providers have an obligation to accept and assist patients regardless of their ability to pay.

Under current law, operators of hospitals, ASCs, diagnostic and treatment centers and other providers covered by Article 28 of the Health Law are required to submit applications and receive formal state approval to open or expand healthcare facilities through the Certificate of Need (CON) process.

Although the law was expanded to require certain CON applicants to include a community health needs assessment showing how their projects will affect access to care and community health outcomes, there is no requirement to provide free or reduced cost services to underserved populations and communities.

The legislature should consider (a) amending the CON laws to require that all applicants commit to providing services to uninsured and Medicaid patients as a condition of project approval and continued licensure.

6. Freeze or restrict closures or reductions of hospital perinatal services

In the last 25 years, dozens of hospitals across New York have closed and many more have reduced or eliminated "unprofitable" psychiatric, maternity and emergency services.

These widespread and ongoing closures and reductions have been particularly hard for rural areas of the state, creating healthcare deserts, increasing wait times for services, forcing patients to travel greater distances, and worsening local health outcomes.

In 2024 the legislature passed the LICH Act, which would require hospitals to give public notice, publicly post their closure plans, prepare detailed community health impact analyses to show how local health needs will be affected and if local health needs are impacted, to propose alternative services. The LICH Act would apply in cases of the closure of an entire hospital, or the closure of ER, maternity or psychiatric services. Unfortunately, the Governor vetoed the bill in December.

Community hospitals, particularly in rural areas, play an important role in providing healthcare services to the broader population and to pregnant women in particular.

Hospitals are required to accept Medicaid patients and often are the only local providers of care to the uninsured. In addition, local community hospitals also operate extensive primary, ambulatory, and home care networks that offer local communities access to

services that would not otherwise exist. When they close, there is often no other provider to replace them.

We urge the legislature to pass the LICH Act and if necessary to override the Governor's veto.