BLACK MATERNAL MORTALITY TASK FORCE REPORT

THE OFFICE OF
BRONX BOROUGH PRESIDENT RUBEN DIAZ JR.
MARCH 2021

Art by F.Y. EYE for The Bronx Health Link, 2020

Dear Friends:

This past year has been a challenging one for the health and well-being of our neighborhoods across The Bronx. The severe harm that the COVID-19 pandemic has inflicted on our communities has shined a light on the wide disparities in healthcare access and outcomes that have long afflicted our borough, city, state and country. This year, we have expanded our health work into an area that has not seen nearly enough attention: the climbing rate of Black maternal mortality.

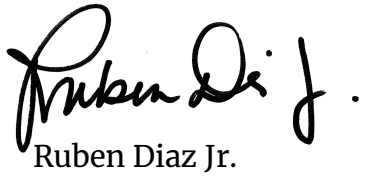
Over the past several years, The Bronx, like the rest of the country, has seen the rate of Black maternal mortality – maternal deaths before, during and after childbirth – increase at a rapid rate. The Bronx's mortality rate is higher than New York State's as a whole and the mortality rate for Black women is much higher than for women of other races. We must address this problem.

Building on past work, including the Taskforce that Governor Cuomo empaneled in 2018 and the legislation introduced by our partners in Congress, my office launched the Bronx Black Maternal Mortality (BMM) Taskforce this past fall. Through extensive discussions, collaboration with a wide range of partners and a virtual meeting of the BMM Taskforce on October 14, we have made a significant step towards understanding the issue of Black maternal mortality and about how to combat this problem in The Bronx. This report represents the findings and recommendations of the BMM Taskforce and next steps for my office, healthcare providers and policy leaders across the borough.

I am particularly excited about the formation of the Bronx Maternal Health Consortium, which will continue this important work in the future. The Consortium will build upon the BMM Taskforce's consensus of priorities, strategies and recommendations to reduce the numbers of women who die or experience serious complications during and after pregnancy, with a particular emphasis on reducing the racial disparities that cause Black women to experience much higher risk of injury or death. This collaborative effort is the kind of leadership that The Bronx needs, and I am proud that my office will take a role in facilitating this Consortium.

I look forward to your comments and feedback on this critical issue and to your ongoing support of our efforts to stamp out Black maternal mortality in The Bronx once and for all.

Sincerely,



Ruben Diaz Jr.

EXECUTIVE SUMMARY

Over the past several years, the rate at which women have been dying due to pregnancy and childbirth has been rising. This increase in maternal mortality is both a national phenomenon and a local one; here in The Bronx, the maternal mortality rate is higher than the rates for the city and the state at large. Additionally, all women do not bear this risk equally – Black women are far more likely to experience maternal death than women of other races.

Combatting this rise in maternal deaths requires a strong, unified strategy among healthcare and policy leaders across The Bronx. To this end, Borough President Ruben Diaz Jr. assembled a Taskforce of policy experts and healthcare leaders to discuss issues and propose solutions. The Bronx Black Maternal Mortality (BMM) Taskforce met virtually on October 14, 2020 and this report serves to articulate its findings in the form of policy recommendations and action steps and to provide a narrative of health disparities in The Bronx. Borough President's office will continue to engage with these experts and leaders going forward to maintain a strong push towards eliminating maternal deaths.

Recommendation: **Targeting Racial Bias.** All Health professionals should undergo rigorous and comprehensive racial anti-bias trainings before working with patients. Eliminating unconscious bias in the provision of medical services can help reduce the risk for Black and Latina women who face disproportionate negative outcomes during pregnancy and childbirth.

Recommendation: **Improving Health Coverage and Care Services.** One of the great challenges to overcome in dealing with maternal deaths is to achieve equitable access to vital services for all. The state must change and expand Medicaid reimbursements and coverage, birth workers such as doulas and midwives should be used more readily and patients must have greater access to tele-health services.

Recommendation: **Doula Advocacy and Access.** Doulas can be essential to protecting women before, during and after childbirth. Both government agencies and medical providers should work to make doulas more accessible to women who need these services the most. The state should expand its doula pilot with a competitive reimbursement rate per patient.

Recommendation: **Addressing Communication Barriers Within and Between Hospitals.** Hospitals in The Bronx currently use different platforms for patient records, and must coordinate their communications of patient health information in a more unified way. These communication barriers must be broken down so medical professionals best know how to treat patients who have previously received care in other locations.

Recommendation: **Improving Patient Education**. Healthcare organizations must make increased efforts to ensure that expectant mothers know their rights as patients, how to prepare for visits, what questions to ask, what constitutes a pregnancy warning sign, what to do if a medical issue arises, and what to expect before, during and after childbirth.

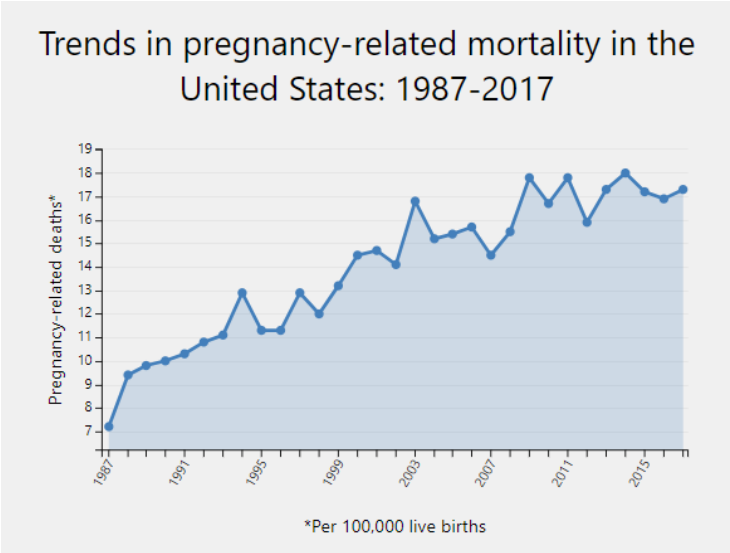
Recommendation: **Making Black Maternal Mortality a Public Health Priority.** Advocates must push government leaders to prioritize this health crisis and support funding for interventional programming. They must make combatting maternal deaths a priority in the broader public health strategy.

Recommendation: **The Bronx Maternal Health Consortium.** The next steps for this Taskforce will be to continue work on this issue by reestablishing a borough-wide Consortium. The Consortium will continue to facilitate collaboration among the membership so that open lines of communication are maintained, best practices are followed and real change can be implemented.

TABLE OF CONTENTS

BACKGROUND AND THE PROBLEM

Maternal mortality is defined as the death of a woman due to complications arising from pregnancy or birth. This mortality can occur at any time from conception, to labor and delivery, to up to a year after birth. When a woman dies due to pregnancy complications, she leaves behind a family that will irreparably be broken by her loss.



Despite being one of the most medically advanced countries in the world, the United States experiences comparatively high levels of pregnancy related mortality and the situation is getting worse. As the graph on the right shows, maternal mortality has been increasing nationally over the past 30 years.[1] Furthermore, this problem disproportionately affects Black women, with their maternal mortality rate being 42.8 deaths per 100,000 nationally in the 2011-2015 period, as compared to 13.0 deaths per 100,000 for White women.[2] And, while these numbers are growing, the majority of maternal deaths remain preventable, with the CDC saying that approximately 60 percent of reported maternal deaths could have been avoided.[3] In late 2017, the New York City Department of Health and Mental Hygiene (NYC DOHMH) established two committees with the aim of eliminating preventable maternal mortality and severe maternal morbidity and to achieve the broader goals of *reproductive justice* and *racial equity* in maternal health outcomes in New York City.[4] This has focused close attention to identifying evidence-based factors involved in the preventable deaths of Black women.

Disturbing numbers are reflected at the local level as well. In 2014, the overall maternal mortality rate in The Bronx was 36.2 deaths per 100,000[5] as compared with 18.9 deaths per 100,000 citywide in 2011-2015.[6] Alarmingly, on a citywide basis, the mortality rate for Black women in the 2011-2015 period was 51.0 per 100,000. This means Black women were more than eight times as likely to die of a pregnancy-related cause as White women were.[7] While there is no data for maternal mortality available at the neighborhood level, the data for severe maternal morbidity (i.e. a pregnancy that has "significant short- or long-term consequences to a woman's health"[8]) shows that the Bronx neighborhood with the highest rate is Williamsbridge (Community Board 12), an

[1] The graph is from the CDC: https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
[2] https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm
[3] https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm
[4] https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths
[5] Via NYC Department of Health and Mental Hygiene statistics.
[6] https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2011-2015.pdf
[7] https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2011-2015.pdf
[8] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

area with a large Black population.[9] There are approximately 100 cases of severe maternal morbidity for every maternal death, showing that this is a serious problem as well.[10]

The mortality gap between White and Black women is not simply a function of income – Black women have higher rates of maternal mortality even when accounting for socio-economic status or educational attainment. New York City DOHMH data from 2008 to 2012 shows that Black women with a college degree are more likely to experience severe maternal morbidity than a woman of any other race who has not graduated high school.[11] This clearly shows that a woman's race has an effect even when accounting for class, income or education.

Black women are more likely than White women to have comorbidities such as hypertension, diabetes and asthma that increase risk of pregnancy complications.[12] And one study found that the racial mortality gap was widest among women who did not have any of these comorbidities.[13] Additionally, approximately one-third of maternal deaths occurred among women who received late or no prenatal care. Black and Latina women are less likely to start prenatal care in their first trimester of pregnancy and are more likely to have five or fewer prenatal visits.[14]

Several factors affect Black women in particular, leading to worse maternal outcomes. Studies have shown that one of the largest causes for adverse maternal outcomes is hospital quality. Simply put, Black women are more likely to deliver their children in lower quality hospitals than White women are, even controlling for socio-economic status. One quarter of the nation's hospitals account for 75 percent of Black women's deliveries, but the same hospitals only account for 18 percent of White women's deliveries. If the hospitals Black women are using are lower quality, this will result in adverse outcomes that fall disproportionately on those women.[15] In New York City between 2011 and 2013, 65 percent of White babies were born in the lowest morbidity hospitals while only 23 percent of Black babies were born in those same hospitals.[16]

Here in The Bronx, several local factors have resulted in disproportionate negative health impacts on communities of color, and Black residents in particular. The long history of redlining has resulted in de facto residential segregation. In the communities along the Cross Bronx and other high-traffic roadways, asthma rates are elevated, leading to "Asthma Alley" in the South Bronx. Pollution in the waterways including the Bronx, Harlem and Hutchinson Rivers has also inflicted harms on the communities that live nearby. There have been multiple outbreaks of Legionnaires' Disease due to poor cleaning of water tanks, and Borough President Diaz has worked with the City Council to address this problem through legislation.[17] Additionally, the residents of NYCHA have been exposed to lead, mold and pests that have harmed their health. The city's

[9] Via NYC Department of Health and Mental Hygiene statistics.
[10] https://pubmed.ncbi.nlm.nih.gov/27179441/
[11] https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf, page 15
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/
[13] https://pubmed.ncbi.nlm.nih.gov/10981453/
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/ citing: https://pubmed.ncbi.nlm.nih.gov/28079772/
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/. The hospital quality effect also holds true for Latina women vs. White women as well, but with a smaller difference: https://pubmed.ncbi.nlm.nih.gov/28079772/
[16] https://pubmed.ncbi.nlm.nih.gov/27179441/
[17] http://bronxboropres.nyc.gov/2015/08/10/statement-from-borough-president-diaz-re-legislation-on-legionnaires-inspections/

efforts to clean up NYCHA have been seriously flawed and ultimately underwhelming. The racial health disparities in The Bronx must be understood through this lens of historic disregard for the people who live in the borough. The data published by the city Department of Health and Mental Hygiene (DOHMH) in the Community Health Profiles clearly shows the disparate health outcomes in Bronx neighborhoods.[18]

Black women also experience adverse outcomes directly due to racism and discrimination. Black women are the racial group most likely to experience high-stress events in the year preceding birth, even accounting for income.[19] According to one survey, nearly one quarter of pregnant women reported discrimination during labor and delivery hospital stays, and Black and Latina women reported discrimination at higher rates than White women did. Additionally, Black women with higher levels of education were more likely to experience communications issues with their providers than Black women with lower levels of education, [20] showing that there is a racial effect that is about more than class.

Federal, state and local governments are beginning to engage more rigorously with the problem of maternal mortality and its disproportionate impact on Black women. Governor Andrew Cuomo convened a Maternal Mortality Taskforce in 2018 that released its recommendations in March 2019[21] and another set of recommendations specifically about maternal care and COVID-19 in April 2020.[22] In 2018, the New York City Department of Health and Mental Hygiene (DOHMH) and NYC Health + Hospitals received funding to collaborate on a strategic plan for comprehensive maternal health programming. This collaboration resulted in the launch of the Maternal Health Quality Improvement Network (MHQIN) and four initiatives to be implemented across all 11 public hospitals: simulation training in obstetric life support, a Maternal Medical Home model to coordinate all services, a Pregnancy Optimization Program, and Mother-Baby Coordinated Visits. The DOHMH also created the Maternal Mortality and Morbidity Review Committee (M3RC) with a panel of diverse experts to critically review each maternal death and elucidate key contributing factors, with the mission of reducing preventable deaths.

Congress is considering several pieces of legislation related to maternal care, including the Black Maternal Health Momnibus Act, which was introduced by Vice President Kamala Harris. This bill – which Borough President Diaz last urged New York City's congressional representatives to support – would create a coordinated federal plan to combat rising maternal mortality rates and make specific results-oriented interventions to accomplish that goal. President Biden and Congress should work together to get this bill passed.

The Bronx in particular has several intertwined health challenges that all exacerbate each other. High rates of poverty and generations of disinvestment have resulted in a situation where The Bronx is consistently ranked last out of the 62 counties of New York State in health metrics. Borough President Diaz has made the #Not62 campaign one of

[18] https://www1.nyc.gov/site/doh/data/data-publications/profiles.page#bx
[19] https://pubmed.ncbi.nlm.nih.gov/25789817/
[20] The discrimination reported was due to more factors than just race/ethnicity, including for having pre-existing conditions such as diabetes. https://pubmed.ncbi.nlm.nih.gov/26340663/
[21] https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf
[22] https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/042920_CMTF_Recommendations.pdf

the centerpieces of his health advocacy. This campaign recognizes that the largely Black and Latino communities of The Bronx require more investment and attention to ensure that health outcomes are equitable and approach the levels of the rest of the city and state. Maternal mortality is representative of this struggle – the numbers are higher in The Bronx than in the city and state overall, and the issue disproportionately affects women of color, particularly Black women in the borough.

During this COVID-19 crisis, the inequities that plague the healthcare system were laid plain for all to see. The death rates among Black and Latino New Yorkers eclipsed those of White New Yorkers, and the death rate in The Bronx is higher than any of the other four boroughs.[23] In July 2020, Borough President Diaz hosted a panel discussion of health disparities in relation to COVID-19, and the situation is even more disparate with regards to maternal mortality. Like with the COVID- 19 crisis, the perspective of local maternal health experts is essential to identify areas for intervention and to propose strategic solutions that may work at healthcare institutions across The Bronx.

THE BRONX BLACK MATERNAL MORTALITY TASKFORCE

Recognizing the increasing rate of maternal morbidity and mortality in The Bronx and across the city, state and country, and recognizing that this crisis disproportionately affects Black women in the borough and beyond, the Office of Bronx Borough President Ruben Diaz Jr. launched the Bronx Black Maternal Mortality (BMM) Taskforce in the fall of 2020. This Taskforce brought together healthcare leadership and leading maternal health advocates from across The Bronx and New York City: to better target the problem, to build a broad coalition of support and expertise around maternal health, to consider the problem through a local lens and to identify possible interventions to address the problem. The focus on the specific challenges faced by women – particularly young Black women – before, during and after childbirth has provided a narrative of health disparities in The Bronx and a better understanding of the state of maternal health in public and private healthcare institutions across the borough.

The members of the BMM Taskforce represented healthcare leadership from both public and private hospitals, leadership from the city's Department of Health and Mental Hygiene and Health + Hospitals, direct healthcare providers from the hospitals, clinics and community-based practitioners from across the borough, advocates on both the local and national levels and policy staff who work on healthcare provision and access. The healthcare providers included doctors, nurses, midwives, doulas, students, hospital administrators and other community-based health workers. Representatives from organizations such as the National Black Leadership Commission on Health, Planned Parenthood and March of Dimes were also members of the Taskforce.

The members of the BMM Taskforce shared ideas and suggested other potential contributors before the Taskforce formally began. The half-day first meeting of the Taskforce on October 14 included a keynote address from the National Black Leadership Commission on Health (Black Health) CEO and former Manhattan Borough President C. Virginia Fields and three breakout discussion groups that articulated specific issues

[23] https://www1.nyc.gov/site/doh/covid/covid-19-data-totals.page

and avenues for improving maternal outcomes in The Bronx. There were three groups focused on: (1) advocacy through policy, (2) changing the narrative in healthcare through staff and patient training and (3) improving outcomes at the hospital level. The ideas generated in these groups and through other discussion form the basis for the recommendations in this report.

The work of this Taskforce is ongoing. Maintaining continuity of communication between patients, advocates and healthcare providers, and ensuring collaboration among hospitals will be essential to develop an effective strategic plan to tackle this crisis in The Bronx. As detailed later in this report, appointing a standing, borough-wide consortium of all stakeholders, with support from the Borough President's Office, will help to shape the critical next steps for this work. The reestablishment of the Bronx Maternal Health Consortium (BMHC) will be the first measurable outcome of the BMM Taskforce.

BRONX BLACK MATERNAL MORTALITY TASKFORCE

Ruben Diaz Jr. – Bronx Borough President

C. Virginia Fields, MSW – President and CEO, National Black Leadership Commission on Health

Participants

Chinyere Anyaogu, MD, MPH - Deputy CMO and Vice Chair of Women's Health Service at North Central Bronx (NCB), NYC Health + Hospitals / Jacobi / NCB

Veronica Ades, MD, FACOG - Vice-Chair, Department of Obstetrics & Gynecology at Jacobi Hospital, NYC Health + Hospitals

Melissa Baker, MPA – Senior VP, National Black Leadership Commission on Health (NBLCH)

Nerys Benfield MD, MPH - Senior Associate Dean for Diversity and Inclusion, Fellowship Director in Family Planning in the Ob-Gyn and Women's Health Department, Montefiore

Sarah Bellinson, RN, MSN, CNM - Nurse Midwife in the Bronx, (31 years at Montefiore)

Jonelle Bingham-Alexander, MD, FACOG, CHCQM - Director of Quality Assurance for Obstetrics and Gynecology, and Ob-Gyn attending, Bronx Care Hospital Center

Evelyn Botwe – Senior Program Coordinator, National Black Leadership Commission on Health

Talitha Bruney, MD – Associate Residency Program Director, Obstetrics & Gynecology, Montefiore

Jacqueline Cafasso - Development Specialist for the March of Dimes, New York City

Melissa Cebollero - Senior Director, Government & Community Relations, Montefiore Health System

Darcy Dreyer - Director of Maternal and Child Health at the March of Dimes, 31 NYS Counties

Anne Gibeau, PhD, CNM - Director of Midwifery at Jacobi Medical Center, NYC Health + Hospitals, New York University Midwifery Education program

Rosemary Hernandez, CLC - Perinatal Health Educator, Bronx Health Link

Sandra Kumwong - COVID Program Coordinator, National Black Leadership Commission on Health

Lewis Marshall, MD, JD, MS - Chief Medical Officer for NYC Health + Hospitals / Lincoln

Maryam Mohammed-Miller, MPA - Manager of Government Relations, Planned Parenthood of Greater New York

Patricia Moncure, MPH - Senior Legislative Analyst, NYC DOHMH

Susan Papera, CNM - Director of Midwifery, North Central Bronx Hospital, NYC Health + Hospitals/ NCB

Marilinda Pascoe, CNM/FNP – Nurse Midwife, NYC Prenatal Exercise

Anita Reyes, MPH - Executive Director of Bronx Neighborhood Health Bureau

Mark Rosing, MD, FACOG - Chair of Maternal Fetal Medicine at St. Barnabas Hospital, SBHS.

Charmaine Ruddock, MS - Executive Director at Bronx Health REACH, Chair of the Board of Directors of the National REACH Coalition

Liz Spurrell-Huss, MPH, LCSW - Director of Community Education at Montefiore Health System

Hal Strelnick, MD – Professor and Chief, Division of Community Health, Department of Family and Social Medicine, and Chair of the Board of Bronx Health Link

Colette Sturgis, MA-MCHS - Director of Maternal Infant Community Health Collaborative (MICHC) at Urban Health Plan

Carmen Sultana, MD - Chief of General Obstetrics and Gynecology, Female Pelvic Medicine and Reconstructive Surgery, NYC Health + Hospitals / Lincoln

Latham Thomas – Doula and Trainer at MamaGlow

Sheila Whitaker - Vice President of Health Centers Operations, Planned Parenthood of Greater New York

Daryl Wieland, MD, MS, FACOG – Chair, Department of Obstetrics & Gynecology, NYC Health + Hospitals/ Jacobi / North Central Bronx

Wendy Wilcox, MD, MPH, FACOG – Clinical Director, the New York City Maternal Mortality Reduction Program; Chair, Women's Health Council; Chair, Department of Obstetrics and Gynecology, NYC Health + Hospitals / Kings County

Paulette Zalduondo-Henriquez - Executive Director, The Bronx Health Link

Bronx Borough President's Team: Deputy Borough President Marricka Scott-McFadden, Policy Analysts Eric Pesner and Alexis Walters, and Dr. Nancy Kheck, Director of Health and Human Services

RECOMMENDATIONS

The convening of the approximately 40 members of the Black Maternal Mortality Taskforce produced a myriad of suggestions and proposals that are coalesced here into several recommendations. These recommendations capture the essence of what participants discussed in the October 14 meeting and reflects the expertise, ideas, solutions and resources put forward by the Taskforce. This is a strong starting point, but the work of eliminating Black maternal deaths will be a long-term endeavor extending far beyond the starting points discussed below. The ideas proposed by the BMM Taskforce will be shaped and refined by the BMHC, and these recommendations will ultimately be implemented across every domain in maternal care. *The overarching goal is for no woman to die or experience life-threatening complications during pregnancy, childbirth or the postnatal period.*

Critically, the very existence of the Black Maternal Mortality Taskforce is a step in the right direction. It has been several years since the healthcare leadership of the borough came together to work on the issue. Restoring the consortium is a vital tool for borough-wide collaboration and problem solving on the issue of maternal health, and it will enable the borough's healthcare providers to improve outcomes and break down the barriers Bronx families face during and after pregnancy. This work will lead to more integrated, supportive and seamless services for expectant and post-partum mothers.

The recommendations below do not touch on everything that the members of the BMM Taskforce discussed, but only the ideas that can be most readily implemented at the local level. Some other ideas discussed include: increased National Institutes of Health (NIH) funding for maternal and child health outreach, a more substantive maternal leave policy for working people (through federal legislation,[24] following the expansion that recently occurred in New York State[25]) and the expansion of private and CDC funding for programs like the **R**acial and **E**thnic **A**pproaches to **C**ommunity **H**ealth (REACH) Initiative which has engaged and supported Black churches to reduce chronic illnesses in their communities. Engaging in advocacy on these issues will be part of the expanded work of the Bronx Maternal Health Consortium.

The Bronx Borough President's Office will work to enact these recommendations, build a consensus on local priorities and strategies and support the consortium's work to reduce the mortality and severe morbidity of mothers in The Bronx. The Borough President and his office will push policy solutions and the legislation at the state and federal levels that can make the most impact. The office will also support the ongoing work of the BMM Taskforce and the Bronx Maternal Health Consortium in their efforts to improve maternal outcomes.

[24] https://www.washingtonpost.com/health/black-baby-death-rate-cut-by-black-doctors/2021/01/08/e9f0f850-238a-11eb-952e-0c475972cfc0_story.html

[25] https://www.governor.ny.gov/news/governor-cuomo-announces-new-yorkers-can-begin-using-new-paid-sick-leave-benefits-starting, https://paidfamilyleave.ny.gov/

Recommendation: Targeting Racial Bias

The Center for Disease Control and Prevention has reported that Black women are two to three times more likely to die from pregnancy-related causes than White women are. Many of these deaths were determined to be preventable. As previously discussed, there are numerous reasons for this racial disparity, and providers and other stakeholders must address the gap through multi-faceted programming.[26] The federal Department of Health and Human Services (HHS) released a report on developing and implementing a Quality Improvement (QI) Plan for healthcare organizations. An effective QI Plan suggests a "continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvements."[27] New York City has implemented this process with the Maternal Health Quality Improvement Networks (MHQIN) and participation of hospitals across the city. Hospitals have created systematic processes with identified leadership, accountability and dedicated resources to implement these plans.

When a mother dies in a hospital from a preventable cause, the hospital and individuals involved should be held accountable, following independent review by the Maternal Mortality and Morbidity Review Committee (M3RC). New York City established this multidisciplinary committee structure to review every case of maternal death – to determine cause, contributing factors and responsibility – and this will inevitably make progress in the reduction of death and injury to mothers. The short- and long-term impact of this review process must be assessed in an evidence-based manner. Reports from the M3RC investigations should be made public in a redacted form so that the woman's family and other stakeholders can understand the findings. Providers should swiftly implement committee recommendations for quality improvements (QI) or face penalties for failing to make changes. State agencies and other governing bodies must use leverage to enforce compliance with best practices – including potential loss of accreditation or state funding – while stakeholders must advocate for transparency and rigorous oversight of facilities where deaths have occurred. A number of BMM Taskforce members serve on the M3RC and MHQIN, and these committees provide a crucial point for continuity between the city's mission of QI and accountability with Bronx hospitals and community organizations at the borough level.

Doctors and other health providers must become more aware of the different way that they listen and respond to patients, depending on the race and sex of the patient. Black women in particular report not being heard or listened to, particularly when it comes to how they report their experiences with pain.[28] There is a history of doctors making false assumptions about pain thresholds of women, particularly Black women, and this can result in life threatening consequences, especially in a labor and delivery context. Providers must be more intentional in listening to their patients and understand that individuals are the best judges of their own experiences of pain and distress. Doctors make more informed decisions when the patient's viewpoints are fully heard, understood and integrated into their clinical decision-making; this leads to the best outcomes.

[26] https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html
[27] https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/developingqiplan.pdf
[28] https://www.today.com/health/implicit-bias-medicine-how-it-hurts-black-women-t187866

The Health + Hospitals members on the BMM Taskforce, from Lincoln, Jacobi and North Central Bronx Hospitals, shared the advances that the public hospitals have made with newly funded simulators and comprehensive programming to model best practices in maternal health care. These programs also use standardized patients in clinical training scenarios to combat biases and promote culturally appropriate care among all staff with patient contact. This work has been progressively rolled out across H+H facilities to provide education about implicit bias using simulation and case-based small group discussions, so medical students and staff can learn firsthand how errors in judgment can result from assumptions and hidden racial bias. The H+H approach is systematically implementing best practices.

All U.S. educational programs that train doctors, nurses and other associated health professionals have embraced some form of anti- bias training to counteract the pervasive effects of racism and to teach the importance of patient-centered, culturally competent care.[29] Doctors who are in residency also need this training. Professionals who have received their medical training abroad may not have developed the social-cultural framework for understanding how much the racial bias of doctors can undermine the quality of care they provide to their patients, whereas it is mandated within the educational standards for all US medical schools. In fact, in The Bronx, there are international medical graduates (IMGs) in residency training at almost every hospital. There is great benefit for patients in having a diverse healthcare workforce because they can see doctors that look like them, have similar life experiences to them and speak their languages. However, this also underscores the need for a standardized approach to implicit bias work, and re-training health professionals at each level of advancement. This creates a uniform high- level standard for all to observe and model, including Black and Hispanic trainees and staff.

Identifying the challenges and opportunities for coordinating anti-bias training across Bronx institutions and in community settings has revealed that many BMM Taskforce members are involved in a number of efforts already underway, including at Montefiore and the borough's three H+H public hospitals (Jacobi, Lincoln and North Central Bronx). While over 90 percent of Bronx residents are Black and Latino and this is reflected in the borough's healthcare workforce, a systematic and rigorous approach to anti-bias training is still essential and must be conducted with every healthcare worker that comes in contact with patients. This work requires extensive investment in time, effort and resources, which smaller private hospitals may not be able to afford. Taskforce participants from Black Health reported that their organization conducts implicit (anti-) bias trainings at medical schools and hospital-based residency programs around the country. They offer a model that any institution can afford and adopt. Early anti-bias education preemptively shapes the conduct of health professionals during training and model culturally competent care in medical education and hospital-based training.

Racial bias can also be reduced through hiring more Black doctors, but several barriers must be broken down for this to occur. One of the major reasons that Black Americans are less likely to enter medical school is cost. The wealth gap of Black households – driven by intergenerational disinvestment and poverty – has rendered many Black

[29] https://www.aamc.org/what-we-do/diversity-inclusion/unconscious-bias-training

prospective doctors unable to attend medical school for financial reasons.[30] Scholarships, unique subsidies or loan forgiveness mechanisms must be considered to create a more diverse medical workforce, especially for those who go into primary care fields like family and internal medicine, pediatrics and obstetrics and gynecology. Additionally, there is a reported perception among young Black Americans that they could not succeed in medicine because they had never met another Black doctor before who could serve as a mentor and role model.[31] In this way, the racial gap perpetuates itself. Eliminating this gap is important – a recent study found that when Black doctors cared for Black babies their mortality rate fell by half.[32]

Research from health education professionals and Black Health's experience with anti-bias work in medical schools and residency programs show that training is best conducted by neutral outside parties, never by anyone in direct reporting relationships with staff, and in environments where difficult conversations about racism can be open, safe, confidential and productive. This is where the effects of hidden and unconscious racial bias are manifested in real life examples of harm, and where biased behaviors must be challenged and unlearned. Hospitals are only as good as their care teams, and this professional development must be ongoing and revisited in teaching cases where bias is implicated in poor care. The effects of training must be periodically evaluated to ensure that these barriers to quality healthcare for women of color are permanently broken down.

March of Dimes' Implicit Bias Training: Breaking through Bias in Maternity Care also provides a useful and effective format to provide training for medical and administrative staff in community clinics and any organization that provides maternal healthcare. The training includes four essential parts: an overview of implicit bias and personal assessment, a historical overview of structural racism in the United States, strategies to mitigate racial bias in maternity care and building a culture of equity within an organization.[33] At a national level, the American Association of Medical Colleges has developed an array of tools, curriculum resources and professional development webinars to help academic institutions address unconscious biases in a standardized way across every level of medical training and practice.[34]

Research on implicit (and explicit) bias in healthcare shows that it plays a role in the mortality rate for Black mothers, and this training must be incorporated into systematic quality improvement initiatives. California has been leading the way in trying to curb this health crisis – they have decreased their mortality rates by investigating and identifying opportunities for interventional programming and using data to drive change and standardize clinical OB-GYN practices to improve these outcomes. As a result the state maternal mortality rate has reduced by approximately 55 percent.[35]

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[30] https://www.nbcnews.com/health/health-news/why-dearth-black-men-medicine-worrisome-n885851
[31] https://www.auamed.org/blog/why-are-there-so-few-black-doctors-in-the-u-s/
[32] https://www.washingtonpost.com/health/black-baby-death-rate-cut-by-black-doctors/2021/01/08/e9f0f850-238a-11eb-952e-0c475972cfc0_story.html
[33] https://www.marchofdimes.org/professionals/professional-education.aspx
[34] https://www.aamc.org/what-we-do/diversity-inclusion/unconscious-bias-training
[35] HEALTH AFFAIRS VOL. 37, NO. 9: CALIFORNIA: LEADING THE WAY? Addressing Maternal Mortality And Morbidity In California Through Public-Private Partnerships, Authors: Elliott K. Main, Cathie Markow, and Jeff Gould, https://doi.org/10.1377/hlthaff.2018.0463

The BMM Taskforce also explored the beneficial use of patient-centered providers at birth such as midwives and doulas, in providing patient education to improve health literacy, and how they can empower and frame the expectations of pregnant women long before they go into labor. Training staff about racial bias is part of a comprehensive organizational toolkit, which must also include education of patients on their rights, personal advocacy and responsibilities. Actively preparing mothers for birth at the hospital, in community-based workshops and via educational outreach programs can have a profound positive impact on women's birth experiences.

These tools empower mothers to advocate for themselves during one of the most dangerous moments in their lives – giving birth. The New York City Standards for Respectful Care at Birth are a basis to inform, educate and support women in making decisions before, during and after labor.[36] It is the BMM Taskforce's consensus that birth workers, CHWs and staff affiliated with maternal health services should be aware of these standards for patient education and that training offered by DOHMH for how to use these standards should be conducted that all Bronx hospitals as well as major community-based maternal health clinics.

Recommendation: Improving Health Coverage and Care Services

One of the most enduring challenges in healthcare, particularly in low-income neighborhoods and communities of color, is adequate and equal access to quality care. This disparity naturally extends to maternal and perinatal care. The BMM Taskforce identified several areas where coverage and care services should be expanded and improved.

Low-income families are disproportionately likely to get their health insurance coverage through Medicaid. Medicaid in New York has limitations and possible areas for change that would improve outcomes for women in the birth process. First, the post-partum period under Medicaid should be extended beyond its current 60-day period. When a woman gets access to Medicaid for pregnancy-related reasons, the coverage lapses after 60 days. However, a significant number of maternal deaths occur beyond this 60-day period.[37] Therefore, this post-partum period should extend to a full year after birth. There is legislation pending at both the state and federal levels to do this. The State Legislature should consider moving forward on the Bill NY S01411 in 2021.[38]

Second, New York's Medicaid program must reconsider its coverage of doula services. While the state began a pilot program in 2019, the program must be expanded.[39] The pilot extended only to Brooklyn and Erie County and grossly undervalued fees for doula services. Other states such as Virginia are moving to expand their doula reimbursements, and New York should act to achieve parity with other progressive states that have invested in maternal health. If the reimbursements remain unreasonably low, making it unsustainable for the doulas to take on Medicaid patients,

[36] https://www1.nyc.gov/assets/doh/downloads/pdf/ms/respectful-care-birth-brochure.pdf
[37] https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage
[38] https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=S01411&term=2021&Summary=Y
[39] https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm

this will continue to prevent many low-income women from accessing potentially life-saving services.

The COVID-19 pandemic has reaffirmed the importance of nurses and other hospital workers to the care and treatment of patients in New York's hospital and clinics. These workers – including labor and delivery nurses, midwives and breast-feeding specialists – are an essential part of the pregnancy and birth process and their number should be expanded to meet the need. There has been a decline in the funding streams available for hospitals to provide some of these services, forcing doctors into roles that other health professionals are better suited to manage. Reversing this trend of minimizing the labor and delivery team will help to improve maternal health outcomes and minimize mortality and morbidity.

It is important for Bronx health leaders to reevaluate the role of all birth workers in local communities. They provide an essential role in ensuring the health and well-being of mothers and their newborn children. Birthing facilities must do needs assessments to ensure that mothers are well-supported and that birth workers are engaged at a sufficient level. Expanding capacity is essential to connecting higher risk patients with these services. Otherwise, young women of color will continue to face disproportionately adverse outcomes.

Government and private health insurers should also cover early childhood home visitation programs to support at risk women. Several taskforce participants, nurse midwives from H+H Jacobi Hospital, are involved in delivering this type of care (although scale is limited by available funding), and only for first-time young Black mothers. Midwives in the "Nurse-Family Partnership" program focus on personal health, maternal and child life-course development, from pregnancy to the child's second birthday. Jacobi midwives have innovated to create prenatal exercise regimens and networking opportunities (e.g. walking dates) for these young expectant mothers. This model incorporates multiple best practices and is a priority for potential expansion in The Bronx. Retired nurses, doulas and midwives would be prime candidates to expand the corps of providers that make these home visits, to examine mother and baby, answer questions and provide individualized support and patient education. It would require broad funding from federal agencies and collaboration by the Bronx Maternal Health Consortium members to write the grants and conduct strategic planning with community partners for how to expand this model program in the Bronx.

The COVID-19 pandemic has also demonstrated that the expanded use of telehealth services connects patients more readily and effectively with their healthcare providers. Perinatal services should be supported in the same way. But because of the Digital Divide, the low-income women most at-risk for complications in pregnancy and childbirth are also the least likely to have access to these internet and digital technologies. Increasing use of technology to connect providers and patients must not leave out the women who most need pre- and post-natal consultations.

Recently released research from Montefiore on tele-health showed most patients expressed very high levels of satisfaction via phone contact, whereas video-conferencing presented challenges. Additionally, there are billing ramifications to take into account, with insurance often favoring video over engagement via regular audio

phone service. The convenience and the flexibility offered by remote care are still high and represent potential avenues for the consortium to seek infrastructure funding as well.

Bronx Healthy Start Community Workers are also getting trained and working on the Valera smart phone app. Use of both audio and video capacity supports training in the "Centering Pregnancy" program for high risk women getting prenatal care at North Central Bronx and Jacobi Hospitals. Competition that may have divided public and private hospitals in the past is not an issue with shared programs like the Healthy Start partnership. This health issue represents a nexus of purpose and commitment to support mothers in the Bronx; having sufficient federal funding levels the playing field, limits competition for profit and makes the positive outcomes of such partnerships the more powerful incentive. A major goal for the Bronx Maternal Health Consortium is to expand funding for community-based programming in the borough.

Recommendation: Doula Advocacy & Access

During pre- and postnatal visits, there is an important support function for the mother when someone else is there to help her negotiate the encounter: to hear numerous observations, medical information and care recommendations pertaining to her pregnancy. Everyone should have a family member or friend in the perinatal care regimen and it need not be a spouse, relative or the father of the baby. This advocacy role can also be fulfilled by a professional doula. Doulas are essential to the well-being of the mother; they may note and communicate key observations to inform the doctor of maternal health concerns. Since the Bronx is at the bottom of New York State health rankings, at #62 of all New York counties, it is highly possible that expectant mothers will have some underlying health issues. The caregiver who participates in the mother's care can be a lifesaver and presents the doctor, midwife and other providers with the opportunity to make a more effective and meaningful connection with the mother through this advocate. The first step in addressing the need for more patient-centered prenatal care is creating more options for expectant mothers. Redefining and expanding the role of doulas would create a new normal for mothers in supportive maternal care.

With that extended care team concept, Montefiore's Department of Obstetrics and Gynecology has been raising funds through grants and philanthropy for expansion of the Community Health Worker (CHW) network and doula access for patients. There are some incredible doula programs, but many are oversubscribed and unaffordable for patients. Doula access is one way for those women who do not have a partner or advocate who is experienced with the birth process, to engage a dedicated support person for their pregnancy. The CHW infrastructure is critical, and current telemedicine research has found that women are responsive to that model and find it a convenient option. The COVID-19 pandemic is proving that innovations born out of necessity are pivotal; telemedicine can change the post-partum care paradigm and more easily enable providers to reach out into the community to access new mothers or early pregnancy patients. It could be transformative in providing greater access to care for all patients, not just expectant mothers.

There is consensus amongst OB-GYN providers that doulas provide essential support to mothers and that they can facilitate the exchange of vital patient information at the point of delivery, which improves outcomes. Working towards expanded doula coverage would be valuable to all patients, but the ones who can afford it need it the least, whereas most Bronx patients cannot afford it but need doula services the most. It is ironic that the state has mandated that doulas may be present for births during the COVID-19 pandemic but does not adequately fund doula care. The New York State Medicaid Doula Pilot Program pays only $500 per patient for doula services – an insufficient reimbursement of their longitudinal clinical services, which is typically from the third trimester through the labor and delivery and into the post-partum period to support nursing and infant care. Members of the BMM Taskforce proposed expanding this pilot and increasing its reimbursements so that more low-income women have access to these essential services. Other states such as Virginia provide much higher rates of reimbursement – up to $2,500 per patient.

For a long time, there has been a misperception of doulas as a "birth companion"; however, their role has evolved to something more like a maternal care coordinator. Doulas advocate for and provide a range of services like patient education, an early warning system and arranging medical transport and specialty appointments, as well as their traditional role in supporting patients through labor and delivery. Legislators must better understand what doula care is really about; they provide vital support services that demonstrably improve health outcomes for mothers.

New York needs to restructure the payment to doulas, as well as to the community-based organizations that help to bring these services to mothers. The Bronx Health Link was originally the nonprofit fiscal conduit for "Healthy Mothers, Healthy Futures" that provided Bronx mothers with doula services, funded by the city DOHMH. Over the past decade, funding mechanisms were reorganized in ways that have been detrimental to The Bronx. Currently all support to New York City is now coordinated though one agency in Brooklyn, the Caribbean Women's Organization. This does not work for Bronx expectant mothers seeking services because they must travel to Brooklyn to access them. Moreover, the Medicaid pilot was limited to just one site in Brooklyn and one Upstate. The Bronx is a very young borough, with a rapidly growing population of families.[40] These restrictive points of access to state and federal programs for mothers are contributing to greater disparities in the borough.

The flow of public funding must be revised on this issue: these services must be deployed in a more effective and equitable way, and there must be reform in the way doulas qualify as Medicaid providers, whether as independent "fee for service" providers or working as part of a Federally Qualified Health Center (FQHC). Doulas provide comprehensive maternal care, and OB-GYN providers should fully integrate them into the birth team. There are already small organizations like Bronx ReBirth (a collective of doulas that helps support mothers in need) engaging in community-based networking. Working with organizations to coalesce services around underserved

[40] Via NYC Department of Health and Mental Hygiene statistics, https://www.census.gov/quickfacts/bronxcountybronxboroughnewyork, https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=36005&top=2&stop=1&lev=1&slev=6&obj=1&dv=ro#:~:text=The%20birth%20rate%20in%20Bronx,1%2C000%20women%20ages%2015%2D44.

patients across the borough may be another avenue for seeking funding and bringing together existing networks to support maternal health initiatives.

The birth worker community in the Bronx should organize to represent what is available to all patients in this landscape. The full scope of services for prenatal, birth and post-partum care must be better identified. There are midwives who have private practices and offer specialized care for out of hospital births and doulas that serve as breast-feeding specialists. There is a Doula Coalition that has been advocating at the citywide level (and asking for Mayoral and City Council support) on some of these issues, and to support and expand the reform of financing for doula services and recognizing their comprehensive and longitudinal experience as well as the improved outcomes in terms of morbidity and mortality.

CHWs, nursing staff, midwives and a wide range of providers must have this kind of collaborative effort and representation. Supporting additional direct patient-centered support through the pregnancy and peri-partum period will be a win-win situation.

Recommendation: Addressing Communication Barriers Within and Among Hospitals

Care of new and expectant mothers is interdisciplinary, and it is important to critically review how all members of the clinical team that are involved with patient care are trained to observe and interact with patients. Ideally, this should be part of an annual plan for quality improvement. The physician is often the last one left holding the baby, but much effort and teamwork goes into safely bringing the mother to that point. Training the health workforce to be able to achieve optimal outcomes and have everyone feel responsible and invested as part of the team is an overarching goal for all healthcare organizations. Key principles of operations management have been imported from the business world to hospitals, and one of the most essential is that once best practices have been established, the system must eliminate variability from that protocol. In medicine, this translates into reducing medical errors and saving lives. When something deviates from the norm or goes wrong during labor, effective communication makes a fundamental difference in patient outcomes.

Hospitals must improve communication within their institutions. Severe maternal morbidity or mortality is often associated with operative deliveries and with women who have chronic underlying illness or may be acutely ill. Mothers may come in with hidden illnesses or warning signs that may not be recognized or accessible via their contacts and records. Given the number of staff that engage with the patient upon intake, when the mother is admitted in crisis condition it is important to have access to this relevant information, whether through emergency response, emergency department staff or other mechanisms to increase interdepartmental awareness. Continuous updating of information will lead to better tracking of what is happening with any pregnant women in distress and can therefore improve outcomes.

OB-GYN physicians have improved their practice through simulation trainings, obstetric life support and in responding to conditions like acute hemorrhage, but the primary staff members in close contact with the mother are not necessarily physicians and thus do not have the same knowledge or experience. It is critical that all team

members understand that women present with less clearly defined signs of cardiac distress and symptoms may be subtle when she gets to the emergency department. Additionally, women are more likely to put off reporting symptoms or seeking treatment, and critical information may be lost unless providers communicate about how every patient must be handled systematically to catch these diagnoses when they occur. This must not only be taught and trained, but also tracked with metrics to prove that this level of monitoring the patient is actually happening. This is an essential component of QI.

Very often, women go to a hospital for delivery where the mother has not had prior care. Patients often assume that any healthcare provider can access their medical records, even when the care was at a different institution. However, this is generally not the case. Treating the patient holistically often requires a provider to contact the patient's past providers to get them to release and send along the patient's records. Community-based clinics in particular refer patients to deliver at acute care facilities that may not have access to the patient's charts. *This must change to facilitate open access of patient records across The Bronx.*

Hospitals in New York enter their medical records into a State Health Information Network (SHIN-NY) via Regional Health Information Organizations (RHIOs), this serves as a hub for patient health information among hospitals, providers, health plans and public health officials in a secure and confidential manner.[41] Over 84 percent of hospitals, 50,000 providers and 34 health departments contribute through one of the ten RHIOS across New York, and over seven million patients have consented to share their record statewide. In New York City, the private and public Health + Hospitals facilities and community-based clinics are variable in use of their local RHIO as a shared platform. The clinical chairs on the BMM Taskforce recognized this is an area for intervention because each institution uses one or more type of electronic medical record (EMR) system, and none are shared by all six hospitals in The Bronx.

For the H+H system and Montefiore, using EPIC has been a game changer for sharing labs and looking at trends over time from other institutions, and several Taskforce members think that expanding this to include imaging data would be most helpful to improve care. Montefiore has created specific staff roles to improve connections with the community health centers so that this information can be readily shared. Approximately 40 percent of patients that deliver at Montefiore hospitals get prenatal care elsewhere, so access is key. The "Pregnancy Passport" program addresses this issue and is part of a patient education process; patients get a virtual tour of where they will deliver, how to get specialty services and how to coordinate services in advance. It also helps to train the clinic staff for how to better interface with the hospital and to get patients familiar with what to expect when they arrive at the hospital to deliver. H+H facilities also use the Pregnancy Passport to incorporate all pregnancy-related data and have extended it into the fourth trimester or post-partum period, so mothers and their providers are never without access to vital health data. This is a best practice and one that can be readily shared across the borough.

[41] https://www.health.ny.gov/funding/single_source/c029652_comb.htm

Hospitals in The Bronx provide information to the Bronx RHIO for other facilities to access because they use other EMR systems (for example, one uses Centricity for Labor & Delivery and All-Scripts for other uses, while others use EPIC). Smaller outpatient community-based practices that provide maternal health services may operate outside of a hospital system and for technical and financial reasons do not participate in the local Bronx RHIO. It is important to remedy that variability to ensure that patient information is transparent and accessible. The state and city must facilitate a uniform playing field and invest in local infrastructure in underserved communities to help community-based providers gain access to the premier EMR systems like EPIC. Large health systems have used them to develop pragmatic solutions in response to urgent and evolving needs. For example, with the COVID-19 pandemic, the leading city hospital systems were able to facilitate sharing without many of the obstacles that have hindered this in the past.

There are several ways to share an electronic medical record. Bronx public hospitals, H+H Jacobi, North Central Bronx and Lincoln, have an opt-in/opt-out option to be able to share patient data through the *Care Everywhere* feature on EPIC (for sharing across Epic EMRs). H+H also uses Epic *Care Quality* (to share across different EMRs). NYC H+H is part of the largest RHIO in the state (Healthix) and the good news is that all RHIOs share their data with the state SHIN-NY, which allows information exchange between the RHIOs. However smaller hospitals, community-based clinics and providers that cannot afford EPIC are left out. The fact that hospitals use different EMR systems and it varies how EMR access is shared, remains a point of disconnect for patients' health information across the borough. Everyone shares with the State but solutions could be more local. The H+H system has taken the concept of a Pregnancy Passport to a new level and implemented a portable patient health record; "MyChart" is a feature of EPIC that allows *patients* to access and review their EMR any time, as well as share them with any provider they choose. During the COVID-19 pandemic, MyChart has been instrumental in the New York City Test and Trace program for maintaining portable records of citywide testing data and results. Imagine if all maternal health providers had access to such tools.

It is a timely for Bronx healthcare providers to collectively work on making records from proprietary systems fully accessible to serve patients independently of where they are treated; this would be a crucial step forward. Knowing what a patient has been treated for, where they have been treated and their lab results could make a huge improvement in the type of care they receive in an emergency room situation, and this is clearly relevant to the discussion of how to improve labor and delivery for mothers who come to the hospital in crisis condition.

However, there is a high level of investment involved in the RHIOs and EMRs and this involves fiscal decisions that span not just across The Bronx, but throughout New York City and are made more complicated by the COVID-19 pandemic. Federal funding sources must be identified and secured to build this type of infrastructure connectivity. The state regulates hospitals and must support a unified strategy for all hospitals and providers to connect patient EMR data across The Bronx and New York City. This will take time and an infusion of funding. While this is moved up the hospital executive leadership ranks and the City and State Departments of Health, hospital leadership

needs to put into place interim strategies – smaller changes that do not require moving policy and financial mountains.

Recommendation: Improving Patient Education

According to the CDC, approximately 60 percent of pregnancy deaths in the U.S. are preventable;[42] members of this Taskforce concur. Acute patient cases often show up at the hospital, in a facility they have never been to before, with conditions that are life-threatening to the mother, baby or both. This is a common scenario, but an avoidable one. To catch the patient's condition before they show up in the hospital in a critical condition, the BMM Taskforce discussed prevention through targeted patient education.

Effective patient education can occur through the healthcare institutions, at or in between visits and in a way that is tailored to the patients and their lifestyles. The patient training must also be data-driven, timely and consistent, so it makes sense for the parents and helps them learn what early warning signs should send them to seek care and to make informed decisions about their birth plans. Ideally, all institutions should provide the same patient education so, no matter where patients give birth, there is parity across sites. The Bronx Maternal Health Consortium can achieve this through collaboration.

Additionally, providers must recognize the diversity of The Bronx and the city as a whole. Numerous languages are spoken in this city, but most resources are available in only English and Spanish. Some other large language communities get health material from on the ground community organizations. However, other languages such as Bengali or Albanian are spoken in many areas of The Bronx but are much less likely to have resources written for their speakers. [*Jacobi hospital has a practice that provides this for Albanian patients.] Providers and hospitals must be aware of these potential language barriers and take steps to engage with patient navigators and translators who speak these languages. It is another way to ensure that all mothers can fully grasp what symptoms to be aware of and what to expect during the birth process.

Providers must also look at alternate models in how to best communicate with and educate pregnant women of all ages to help them feel more connected and physically and mentally prepared for birth. The National Institute of Nursing Research at the NIH is promoting a "longitudinal" patient education model for perinatal care. Better communication makes patients learn more effectively and comprehend what happened to them before, during and after their labor and how those events will affect their future reproductive health and subsequent pregnancies. In this way, patients are actively engaged as a "partner" in managing their maternal care. The benefits of this approach are evident.

Healthcare organizations should also collaborate with local organizations and host local drives for medical care with physicians to learn more about the community. The March of Dimes Early Entry into Prenatal Care report states that good patient care comes with knowing community partners.[43] The organization addresses learning about

[42] https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html
[43] https://www.marchofdimes.org/professionals/professional-education.aspx

patient populations and understanding the community context and the available resources to have a better patient and physician experience. Patients can also expand their knowledge of proper care by accessing maternal health resources through public health and advocacy organizations early in their pregnancy. Hospitals should engage in a collaborative effort with local community leaders, stakeholders, organizations and government agencies. This effort leads to finding ways to standardize education across the borough. Hospitals and community-based organizations should expand patient education and make care more accessible and convenient for patients. In the age of social media, organizations can market their services with publicity, marketing materials and word of mouth.

Educating young Black women about reproductive health and resources can contribute to patient education early, long before pregnancy. For example, the National Black Leadership Commission on Health, a partner in this Taskforce, hosted a Young People Initiative Program to educate young people about their bodies and consent. The informative programs support personal development and teach young people about maintaining healthy lifestyles and habits, which will ultimately lead to healthy pregnancies. Churches in the community have congregations that range in age and can share validated health information to educate future patients and mothers.

The best way to measure improvement in maternal care is to select quality metrics that apply to an end goal and develop trends. Patient and public involvement in research for funding decisions should be a priority. The Research Prioritization by Affected Communities (RPAC) used local women to identify and prioritize their unanswered questions about pregnancy, birth, neonatal care and treatment so their views can better inform research funders and researchers.[44] Information from research can guide programs such as the New York City Standards for Respectful Care at Birth implementation and citywide training of patients and hospital staff.[45]

Recommendation: Making Black Maternal Mortality a Public Health Priority

While the salience of the maternal mortality crisis has increased over the past few years, there is still more work to do to increase public awareness and political progress on the issue. The BMM Taskforce brainstormed ways to improve outreach to the public, healthcare providers and policymakers who could have a large impact on how this crisis is handled.

One focus of the Taskforce was the importance of coalition building to raise awareness and make change happen on this issue. A broad coalition with many voices around the table is better able to initiate and facilitate meaningful and progressive change. The BMM Taskforce policy members brought up bringing in clergy, community voices and groups that normally do not focus on maternal mortality issues to be inclusive of many perspectives and to gain traction in doing health outreach work. In this way, advocates for improving maternal outcomes will have a broad base and deep reach into Bronx communities.

[44] https://pubmed.ncbi.nlm.nih.gov/29364217/
[45] https://www1.nyc.gov/site/doh/health/health-topics/sexual-reproductive-justice-nyc.page

The policy group also talked about ways to drive home the importance of addressing maternal mortality and morbidity to elected officials and others who do not directly experience the effects of this crisis. One BMM Taskforce member brought up using "shock tactics" to impart the seriousness of the situation. She talked about using the statistics as well as the stories of individual women – both those who survived and those who did not – to better make the case. This evidence-based approach of communicating with elected officials is key. Numbers matter and they make sense. By understanding the horrible effects that maternal mortality and morbidity can leave on women and their families, the people in the best position to advocate for change will be more informed to make those changes.

Borough President Ruben Diaz Jr. has raised the visibility of Black maternal mortality and morbidity to a high priority on his health agenda. Through the work of the BMM Taskforce and the reestablishment of the Bronx Maternal Health Consortium, the Bronx Borough President's office will ensure the continuity of this important work. This body will act in concert with the Borough President's Office to ensure that lines of communication are kept open between all Bronx providers and that reducing maternal mortality remains a shared goal and priority for the borough.

Recommendation: The Bronx Maternal Health Consortium

Establishing the Bronx Maternal Health Consortium (BMHC) is the first step in implementing the recommendations of this Taskforce. The appointed members of this body will be maternal health leaders representing every hospital and federally qualified health center (FQHC) that delivers these services, as well as advocacy and community organizations dedicated to this work in the Bronx. The work of the BMHC will be to conduct strategic planning and to engage their organizations' leadership in supporting the BMM Taskforce's recommendations and ways to implement them. The consortium will meet three or four times per year to plan, implement recommendations, assess progress and review maternal health outcome data from all over The Bronx. The overall mission of the BMHC is simple: to eliminate maternal morbidity and mortality in The Bronx.

Key objectives for the clinical team are to build consensus around shared priorities and to identify avenues for collaboration and potential funding of the consortium priority projects. A significant motivation for convening this Taskforce was to explore how Bronx stakeholders can work to restore federally funded community-based programming to mothers in The Bronx. This alone can change the narrative for vulnerable mothers in the borough. In the long term, the consortium should evolve to become a hub for academic and administrative leaders and maternal healthcare workers from hospitals, clinics and community organizations to share resources, services and opportunities. The investment by professionals serving patients in The Bronx will create an academic community, opportunities for small regional conferences, sharing of best practices, training opportunities and ways to keep the goals of improving maternal health at the forefront, progressively pushing forward.

Plans for the first meeting of the consortium in spring 2021 will be to discuss facilitating the DOHMH training for providers at Bronx institutions in Respectful Standards of Care

at Birth.[46] Borough-wide patient and staff education on these birth standards is another key outcome for this Taskforce and a way to partner with DOHMH and funded programs like the Birth Justice Defenders (established to serve the needs of uniquely vulnerable women with substance abuse issues in The Bronx). This first initiative is not contingent upon financial resources, but will be fueled by human resources and the motivation of BMM Taskforce members to quickly move to continue this work, with definitive steps to empower women, improve health literacy and birth outcomes for Bronx mothers.

Conclusion

Addressing the rising rates of Black maternal mortality and maternal mortality as a whole will take a national effort with a local focus. The work of the BMM Taskforce is just the first step in establishing a unified strategy to eliminate these needless deaths and will be continued by the work of the Bronx Maternal Health Consortium. The Bronx has particular health challenges stemming from decades of disinvestment and discrimination that necessitate an increased focus on these challenges. Combatting these health and healthcare issues has been a priority for Borough President Diaz during his time in office and tackling maternal mortality is the most recent effort on that front.

The past twelve months were challenging for communities here in The Bronx and across the country. But the lessons learned from the dual epidemics of COVID-19 and racial injustice can inform the work that Bronx healthcare leaders do to end the preventable maternal deaths that plague the borough. Recognizing that the disproportionate risks that young Black women face during pregnancy and childbirth due to racial bias, poverty and low healthcare access can help inform the solutions that ensure every woman survives pregnancy. Together, The Bronx can lead the way to end Black maternal mortality.

[46] https://www1.nyc.gov/assets/doh/downloads/pdf/ms/respectful-care-birth-brochure.pdf