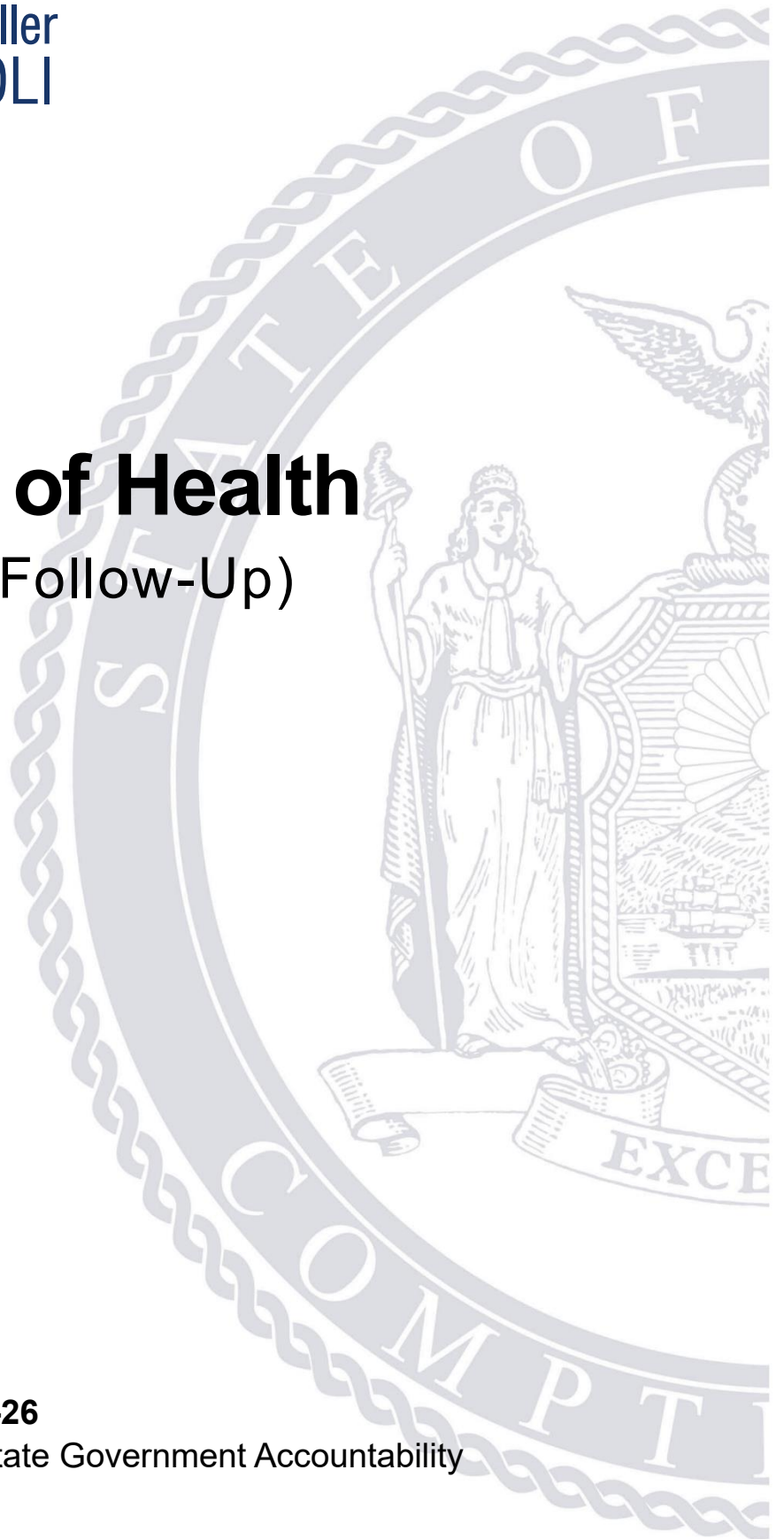


New York State Comptroller
THOMAS P. DiNAPOLI

Department of Health

Maternal Health (Follow-Up)



April 2026 | Report 2025-F-26

Prepared by the Division of State Government Accountability

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Authority

Pursuant to the State Comptroller’s authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health (DOH) to implement the recommendation contained in our audit report, *Maternal Health* (Report [2022-S-25](#)).

Background, Scope, and Objective

One key indicator of the overall health of a population is its occurrence of maternal mortality and morbidity. Maternal mortality refers to deaths of pregnant persons during pregnancy or within a year of the end of pregnancy. Morbidity refers to having a disease or a symptom of disease, or to the amount of disease within a population; whereas severe maternal morbidity (severe morbidity) is defined as unexpected outcomes of pregnancy, labor, or delivery that result in short- or long-term consequences to a person’s health, including postpartum depression and any life-threatening medical complications or the need for life-saving interventions during delivery.

According to Centers for Disease Control and Prevention (CDC) 2023 data, the United States has a maternal death rate of 18.6 deaths per 100,000 births. There are also persistent racial and ethnic disparities in these deaths, with Black women dying nationally at a rate three times higher than White and Hispanic women. These disparities were exacerbated during the COVID-19 pandemic.¹

New York has made progress in comparison to other states: Once ranked 46th among other U.S. states in 2010, it climbed to 17th with a maternal mortality rate of 22.4 deaths per 100,000 live births for 2018 to 2022. However, despite this progress, Black women were still dying at a rate over three times higher than White women. The cesarean section rate is also a significant factor in maternal deaths. According to CDC data, New York’s cesarean section rate improved slightly from 34.1% in 2021 to 33.9% in 2023, but it is still higher than the national rate of about 32% for both these years. According to a June 2023 U.S. Department of Health and Human Services press release, nationally, severe morbidity cases are on the rise, increasing from 146.8 per 10,000 discharges in 2008 to 179.8 per 10,000 discharges in 2021—a 22% increase.

To address these alarming rates, New York established the Taskforce on Maternal Mortality and Disparate Racial Outcomes (Taskforce) in April 2018, which produced 10 recommendations to reduce maternal mortality rates and racial disparities. Two of these recommendations called for DOH to convene a statewide expert work group (Work Group) to optimize postpartum care and for New York State to establish a maternal mortality review board (Board). In 2019, Public Health Law Section 2509 officially established the Board and an advisory council on maternal mortality and morbidity. Generally, the Board is required to review all maternal deaths in New York State to determine cause and preventability; report its findings, recommendations, and best practices to DOH’s Commissioner; and issue a public report at least every 2 years. The report, released in

¹ [U.S. Government Accountability Office. Maternal Health: Outcomes Worsened and Disparities Persisted During the Pandemic. October 19, 2022.](#)

April 2022, reviewed 2018 maternal deaths and included 14 additional recommendations. The recommendations required a collaboration between public and private entities, with DOH being a main player in the majority of the recommendations. Further, the Work Group ultimately issued four recommendations in January 2021.

New York State's 2019–2024 Prevention Agenda (Prevention Agenda), developed by the State's Public Health and Health Planning Council and DOH, is New York State's health improvement plan—the blueprint for State and local action to improve the health and well-being of all New Yorkers and to reduce health disparities for populations who experience them. One focus in DOH's Prevention Agenda is maternal and women's health, including a goal to reduce maternal mortality and morbidity in New York and an objective to decrease the rate of severe morbidity.

The objectives of our initial audit, issued on July 30, 2024, were to determine whether DOH had implemented recommendations with the goal of reducing maternal mortality and morbidity in New York State; and whether DOH was effectively monitoring related actions and outcomes to ensure rates of maternal mortality and morbidity are improving. The audit covered the period from January 2018 through December 2023. The initial audit found that while DOH had made progress in addressing the recommendations to improve maternal health in New York State, data from the CDC and DOH showed that maternal mortality and morbidity rates in New York State had not decreased since the Taskforce was established in 2018, and the maternal mortality rate had actually increased, along with increasing racial disparities statistics. We found that DOH needed to do more to ensure that maternal mortality and morbidity rates decline. DOH had not evaluated all of its maternal health programs and, therefore, was unable to determine whether its efforts had made an impact on improving maternal health outcomes. In addition, DOH did not collect severe morbidity data and had no analytic strategy to evaluate it, thus limiting its ability to effectuate change. Further, DOH conducted limited outreach with other agencies and private sector partners to understand their lack of participation in DOH maternal health programs. More robust outreach would likely increase participation of these programs and positively affect mortality and morbidity rates.

The objective of our follow-up was to assess the extent of implementation, as of March 2026, of the one recommendation included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

DOH officials made significant progress in addressing the issues we identified in the initial audit report. The one recommendation in the initial report was implemented.

Follow-Up Observations

Recommendation – Evaluate progress and impact on maternal health to assess the effectiveness of the programs aimed at improving maternal health outcomes. This should include but not be limited to the following:

- Develop objectives, as appropriate, and implement monitoring and evaluation processes to assess the effectiveness of programs and projects aimed at maternal health outcomes.

- Identify and analyze severe morbidity data and develop a strategy to address risks.
- Increase outreach and collaboration efforts with birthing hospitals and other involved entities (such as providers and applicable agencies) to maximize participation in efforts to decrease maternal mortalities and morbidities.

Status – Implemented

Agency Action – Since the initial audit, DOH has integrated objectives, as well as monitoring and evaluation processes geared toward those objectives, in its programs and projects aimed at maternal health outcomes. During our follow-up, we reviewed program documentation for a sample of six initiatives focused on addressing maternal health outcomes. Of the six initiatives, four had been created prior to our initial audit and two were new initiatives established within the past 2 years. We found that DOH had objectives and monitoring and evaluation processes to assess the effectiveness of all six initiatives we reviewed. For example, in August 2024, DOH created the Universal Virtual Home Visiting pilot project. This project pairs a community birthing hospital with an existing maternal and infant home visiting program that serves an overlapping geographic area. The community-based organization conducts virtual home visits by trained community health care workers to newly postpartum individuals after they are discharged from the hospital, providing support, resources, and education. DOH developed SMARTIE (Specific, Measurable, Attainable, Relevant, Time-Based, Inclusive, and Equitable) objectives for the project. It also developed data collection systems, process and outcome measures, and performance indicators. DOH requires participating hospitals to track and submit their activity on a quarterly basis, and DOH analysts and evaluation specialists will monitor and evaluate whether the project has made an impact on improving maternal health.

In addition, DOH has dedicated resources to identifying and analyzing data on severe maternal morbidity. Since our initial audit, DOH has analyzed hospital discharge records for delivery hospitalizations from its Statewide Planning and Research Cooperative System (SPARCS) to better understand the issues and determine steps to address them. In May 2025, DOH published a report titled *Severe Maternal Morbidity in New York State (2017–2022)*, based on its analysis of SPARCS data. The report presents severe maternal morbidity rates and trends, including geographic and demographic breakdowns and key indicators of severe maternal morbidity in New York State between 2017 and 2022, based on SPARCS data. The report also identifies steps DOH is taking to address severe maternal morbidity. According to officials, DOH will continue to monitor maternal morbidity data and adjust its programs accordingly. As of March 2026, DOH had already analyzed data through 2024 and plans to publish an updated report in December 2026.

DOH has also increased outreach and collaboration efforts with birthing hospitals and other involved entities to help improve participation in efforts to decrease maternal mortalities and morbidities. Officials provided information on 14 programs and initiatives they have implemented to boost these efforts. One example is the Perinatal Project Extension for Community Healthcare Outcomes (Project ECHO), which was launched by DOH in March 2024. Project ECHO provides clinical provider education by connecting health care providers and subject matter experts through videoconferencing, featuring brief lectures and case-based learning. DOH also established multiple other training initiatives in 2024 and 2025:

- A partnership with an upstate New York hospital and its affiliates to pilot a subscription to Relias, LLC's *Optimizing Obstetric Outcomes* training program, which focuses on maternal safety measures.
- Collaboration with professional associations to develop a webinar, *Care of Pregnant and Postpartum Patients in the Emergency Department*, which took place in January 2025 and is accessible online for health care providers.

Furthermore, throughout 2024 and 2025, DOH conducted additional outreach and engaged with various entities, including regional perinatal centers, midwifery practitioners, and professional associations, to discuss issues related to maternal mortality and morbidity. In September 2025, DOH launched a media campaign called "Hear Her," targeted at clinical providers. This campaign used social media and digital billboards statewide to raise awareness about recognizing early maternal warning signs during pregnancy and postpartum, urging providers to discuss these with their patients.

We thank the management and staff of DOH for the courtesies and cooperation extended to our auditors during this follow-up.



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