July 2020

Giving Birth in a Pandemic: Policy Recommendations to Improve Maternal Equity During COVID-19

Introduction

The Massachusetts COVID-19 Maternal Equity Coalition's mission is to develop policy recommendations for equitable, evidence-based perinatal care to drive change in the Commonwealth during the COVID-19 pandemic. We are an interdisciplinary advocacy body that centers the voices of Black and brown women and people who give birth,[1] referred to throughout this report as "birthing people." We aim to promote both consistent clinical best practices and community-informed practices for perinatal care and advance racial equity in outcomes using an antiracist approach.[2]

Box 1: Disparities in Maternal Mortality and Morbidity in Massachusetts

- Black women are twice as likely to die from pregnancy-related causes as white women.
- Black women are twice as likely to have severe maternal morbidities as white women.
- Women covered by MassHealth are three times as likely to die from pregnancy -related causes and have higher rates of severe maternal morbidities as those who have private insurance.

The COVID-19 pandemic has strained our hospitals and health systems, further exposing our already inequitable maternity care system in the Commonwealth. Over the last few months, we have heard urgent pleas from birthing people and caregivers to address the dire impact of the COVID-19 pandemic on perinatal care. The multiple crises and related traumas of the pandemic, systemic racism, and economic injustice offer opportunities to ensure that the care received by all birthing people is safe, equitable, respectful, and evidence-based. According to the CDC, 60% of maternal deaths are preventable. In Massachusetts, maternal mortality and severe maternal morbidities have been rising for years, with persistent racial and geographic disparities (Box 1). Furthermore, at least one in five women in the Commonwealth experience a mental health or substance use disorder during pregnancy or in the first year postpartum. Additionally, in recent years, we have seen troubling trends in costs and variation in provision of maternity care. In 2018, maternity-related stays at community hospitals declined, pointing to a trend of low risk birth taking place at academic and teaching facilities, which are higher cost given higher rates of surgical interventions. There continues to be significant inter-hospital variation in frequency of use of interventions from cesarean to episiotomy and labor induction without equitable, sustained improvements in outcomes. Lack of proactive support for lower-level obstetric care in the community has resulted in the closing of community-based maternity units across the state. For example, recent closures at Holyoke Medical Center and Tobey Hospital left primarily Latinx communities without convenient access to supportive, community-based care.

[1] The term "centered" or "community-of-color centered" has been defined as intentionally focusing on people of color, to physically and mentally shift, and pivot from the default habit of centering and prioritizing whiteness. Our Coalition Steering Committee is composed of a majority of Black and brown members, and our governance is structured to ensure representation of diverse voices.

[2] The Centers for Disease Control defines health equity as when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Anti-racism is "an active and consistent process of change to eliminate individual, institutional, and systemic racism" and redistribute power and privilege. We understand systemic racism to mean "the institutionalization of racism through policies and practices which may appear neutral on the surface but which have an exclusionary or harmful impact" that advances racism, the structuring of opportunities or values based on the social interpretation of how one looks.

The COVID-19 pandemic is exacerbating these troubling trends. **It is now more critical than ever that the Commonwealth enact long-term, stabilizing policies that better support growing families, especially for our most vulnerable and historically marginalized populations.**

This report aims to alert policymakers to the state of maternal health during the COVID-19 pandemic and urges immediate action on **six critical policy recommendations** developed through a collaborative, community-informed process to improve maternal health outcomes in the Commonwealth. This report and the policy recommendations have been endorsed by the American College of Nurse Midwives - Massachusetts Affiliate, Bay State Birth Coalition, Group Peer Support, Health Care For All, March for Moms, Massachusetts Commission on the Status of Women, MassNOW, Massachusetts Postpartum Depression Fund, NARAL Prochoice Massachusetts, Our Bodies Ourselves, Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN), Quietly United in Loss Together, Resilient Sisterhood Project, and Tufts University School of Medicine.

Listening to Our Community

On June 3, 2020, our Coalition hosted a virtual Town Hall with Senator Elizabeth Warren, Congresswoman Ayanna Pressley, Congresswoman Katherine Clark, State Senate President Karen Spilka, State Senator Becca Rausch, State Representative Liz Miranda, and State Representative Kay Khan. Nearly 700 participants registered to participate, learn, and share experiences of being pregnant, giving birth, or serving birthing people during the COVID-19 pandemic. While reliable quantitative data examining the impact of the COVID-19 pandemic on maternal and infant health outcomes are not yet available, the testimony Town Hall participants shared about their lived experience illuminated the myriad impacts of the pandemic on birth experiences. Participants shared experiences of traumatic isolation, fragmented care, disrespectful care, confusion about where to go for assistance, limited prenatal visits, pressure to induce labor, separation from newborn without a confirmed medical indication, unclear and variable COVID testing policies impacting NICU visitation, prohibition of birth companions, and restrictions on breastfeeding for COVID positive birthing people. These perspectives reflect variation in provider response, institutional policy, and adoption of up-to-date guidelines from the Centers for Disease Control, World Health Organization, and professional organizations.

"My follow up care was canceled and it was rescheduled as a call-in instead of an in person meeting and that caused great alarm for me...if you are a Black woman the numbers are always in the back of your head and you carry that fear with you throughout your pregnancy. And you carry the fear with you when you [become] postpartum. So I was faced with a dilemma." *Manikka Bowman, recently gave birth*

"If I had to pick a single word to define the impact of COVID-19, on my pregnancy and birthing experience, I would say isolated. I was isolated from my husband during my third trimester as I attended my routine prenatal appointments alone, because no visitors were allowed. Three weeks before my due date, I found out that I would need to be induced early in just two days... In the hospital, where I stayed for five long nights, we couldn't leave our room, not even to stretch our legs in the hallway or to visit our son in the nursery where he received a full day treatment. And while every book I read told me to take advantage of friends and family when we got home, to have

them cook for us and hold the baby so that we could take a shower or nap, that has not been possible due to COVID. Again, my husband and I are on our own." *Emma Reidy, recently gave birth*

"We just lost a woman who was incarcerated, contracted COVID-19 and gave birth while on a ventilator and handcuffed and died. The child survived, but we lost her. The need for legislation is urgent and has only become urgent during this pandemic." *Congresswoman Ayanna Pressley*

"Patients are being limited in the number of support people they can bring into the delivery room...families have to choose between their significant other and someone else in their family or community or a doula. Access to doula care is vital, it is essential, and we need doulas for successful deliveries especially for Black and brown women. They provide constant care, comfort, support, knowledge and advocacy that families need... I think it's going to take a lot of strong leadership and policies in place to help ensure these families are receiving the care they need and make sure moms are not pushed out in the postpartum period...moms need their full amount of time in the postpartum period to get that care and education from the staff...we're really trying our best on the frontlines to protect moms and babies and families, we just need the support of our senators, our congresspeople to help us do an even better job." *Tiffany, L&D nurse*

"We have a lot of patients at BMC who are really apprehensive around telemedicine. They have inconsistent access to technology because they share a phone, or have limited data plans...and a lack of privacy, housing insecurity...As we are blazing ahead with this new world of telemedicine, I want to put out a call that we need input from both patients and providers about what this new world is bringing us." *Dr. Kate White, OB-GYN*

These stories represent only a sliver of the broader experiences of birthing people in the Commonwealth at this moment. They are illustrative of the intersectionality of experiences spanning incarceration to immigration to racism to childbearing, elucidating trauma and mistreatment within fragmented systems of care with unmeasurable long-term impacts. There are hopeful signs as well—person-centered innovations in perinatal care and how we pay for it, including adaptations towards more flexible care where appropriate, increased use of doulas to support families both before and after birth, a shift out of the hospital to care delivered at home and in communities.

Guidance on Maternal Care during the COVID-19 Pandemic from Global and National Authorities

The **World Health Organization (WHO)**, the **Center for Disease Control and Prevention (CDC)**, and leading health care professional societies have issued resources and guidance documents relating to perinatal care during the COVID-19 pandemic. A common theme across these recommendations is shared decision making regarding the course of care, birthing options, separation of newborns, and breastfeeding—a recommendation that has not been universally implemented by health providers and hospitals across the Commonwealth.

Maternity care: The WHO recommends that pregnant and postpartum women with suspected, probable or confirmed COVID-19 should have access to person-centered, respectful skilled care, including midwifery, obstetric, fetal medicine and neonatal care, as well as mental health and psychosocial support, with readiness to care for maternal and neonatal complications. They recommend that mode of birth should be individualized, based on obstetric indications and the woman's preferences. The WHO recommends that induction of labor and caesarean section should only be undertaken when medically justified and based on maternal and fetal condition. COVID-19 positive status alone is not an indication for caesarean section.

Maternal-newborn separation: WHO clearly states that regardless of COVID-19 status, all birthing people should be supported to hold and touch their newborns, have skin to skin contact, share a room with the baby, and breastfeed with good respiratory hygiene and handwashing. While the CDC states that "temporary separation of the newborn from a mother with confirmed or suspected COVID-19 should be strongly considered to reduce the risk of transmission to the neonate," the CDC also states that decisions around separation from newborns should be made in accordance with the birthing person's wishes. The National Perinatal Association and National Association of Neonatal Nurses issued a joint position statement in May of 2020 recommending shared decision making between the patient and the clinical team to determine postpartum and newborn care, noting that the ideal scenario is to keep the mother and newborn together.

Breastfeeding: The WHO recommends that birthing people with suspected or confirmed COVID-19 should be encouraged to initiate and continue breastfeeding. From the available evidence, mothers should be counselled that the benefits of breastfeeding substantially outweigh the potential risks of transmission. CDC recommends that decisions about breastfeeding be made in collaboration with birthing people and their health providers.

Best available guidance should be used in conjunction with feedback from the community to inform policy and practices for maternity care and support during the COVID-19 pandemic.

Recommendations

Based on the experiences of pregnant and birthing people in the Commonwealth during the COVID-19 pandemic, in consultation with the leadership of Coalition partners, and national and international best practices, we propose all of the following policy recommendations (unranked) for immediate attention by the Governor and Legislature.

Recommendation #1: Form a COVID-19 Emergency Maternal Equity Taskforce

We recommend that Governor Baker create, via Executive Order, a COVID-19 Emergency Maternal Equity Taskforce to: 1) investigate the issues described in this report; 2) make recommendations on policies, standards, and protocols to systematically address perinatal health care and experiences during the COVID-19 pandemic; and 3) monitor implementation of policies and practice changes in consultation with the state's Executive Office of Health and Human Services and Department of Public Health (DPH). New York, Michigan, and Louisiana have recently convened COVID-19 taskforces that have focused on health equity in general or maternal equity in

particular. In New York, the COVID-19 Maternity Taskforce made recommendations addressing many of the same issues we have identified in the Commonwealth. The Taskforce completed its work within a week, and based on their recommendations, an Executive Order was issued to immediately establish additional birthing sites. We believe such a model would work well and efficiently here in the Commonwealth as well, if paired with explicit attention to representation and equity in taskforce membership.

> "I'm being told by my clients that informed consent [and] discussions about new hospital policies are not being had. This is leaving expectant parents feeling **frightened, and coerced, and out of control.** For survivors, this replicates their experiences of trauma, of having their autonomy stolen, of their voices not mattering."
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> *Dr. Justine Leach, MCPC Town Hall*

Given the dire statistics around inequities in maternal health outcomes in the Commonwealth, we strongly suggest that the Governor's office or the Secretary of Health and Human Services (EOHHS) co-chair this taskforce in partnership with leadership from the advocacy community. We also request adequate funding for EOHHS to staff the Task Force to convene virtually and complete its report on a timely basis. We suggest a maximum of 15 individuals to serve on the Taskforce: a majority Black and brown birthing people; at least one doula; at least five clinicians (an OB/GYN, a Certified Professional Midwife, a Certified Nurse Midwife, a pediatrician, and a maternal behavioral health provider); a public health researcher; a representative of the state's perinatal quality collaborative, PNQIN; a member of the Massachusetts COVID-19 Maternal Equity Coalition**;** at least three consumer advocates who are not clinicians; one representative of Massachusetts Hospital Association; the Commissioner of DPH or their designee; the Commissioner of Insurance or their designee; and the Medicaid Director or their designee.

Recommendation #2: Data Collection on Pregnant and Birthing People, Race, and COVID-19

> "Through my work, I listen to many Black families with less resources express their grievances, fears, and concerns about their care, even more now with COVID. So I'm hoping we continue to lift those voices up in everything we say, do and work towards. Please do not let our progress be reversed. Do not let the work of Black women who have experienced this failing system who give their very personal, painful experience to this fight be in vain and let these issues remain a priority until we all have accessible, safe, and self-selected birthing options."
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> *Morgan Taylor, Birth and Postpartum Doula*

We recommend supporting a robust surveillance infrastructure to better understand the short-term and long-term impacts of the pandemic on birthing people's health outcomes, including disparate outcomes among communities of color. The Pregnancy Risk Assessment Monitoring System (PRAMS), administered jointly by the state's DPH and the CDC, collects data on maternal attitudes and experiences before, during, and after pregnancy, with the goal of improving maternal and infant health and reducing adverse outcomes. We understand PRAMS is being adapted to help us understand the public health impacts of COVID-19 on maternal and infant health outcomes and make evidence-based recommendations. We recommend that DPH receive adequate funding to ensure an effective response to COVID-19 surveillance needs. Further, efforts to fully understand and mitigate the impact of the COVID-19 pandemic rely on quality, inclusive, and comprehensive data collection and research. It is essential that pregnancy status and race be included as part of the data collected and reported on

COVID-19, ideally disaggregated (i.e. Afro-Carribean, African descent, Afro-Latinx, etc.), to establish the evidence base to inform future policy to protect pregnant and postpartum women.

Recommendation #3: Ensure Consistency in Hospital Perinatal Policies, Including Support People and Mother-Infant Separation

The latest recommendation per the June 6, 2020 memo from the Massachusetts Bureau of Healthcare and Safety at DPH states that to protect the safety of patients, a patient is allowed one visitor at a time in the hospital and that hospitals may prohibit visitation on a case-by-case basis if a patient tests positive for COVID-19, shows symptoms of COVID-19, or if visitation poses a significant infection control risk to the patients, visitor, or staff. This recommendation also states that birth partners are not to be considered visitors, though they must be screened. We recommend that Governor Baker charge the Task Force with recommending policies that both reduce inter-hospital variation regarding labor support and parent-infant separation, and ensure a shared, decision-making approach with pregnant people who need to be given complete and transparent information to make their own decisions about labor treatment and newborn separation. Furthermore, we recommend that the Task Force also develop a method for: 1) informing pregnant people about evolving hospital policies on perinatal care during the COVID-19 pandemic, 2) receiving timely information, 3) reporting mistreatment before, during, and following birth, miscarriage and/or abortion care , such as through a hotline managed by DPH or PNQIN, to inform care decisions.

> "Families shouldn't have to choose between a doula or their husband or their wives or whoever they want to bring into the room and doulas and the care that they provide need to be an exception...We have to take proper precautions to prevent the spread of the virus. And that's our number one priority at the hospital. But it's also very important that we ensure patients have a memorable delivery experience and have a very good outcome."
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> *Tiffany, L&D nurse, MCPC Town Hall*

Recommendation #4: Ensure Immediate Access to Ongoing Mental Health Care for Birthing People

> "My follow up care was canceled and it was rescheduled as a call-in instead of an in person meeting and that caused great alarm for me. Because if you are a Black woman the numbers are always in the back of your head and you carry that fear with you throughout your pregnancy... These are the experiences that Black women are having. These are the experiences that mothers are having. And then you compound that with the reality of our current state of affairs, where **Black pain**, when it comes to racism, is at the forefront in our society in a way that caused a whole other level of stress to black moms."
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> *Manikka Bowman, MCPC Town Hall*

Before the COVID-19 pandemic, 10-15% of the childbearing population experienced perinatal depression and anxiety. Preliminary research is indicating that these numbers have increased dramatically since the onset of the pandemic with a conservative assessment of perinatal depression at 45% for the general population.[3] We recommend that Governor Baker charge the previously recommended Task Force with recommending policy to ensure and increase access to perinatal mental health services and supports including but not limited to screening, clinical care, support groups, postpartum doula care, home visiting and parent to parent support programs. Additionally, we recommend a review and increase of the telehealth mental health screening pathway with direct

[3] Unpublished data from Sharon Dekel at Harvard University and Maria Muzik/Cheryl Moyer at the University of Michigan

access for referral to mental health care including psychiatry, therapy, peer and community support, i.e. support groups, home visiting and parent-to-parent support programs.

Recommendation #5: Ensure Ongoing Comprehensive Medicaid Coverage for Birthing People

We recommend that Massachusetts join the nearly 15 other states in applying to extend full-scope Medicaid coverage for postpartum people to at least 12 months after giving birth through the state's next 1115 waiver. Women who are covered by MassHealth are almost three times as likely to die from pregnancy-related causes and have higher rates of severe maternal morbidities as those who have private insurance.

As over a million people in Massachusetts lose their jobs due to the COVID-19 pandemic, many are also losing employer-sponsored health insurance. In 2018, Medicaid covered 40 percent of Massachusetts births, but that number is expected to skyrocket as a result of the current crisis. Medicaid provides essential coverage for people while they are pregnant, during delivery, and up to 60 days postpartum. However, continuous health coverage is essential throughout the postpartum year. Four out of ten Medicaid beneficiaries cannot attend a postpartum visit 6-10 weeks after birth, and the following 6-12 months are especially critical for mothers who had medically and/or socially complicated pregnancies. Furthermore, one in three pregnancy-related deaths occur one week to one year after delivery and most of these deaths are preventable. The administrative efficiencies and cost-saving potential of continuing Medicaid coverage through one year postpartum cannot be overstated, as it is estimated that the second six months of Medicaid coverage costs about 30 percent less than the first six months of coverage in a year.

We also strongly recommend that MassHealth and commercial payers consider aligned payment policy updates to ensure seamless access to 1) home visiting postpartum care, 2) doula support, and 3) access to virtual and community-based lactation support statewide for all birthing people. We understand there are a number of bills already filed by the Legislature that would support payer efforts in these areas.

Recommendation #6 : Expand Midwifery Care and Community Birth Options

We recommend that Massachusetts ensure access to midwifery care and community birth options to provide people with low risk pregnancies a safe, evidence-based birthing option. Midwifery care in community settings (homes and freestanding birth centers) is associated with improved outcomes for people with low-risk pregnancies and reduced health care costs, while freeing hospital resources for those requiring higher levels of care. The lack of access to midwives and community birth in Massachusetts places us behind most other states; a 2018 study on integration of maternity care ranked Massachusetts 32/50, and we have fallen further behind since.

Midwives and community birth options (freestanding birth centers, auxiliary maternity units, and supported home birth for eligible people who desire it) can help relieve the pressure on the physician workforce, minimize COVID-19 transmission, and direct health system resources more effectively and efficiently. Unfortunately,

restrictive regulations on midwifery care and community birth, as well as insufficient insurance reimbursement and Medicaid coverage, keep these options out of reach for the people who most need this type of care. Care provided by midwives consistently achieves outcomes that are as good as or better than those of physicians, leading to fewer interventions, comparable newborn health outcomes, higher rates of satisfaction, and lower health care costs. Leading maternity care professional associations have affirmed licensed, accredited, freestanding birth centers remain safe places to give birth during the COVID-19 pandemic.

In order to expand access to midwifery care, we recommend allowing midwives to practice to the full scope of their national certification and designating midwives as essential care providers during the COVID-19 pandemic and beyond. Regulations and financial support must permit birth centers and auxiliary maternity units to open and expand rapidly to meet the increasing demand for out-of-hospital birth, following guidelines from national birth center accreditation organizations. We strongly recommend that the Legislature work closely with MassHealth to support adequate reimbursement rates and facility fees to sustain birth center operations and reliably serve patients enrolled in Medicaid as well as by commercial plans.

We urge Massachusetts policymakers, providers, and health system leaders to prioritize the health and well-being of pregnant, childbearing, and postpartum people in their responses to the COVID-19 pandemic by enacting equitable, evidence-based, system-level policy reforms, detailed in the above listed recommendations. Because of the disproportionate impact on communities of color, these recommendations prioritize and center the voices and needs of women and birthing people of color as a means to solve this crisis for all.

Acknowledgement

The recommendations outlined in this report are based on the experiences of pregnant and birthing people in the Commonwealth during the COVID-19 Pandemic, emerging best practices, and guidance from expert advisors. The report was generated through a participatory and multi-step process. We are grateful to the participants of the Town Hall, hosted on June 3, 2020, particularly pregnant and birthing people and community members, whose stories and ideas that have shaped the recommendations in this report. Members of the MA COVID-19 Maternal Equity Coalition Steering Committee edited and revised multiple versions of this report and in that process incorporated narratives and insights shared by community members during the Town Hall. The Steering Committee would also like to acknowledge the writing team that drafted the initial version of this report: Tejumola Adegoke, MD, MPH, Carrie N. Baker, JD, PhD, Katharine Hutchinson, DrPH, MSN, CNM, Jennifer McKenna, Lois McCloskey, DrPH, MPH, and Kate Mitchell, MPH, DrPH(c), and the expert copy editing support of Jocie Fifield and Tomi Ojo.

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