Policy Brief

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Recommendations for Changing Maternal Care Preferences in the Face of the COVID-19 Pandemic

Authors

Zaneta Thayer, PhD
Dartmouth College
Theresa Gildner, PhD
Washington University in St. Louis

Key Findings

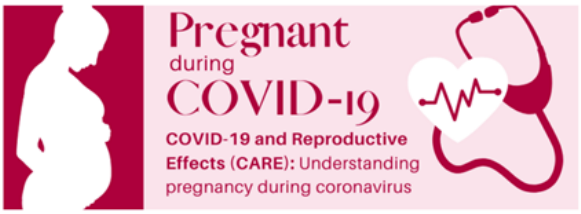
- Overall, 58 participants (5.92% of the sample) reported a new preference for community birth as a result of the COVID-19 pandemic.
- A novel preference for community birth was evident among both women who changed their recent birth plans because of the pandemic and among those who plan to seek community care for the first time in future pregnancies.
- Twenty of these 58 participants (34.5% of participants with a novel community care preference) reported that they expected barriers in accessing their preferred care in the future.

INTRODUCTION

During the COVID-19 pandemic, birth experiences have changed dramatically, potentially influencing future maternity care preferences in the United States. The pandemic has substantially impacted maternity care access and birth plans as pregnant persons respond to pandemic-related hospital restrictions and personal safety concerns. But have these experiences influenced maternity care preferences post-pandemic? Our research team set out to evaluate how and why the pandemic has affected women's future care preferences through an online survey of 980 participants in the United States. This policy brief highlights our findings--which suggest that the pandemic has influenced future maternity care preferences--and presents recommendations for how providers and policy makers should anticipate and respond to shifting maternity care needs.

BACKGROUND ON COMMUNITY BIRTH

In the U.S., more than 98% of births are in the hospital. This reflects a general cultural consensus that technology-intensive birth in a hospital setting is the safest delivery option (1,2). However, evidence suggests that "community" based maternal care and births--so called for being physically centered in a community--are safe and provide many benefits for low-risk pregnancies (3). Community births are typically attended by skilled midwives trained either by apprenticeship or vocational midwifery schools who are required to pass a national exam affirming their abilities to deliver out-of-hospital (4). Birth centers consistently report higher patient satisfaction--women who deliver in a birthing center environment are twice as likely to rate their birthing experience as very positive compared with women delivering in a traditional hospital setting (5). Yet, birth centers, and the community birth they facilitate, are still not very prevalent in the US, with only 0.52% of total births occurring in a birth center in 2017 (6).



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METHODS

To explore how the pandemic has altered future care preferences, and obstacles to accessing preferred care, we used data from the "COVID-19 And Reproductive Effects" (CARE) study -- a survey designed to ask women about their experiences with maternal care during the pandemic. We shared the study on social media platforms. Pregnant women over the age of 18 and living in the U.S. were eligible to participate. We obtained informed consent from all participants. Participants who agreed to be re-contacted received a postnatal survey four weeks after their due date. The data shown here were collected between June 5 and December 15, 2020; a total of 980 individuals completed the postnatal questionnaire in this time period.

The Key Variables we surveyed in changing care preferences are the following:

- Novel preference for community birth
  - A novel preference for community care was defined as women who used community care for the first time during the pandemic and indicated a continued preference for this care model during future pregnancies, as well as women who did not use community care in their most recent pregnancy but intended to during future pregnancies.
- Reasons for preferring this care option
  - Respondents were asked to describe why they would select their listed preferred facility type for future pregnancies
- Expected barriers to preferred care during future pregnancies
  - Participants were asked if they anticipated any factors limiting access to their preferred facility type in a future pregnancy (Yes/No). If participants selected "Yes," they also indicated which of the following factors might limit their access:
    - My preferred care type is not available in my area;
    - My preferred care type is not covered by my insurance;
    - My preferred care type is too expensive;
    - Other, describe.

RESULTS

Eighteen of the participants exhibiting a novel preference for community care reported changing from a hospital to a community birth during the pandemic, and stated they would prefer a community delivery during their future pregnancies as well. Fourteen of these 18 participants reported they switched birth facilities during the pandemic because they were concerned about hospital limits on support persons who could attend their delivery. Thirteen of these participants also reported fears of separation from their baby in a hospital setting, and thirteen indicated they were afraid of contracting COVID-19 at the hospital. Another thirteen participants also reported concerns about hospital policies including being forced to wear a mask during active labor.

An additional **40** participants who gave birth in a hospital reported planning to change their delivery location for future pregnancies, **resulting in a total of 58 participants exhibiting a novel preference for community care.**

Of the 53 participants with a novel preference for community care who described the reasons behind this change:

34% (18/53) stated they believed community care options were closer to a **more "natural" birth model** with less reliance on medical interventions.

30.2% (16/53) stated that they felt community care is **more person-centered** (e.g., more effective provider communication, greater patient autonomy, more personalized care).

11.3% (6/53) preferred a community delivery due to a **lower perceived risk of pathogen exposure**.

37.7% (20/53) described preferring community care because they **felt safe and cared** for in these settings.

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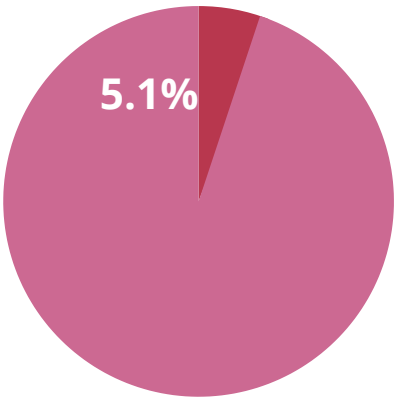
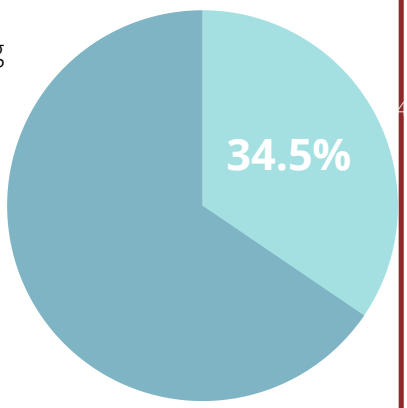
In total, 50 participants (5.1% of the complete sample) reported that they expected barriers in accessing community care. Of those reporting a new preference for community delivery, 34.5% (20/58) expressed concern that factors including local facility availability, insurance coverage, and out-of-pocket cost could prevent them from accessing their preferred birth location.

Barriers to Community Care:



In total, **50 participants out of 980** reported that they expected barriers in accessing community care.



However, of those reporting a new preference for community delivery, **20 out of 58** expressed concern that factors including **local facility availability, insurance coverage, and out-of-pocket cost** could prevent them from accessing their preferred birth location.

POLICY RECOMMENDATIONS

Our findings are consistent with an already growing interest in community births in the U.S. To address real and perceived barriers to community care access, we have compiled policy recommendations.

Federal Level:

The involvement of the U.S. Federal Government is invaluable to the expansion of community birth access. The federal government can:

1. **Initiate policies that help to expand the national midwifery workforce by providing funding to establish new and more midwifery education programs.**
   - Given that most community births are attended by midwives, the government should facilitate the growth of this field. The government should work to establish a funding stream within the Health Resources and Services Administration's (HRSA) Title VIII and Title VII programs specific to Advanced Midwifery Education Grants. This funding will go to university-based accredited schools of midwifery and could be used to establish programs for increasing the number of instructors across the country. Policies increasing student aid or alleviating student debt can make these midwifery education programs even more accessible, thereby increasing the prevalence of high-quality community care (7).
   - Community care should also aim to reflect the racial and ethnic diversity of the national population. The government should specifically increase funding and support for community care led by minority women and strengthen federal grants and traineeships to minority midwifery students for racially equitable maternal healthcare (8).
2. **Expand public insurance plans to include and equally reimburse community maternity care services.**
   - Currently, Medicaid covers more than 40% of U.S. births nationwide and more than 60% of births in several states. Yet many birth center providers struggle to successfully participate in Medicaid due to low reimbursement rates (9).

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- Public programs, including Medicare and Medicaid, should ensure that enrollees have access to midwives and to out-of-hospital community birth options by eliminating barriers to access and inequitable reimbursement rates that discriminate against community birth providers (10).
- Mandating payment by public healthcare insurance programs to birth centers and home births attended by licensed midwives could reduce insurance barriers to preferred care (11).

State Level:

States also possess the power to enact programs and regulations that expand community care funding and access. All state governments can:

1. **Remove barriers limiting access to the full range of maternity care options.**
   - States can ensure that midwives are able to legally practice in hospitals, birth centers, and home birth settings without limiting scope of practice or requiring collaborative agreements with a physician.
     - Decreased barriers, through adequate reimbursement for community based doulas and adjustment of overly restrictive practicing requirements (e.g., limitations on admitting privileges, prohibitively expensive training programs) could ensure greater access to community care (12).
2. **Improve statewide medical insurance coverage of community births.**
   - To alleviate financial barriers to community births, states could expand Medicaid, Medicare, and commercial payer coverage to include: (i) care provided at accredited and licensed home and birth centers; (ii) care provided by certified nurse midwives, certified midwives, and certified professional midwives; and, (iii) care provided by community-based doulas.
3. **Ensure meaningful engagement and collaboration with LGBTQ people and BIPOC, as well as community-based doulas when designing policy.**
   - Funds should be directed to programs focused on training doulas and midwives within BIPOC and LGBTQ communities, as this investment may increase access to community births within communities experiencing the greatest maternal health inequities (12).

Provider and Existing Local Level:

Public agencies, nonprofit organizations, healthcare providers, and individual people can also support community birth models of care:

1. **Include community births attended by midwives in a national registry for maternity care data.**
   - Increased integration and availability of birth data could promote research on pregnancy and birth outcomes for planned community births compared with similarly low-risk planned hospital births.
   - Strengthening data collection is key to understanding birth outcomes across birth settings, while also identifying perceived barriers to community births.
2. **Fund and support existing community-based organizations which facilitate doula and midwifery care.**
   - Existing community-based organizations for doulas and midwives have established relationships and trust within their communities to deliver culturally competent care and support guided by the needs of community members. Yet, a lack of adequate funding impedes expansion and long-term sustainability of this work.

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- Increased fundraising and support to community-based organizations would allow them to expand services and client capacity, support more clients unable to pay out-of-pocket expenses, and ensure that their community care providers are financially, professionally, and socially compensated (12).

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