Konrad Jackson

From: Bethel Belisle <midwifebethel@gmail.com>
Sent: Sunday, January 28, 2024 1:51 PM
To: Sen. Kelly Merrick
Cc: Senate Labor and Commerce
Subject: EO 130

Follow Up Flag: Follow up
Flag Status: Flagged

I am a Certified Direct Entry Midwife (CDM). I received my initial license in October of 1999, license #25 here in Alaska. I am a home birth midwife and I own 2 State of Alaska licensed Birth Centers. One is in Anchorage and the other is in Palmer. I am an employer of CDM's, currently having 3 CDM's in my employment. I am a Preceptor and have 1 student midwife in my practice. I am writing you today as a mother who has delivered most of my babies with a Certified Direct Entry Midwife, and as a grandmother who has delivered my grandbabies as a Certified Direct Entry Midwife. I am also the Chair of the State of Alaska Board of Certified Direct Entry Midwives. I am asking you to vote NO on the Executive Order 130.

I have served on the Board since March of 2020. I served during the Pandemic, insuring mothers in Alaska had both access to care during a very scary period, but also following the Governors directives to provide for emergency licensure of Midwives as well as streamlining licensing requirements for our Military members and spouses. I have served through 2 Legislative Audits and have worked with our Board to correct the concerns that relate directly to Board oversight.

I have personally audited over 1400 charts of Midwives clients during the first 2 years of my service and can attest to the professionalism and safety of the care provided by Alaska's licensed midwives. As a profession we have strived to have exceptional relationships with local hospitals so transports or transfers of care can happen quickly and safely. Because of our Board and current regulations, women in Alaska have the option of care with a licensed midwife rather than unassisted birthing which can be fraught with danger.

My concern over the EO 130 stems from the Legislative Audit of October 2022 which listed 4 concerns related to our Board. Every single concern mentioned in the audit was outside the reach of the Board such as concerns raised over the Department lacking staff, the Governors office not filling board positions and not enough oversight on review of licensing applications. As a Board we took the oversight of applications very seriously and have worked diligently to ensure every application was correct according to our current Statutes and Regulations. Removing our Board and replacing it with "the department' would be detrimental as "the department" has proven itself to not be able to fill positions in a timely manner. The Board has met quorum at all but 1 meeting in 4 years. There has been no given reason to do away with a board that functions well, is financially solvent and has met all legislative requests.

The Board has also strived to bring our current Regulations up to the national standard for midwives. Every midwife in Alaska is also a Certified Professional Midwife, meeting a national standard. We currently have HB175 in committee to have our Statutes to mirror our current regulations. This HB actually reduces the burden of auditing both new and renewing license applications and places it on our National Credentialing body called the North American Registry of Midwives. Bringing our Statutes and Regulations up to National Standards will also meet the request by the Biden Administration to have more Midwives in the USA to lower maternal and neonatal morbidity and mortality. Alaska is so vast and we need more midwives to serve our great Land. I am asking you to support HB175 and its Senate counterpart. By doing so you are showing your support of women and their choices in Alaska.

Thank you for your service and consideration of EO 130 and HB 175 and its Senate counterpart. Please do not hesitate to reach out to me to answer any questions or to confront rumors about my honorable profession.

Bethel Belisle, CDM, CPM, BSM
State of Alaska Board of Certified Direct Entry Midwives
Haven Midwifery and Birth Center
907-444-3027
Midwifebethel@gmail.com

Konrad Jackson

From: carrie.falahi@gmail.com
Sent: Sunday, January 21, 2024 11:59 PM
To: Sen. Jesse Bjorkman
Subject: Exec Order 130; HB 175

Δεαρ Σεν Βφορκμαν,

Ι αμ ωριτινγ ιν συππορτ οφ μαινταινινγ τηε Βοαρδ οφ Μιδωιφεσ ιν Αλασκα.

Ι αμ οπποσεδ το τηε Γοωερνορσ εξεχυτιωε ορδερ 130 τηατ ωουλδ αβσορβ τηισ αυτονομουσ βοαρδ ιντο τηε Δ επαρτμεντ οφ χομμερχε.

Αδδιτιοναλλψ, Ι ασκ τηατ ψου ωοτε ψεσ ον ΗΒ 175 τηισ σεσσιον ασ ιτ μακεσ ιτ ωαψ τηρουγη τηε χομμιττεε π ροχεσσ ανδ υλτιματελψ ωοτεδ ον βψ τηε ωηολε βοδψ.

Ι, περσοναλλψ, ωαντ το χοντινυε Αλασκα□σ στρονγ ηιστορψ οφ αχχεσσ το μιδωιφερψ χαρε ανδ προτεχτινγ τη ε αυτονομψ οφ τηισ προφεσσιον.

Ι βενεφιτεδ γρεατλψ φρομ τηε σερωιχεσ ρενδερεδ βψ Αλασκαν μιδωιφεσ ιν μψ οων ηομε βιρτη.

Βελοω ψου ωιλλ φινδ χερταιν στυδιεσ ανδ στατσ τηατ μαψ βε υσεφυλ ιν συππορτ οφ χοντινυινγ μιδωιφερψ χα ρε ιν Αλασκα.

Τηανκ ψου φορ ψουρ τιμε.

Γρατεφυλλψ,
Χαρριε Χοοκ
Σολδοτνα, Αλασκα

The use of Certified Direct Entry Midwives and autonomy for birthing options has been highly valued by many Alaskans for over three decades.

Alaskans are known for valuing personal freedoms and autonomy, and this mindset is inclusive in choosing a birth attendant.

Maintaining the Board of Certified Direct Entry Midwives ensures Alaskan women and families who desire Midwives have the utmost autonomy over their birthing options and the profession, verses sole government control and dictation of Midwifery regulations which could restrict birth options for Alaskan families.

The current structure of Board of Direct Entry Midwives consists of five members; 2 Certified Direct Entry Midwives, 1 Certified Nurse Midwife, 1 Obstetrician, and 1 public member. With their collaborative knowledge these five members set regulations in a manner that ensures public safety and reflects current provider standards in the field of Midwifery.

Because of the specificity of the Midwifery field, it is difficult to glean how a state administrator will accomplish a similar quality of oversight for the profession. Ultimately, this may lead to restricted birthing choices for Alaskan women and families.

The Midwives Association of Alaska questions the Governor's decision in proposing this abrupt and dramatic change for our regulatory body. It is difficult to understand why this Administration would eliminate a self-sustaining board.

The most recent Legislative Audit of the Board of Direct Entry Midwives completed in October, 2022 determined the necessity of the Board of Midwives. Moreover; the audit recommendations highlighted the shortfalls of the departments' staffing challenges, in turn contributing to license processing delays as well as delays in addressing issues of public safety.

The staffing deficits within the department have been a long-standing issue, and it is not understood how eliminating the Board of Direct Entry Midwives, which are filled on a volunteer basis, would improve efficiency or maintain public safety.

The Midwives Association of Alaska requests additional transparency and reconsideration of the matter. We oppose the elimination of the Board of Direct Entry Midwives and government control of this important health care choice.

Alaskans are more than four times as likely as other Americans to choose a community setting supported by Midwives. Certified Direct Entry Midwives attend 60-80% of all out of hospital births in Alaska therefore; the issue of who over sees Midwives in Alaska is an issue for Alaskans.

According to the Alaska Vital Statistics 2022 Annual Report from the years 2018-2022, Certified Direct Entry Midwives were hired and entrusted by over 2500 families as they expanded their families, welcoming our newest Alaskans into the world.

Numerous studies positively support the outcomes of Licensed Midwives including higher rates of physiological birth, lower intervention rates including lower Cesarean rates, higher rates of Breastfeeding initiation and continued breastfeeding at six weeks postpartum, as well as greater client satisfaction with the birthing experience. Alaskan Midwives can also boast quality services and favorable outcomes for the families we serve.

Konrad Jackson

From: Christy McMurren <christym907@gmail.com>
Sent: Monday, January 29, 2024 5:46 PM
To: Senate Labor and Commerce
Subject: EO 127, 129, 130

Follow Up Flag: Follow up
Flag Status: Flagged

I read, again, about Gov Dunleavy's executive orders to change or eliminate certain boards, etc. I am hopeful that you will examine these orders with all due diligence. I contacted a friend who is a massage therapist and a friend who is a hairdresser. Neither of them knew anything about this and both are concerned what this change would mean for their profession. I am not of the opinion that just because the state can "save" money, that that is an automatic good thing. We cannot "save" our way to prosperity.
Christy McMurren
Anchorage

Konrad Jackson

From: Cindy Earley <arcticmama1@gmail.com>
Sent: Sunday, January 28, 2024 11:25 PM
To: Senate Labor and Commerce; Sen. Click Bishop; Sen. Jesse Bjorkman; Sen. Matt Claman; Sen. Forrest Dunbar; Sen. Cathy Giessel; Sen. Elvi Gray-Jackson; Sen. Lyman Hoffman; Sen. Shelley Hughes; Sen. James Kaufman; Sen. Scott Kawasaki; Sen. Jesse Kiehl; Sen. Kelly Merrick; Sen.Rober.Myers@akleg.gov; Sen. Donny Olson; Sen. Mike Shower; Sen. Bert Stedman; Sen. Gary Stevens; Sen. Löki Tobin; Sen. Bill Wielechowski; Sen. David Wilson
Subject: Opposition to Governor Dunleavy's Executive Order #130

Follow Up Flag: Follow up
Flag Status: Flagged

January 28th, 2024

To Whom it may concern,

My name is Cynthia Earley and I am Certified Direct Entry Midwife (CDM) licensed by the State of Alaska, a Certified Professional Midwife (CPM), wife, mother to eight children, and I vote. As news of Executive Order NO.130 spread throughout the midwifery community this past week, it was met with great alarm concerning the future of midwifery in Alaska. The following letter is an expression of concern and is in opposition to Executive Order NO.130.

The use of Certified Direct Entry Midwives and autonomy for birthing options has been highly valued by many Alaskans for over three decades. Alaskans are known for valuing personal freedoms and self-sufficiency, and this mindset is inclusive in choosing their birth attendant. Alaskans are more than four times as likely as other Americans to choose a community birth supported by Midwives. Certified Direct Entry Midwives attend 60-80% of all out of hospital births in Alaska, therefore the issue of who oversees Midwives is an issue for the Alaskan way of life.

Maintaining the Board of Certified Direct Entry Midwives ensures Alaskan women and families who desire Midwives have the utmost autonomy over their birthing options and the profession, versus sole government control and dictation of Midwifery regulations which could restrict birth options for Alaskan families.

The current structure of the Board of Direct Entry Midwives consists of five members; 2 Certified Direct Entry Midwives, 1 Certified Nurse Midwife, 1 Obstetrician, and 1 public member. With their collaborative knowledge these five members set regulations in a manner that ensures public safety and reflects current provider standards in the field of Midwifery. Because of the specificity of the Midwifery field, it is difficult to glean how a state administrator will accomplish a similar quality of oversight for the profession. Ultimately, this may lead to restricted birthing choices for Alaskan women and families.

The Midwives Association of Alaska questions the Governor's decision in proposing this abrupt and dramatic change for our regulatory body. It is difficult to understand why this Administration would eliminate a self-sustaining board. The last Legislative Audit of the Board of Direct Entry Midwives completed in October 2022 determined the necessity of the Board of Midwives and recommended a four year extension. Moreover, the audit recommendations highlighted the shortfalls of the department's staffing challenges, in turn contributing to license processing delays as well as delays in addressing issues of public safety.

Staffing deficits within the Department of Community, Commerce, and Economic Development has been a long-standing issue, and it is not understood how eliminating the Board of Direct Entry Midwives, which is filled on a volunteer basis, would improve efficiency or maintain public safety.

The Midwives Association of Alaska requests additional transparency and reconsideration of Executive Order No. 130. We oppose the elimination of the Board of Direct Entry Midwives and government control of this important health care choice.

Sincerely,

Cynthia Earley, CDM, CPM

Konrad Jackson

From: Deborah Schneider <midwifecdm@yahoo.com>
Sent: Tuesday, January 30, 2024 11:48 PM
To: Sen. Jesse Bjorkman
Cc: Senate Labor and Commerce
Subject: E.O. 130

Follow Up Flag: Follow up
Flag Status: Flagged

January 30, 2024

Dear Senator Jesse Bjorkman

I am writing this to ask for your support in vetoing E. O 130. I have been a licensed midwife in Alaska for 23 years. I was involved in midwifery in our state before we had licensure or a board of midwifery. The midwives in Alaska have worked tirelessly to provide safe midwifery care for the mothers and babies of Alaska. We have regulated ourselves; we have developed professional standards and regulations; we have served on the board of Midwifery to maintain the highest practice standards. We have held ourselves accountable to our families that we served. We have paid for the board with our licensing fee. The Board of Midwifery has been crucial in making this possible. The DHSS will not have the expertise or time to manage the midwives of Alaska. The Board of Midwifery can continue to provide oversight and expertise over this profession.

Deborah Schneider, CDM

Windsong Midwifery

Konrad Jackson

From: Delissa Owen <dseverson11@icloud.com>
Sent: Friday, January 26, 2024 2:27 PM
To: Sen. Jesse Bjorkman
Subject: Opposition of EO 130 and approval of HB 175

To whom it may concern,

Please hear our voice as we write in support of maintaining the Board of Midwives in Alaska. We are OPPOSED to the governors Executive Order 130 that would absorb this autonomous board into the Department of Commerce.

The current structure of Board of Direct Entry Midwives consists of five members; 2 Certified Direct Entry Midwives, 1 Certified Nurse Midwife, 1 Obstetrician, and 1 public member. With their collaborative knowledge these five members set regulations in a manner that ensures public safety and reflects current provider standards in the field of Midwifery. Because of the specificity of the Midwifery field, it is difficult to glean how a state administrator will accomplish a similar quality of oversight for the profession. Ultimately, this may lead to restricted birthing choices for Alaskan women and families.

Maintaining the Board of Certified Direct Entry Midwives ensures Alaskan women and families who desire Midwives have the utmost autonomy over their birthing options and the profession, verses sole government control and dictation of Midwifery regulations which could restrict birth options for Alaskan families.

We would also ask that you vote YES on HB 175 this session as it makes its way through the committee process and ultimately will be voted on by the whole body.

We want to continue Alaska's strong history of access to midwifery care and protecting the autonomy of this profession.

Thank you for your time,

Delissa Owen
Soldotna, AK

Sent from my iPhone

Konrad Jackson

From: Elizabeth Shier <lizzyj@icloud.com>
Sent: Tuesday, January 30, 2024 11:26 PM
To: Sen. Jesse Bjorkman
Subject: Executive order 130 board of midwives -vote NO

Dear Senator Bjorkman,

I am contacting you on this matter of urgency in regard to Governor Dunleavy's Executive Order 130 wherein he seeks to eliminate the Board of Midwives in Alaska. Quite honestly, as a governor who has on multiple occasions shown his support of pro-life, pro-family issues as well as seeking to be financially responsible this order comes as a shock to me.

Not only is this board of midwives proven to be fiscally responsible over the years even proving it SAVES the state money! Alaska Vital Statistics shows the numbers. Why would the governor choose to do away with this board?

The Board of Midwives has shone as a beacon of medical freedom for the many women and families in Alaska. Reassigning this unique field to be overseen by a bureaucratic department will not end well for Alaskans. How will the unique role of midwives be understood? How will Alaskan women be assured that their freedom of choice in their health, their pregnancies, their birth experiences, ultimately their families be respected? This prospect of direct government control is frankly offensive and terrifying.

As a mother of 8 who has chosen to have midwife support with every single one, I cannot stand by and watch this just play out. Please relay to Governor Dunleavy that this is the wrong move for Alaska. Vote a resounding NO on EXO 130.

Thank you.

Respectfully,

Elizabeth Shier

North American
Registry of Midwives

Providing Certification Standards
For Certified Professional Midwives

Ida Darragh, CPM-ret , LM
Executive Director
Credentialing Specialist
Ida@narm.org

Executive Director
Phone: 888-8424784
testing@narm.org
www.narm.org

January 30, 2024

Senate Labor and Commerce Committee
3rd Floor, State Capitol
Juneau, Alaska 99811

Dear Senate Labor and Commerce Committee,

It has come to the attention of the North American Registry of Midwives that Governor Dunleavy has issued an Executive Order # 130 to remove the Board of Certified Direct Entry Midwives and regulate the practice of direct entry midwifery under the Board of Commerce with no direct input from the licensed midwives in the state. We write this letter to request reconsideration of that change.

The North American Registry of Midwives maintains the accreditation status of the Certified Professional Midwife, (CPM) consistent with the Institute for Credentialing Excellence and the National Commission for Certifying Agencies. This assures that the certification program follows the highest standards in identifying the knowledge and skills critical for midwives practicing in homes and birth centers, and maintains the appropriate assessment instruments for determining readiness for practice. The CPM credential is the basis for eligibility for licensure in the 37 states that license direct-entry midwives to attend births outside of the hospital setting.

The North American Registry of Midwives encourages states to involve those licensed in the practice with significant autonomy in the regulation of their profession. The most effective regulation is that which is consistent with the education, assessment, and professional standards of the profession being regulated. Please reconsider this Executive Order in consideration of the value and relevance of the Board of Certified Direct Entry Midwives in Alaska.

Sincerely,

Ida Darragh

Ida Darragh, Executive Director
North American Registry of Midwives

Konrad Jackson

From: kayla pedersen <gkpedersen10@gmail.com>
Sent: Wednesday, January 24, 2024 2:18 PM
To: Sen. Jesse Bjorkman
Subject: Executive Order 130

Follow Up Flag: Follow up
Flag Status: Flagged

To whom it may concern,
Please hear our voice as we write in support of maintaining the Board of Midwives in Alaska. We are OPPOSED to the governors Executive Order 130 that would absorb this autonomous board into the Department of Commerce.
We would also ask that you vote YES on HB 175 this session as it makes its way through the committee process and ultimately will be voted on by the whole body.
We want to continue Alaska's strong history of access to midwifery care and protecting the autonomy of this profession.
Thank you for your time,
Kayla Pedersen
Kenai Alaska
Sent from my iPhone

Konrad Jackson

From: Laura Young <laura.lynn.lemons@gmail.com>
Sent: Sunday, January 28, 2024 4:37 PM
Subject: EO 130

To Whom it may concern,

My name is Laura Lemons, I am a Certified Professional Midwife, Direct Entry Midwife, and Licensed Midwife. I reside in the Mat-Su Valley and practice in both the Mat-Su Valley and in Anchorage. I am from Dillingham, I am an Inupiat Eskimo, and my family originates from White Mountain, Alaska. I am a member of both the Curiung Tribe and Bristol Bay Native Corporation. I am also a doula providing labor support for indigenous women birthing at the Alaska Native Medical Center at home or birth centers. I am one of two indigenous midwives in Alaska and the only one who is practicing out of hospital.

I am concerned on many levels and am writing in opposition to Executive Order No. 130.

As an indigenous midwife I have witnessed mother's separated from their own community often without their families as well as their support systems while giving birth. In the last year I have seen women coming from small communities choosing to give birth out of hospital. When being separated from home and support persons, the ability to choose the place of birth and birth attendants is empowering and supportive for them. Losing this choice is a serious disadvantage for families from rural communities.

Women in Alaska have been choosing who would support them since the dawn of time. For the last three decades they have enjoyed autonomy to choose Certified Direct Entry Midwives to support and care for themselves and their families. Alaskan women educate themselves on their options for birth and are more than four times as likely as other Americans to choose to birth in a community setting and be supported by midwives. 60-80% of all out of births are attended by Certified Direct Entry Midwives.

Women in your districts are choosing midwifery and community birth because they do their research and have read that births with Licensed Midwives will have higher rates of physiological birth, lower intervention rates including lower C-Section rates, higher rates for breastfeeding initiation and continued breastfeeding at six weeks postpartum. These studies also show greater satisfaction with the birthing experience. Midwives in Alaska provide that care, quality service and have statistics that show favorable outcomes for the families we serve.

This executive order would remove the Board of Midwives which works to ensure Alaskan women and families have the utmost autonomy over their birthing options. Removing this board and placing control in the hands of bureaucrats who do not understand the intricacy of the profession could be detrimental as their focus may not be in maintaining the high quality of care Alaskans have been enjoying for the past three decades. Government control could be restricting on how Midwifery regulations are dictated and could potentially restrict birth options.

The current Board of Direct Entry Midwives consists of five members; 2 Certified Direct Entry Midwives, 1 Certified Nurse Midwife, 1 Obstetrician, and 1 public member. Public safety is ensured because these members collaborate to set regulations which ensures public safety and reflects current provider standards in the field of Midwifery. The midwifery profession is highly specified and it would be difficult for state administrators to provide quality oversight in a similar manner as the current makeup of the board. This change could lead to a restriction of birthing choices for Alaskan women and their families.

This order was proposed abruptly without giving the Midwives heads up as to the dramatic change in our regulatory body. This board has been historically self-sustaining making this executive order more puzzling. It is difficult to understand why this Administration would eliminate a self-sustaining board. The last Legislative Audit of the Board of Direct Entry Midwives completed in October 2022 determined the necessity of the Board of Midwives and recommended a four-year extension. Moreover; the audit recommendations highlighted the shortfalls of the departments' staffing challenges, in turn contributing to license processing delays as well as delays in addressing issues of public safety.

Moreover, staffing deficits within the Department of Community, Commerce, and Economic Development has been a long-standing issue, and it is not understood how eliminating the Board of Direct Entry Midwives, which is filled on a volunteer basis, would improve efficiency or maintain public safety.

I am requesting, along with the rest of the Midwives Association of Alaska, additional transparency and reconsideration of Executive Order 130. We oppose the elimination of the Board of Direct Entry Midwives and government control over this important health care choice. Over 2500 families in your districts choose midwifery care, this is not just an issue for midwives, it is an issue and a potential detriment to all Alaskans.

Sincerely,

Laura L. Lemons CDM, CPM, LM

Indigenous Doula

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

January 28, 2024

To Whom This Concerns,

We, the Board of Certified Direct-Entry Midwives (CDMs), unequivocally oppose Executive Order (EO) 130, which seeks to eliminate our board. We urge you to vote NO on EO 130 in the best interest of the state, the economy, and public safety.

The autonomous practice of midwifery and independent board regulation are vital to the safety of Alaska families. The findings of EO 130 aim to maintain efficient administration, develop professional expertise, eliminate duplication of function, and provide a single point of responsibility for state policy relating to midwifery practices in Alaska.

We are deeply concerned that the proposed changes will undermine the safety and well-being of Alaska families. The use of paid state employees instead of volunteer midwives, professionals, and community members to run our board is not only inefficient but also jeopardizes the expertise of the profession and community connection we bring.

Alaska is already grappling with maternity care deserts, leading to increased costs and increased maternal mortality in all hospital settings while maternal deaths with CDMs has been at zero now for years running. Our midwives play a crucial role in addressing these mortality and care cost challenges, providing exceptional care that results in lowest cesarean and highest breastfeeding rates in the state by care provider type.

We would like to clear up some misunderstandings about the Board and its function and relationship to the state and the safety of the families of Alaska.

We urge you to consider the grave implications of EO 130 on the health and safety of Alaska families and to support the continued existence of the Board of CDMs by voting NO on EO 130. We also implore you to support the immediate approval with a vote YES on HB 175 to help families have increased access to evidence-based maternity care now.

To keep things easy to read, we have organized a listed detailed response below. All data to support the following points can be found in the documents accompanying this letter.

1. **The Board of Certified Direct-Entry Midwives costs the State of Alaska $0.00.**

   The Board of Certified Direct-Entry Midwives (CDMs) is entirely self-funded through licensing fees, costing the State of Alaska $0.00. In FY 2022, the board generated a surplus of $67,329, with total revenue of $142,945 and expenses of $28,242.

   We are committed to maintaining this cost-effectiveness through streamlined processes, as endorsed by the audit committee. It is important to note that the state's proposal to replace the board with a department would incur significantly higher costs. It is estimated that one state employee with benefits would cost the state at least $100,000 a year, not to mention additional expenses for expert testimony and consultation. This would far exceed the current expenses of the board.

2. **CDMs save Alaska Medicaid $5,000,000+ a year. Every year.**

   Midwives (CPM/CDMs) saved Medicaid over $5 million in 2022 through birth fees alone and by serving only 6% of Alaskan births. This amount was also averaged in 2021 and 2020. **The cost savings to the State of Alaska from the care of CDM/CPMs is approximately 192 times more than the cost of administering the State Board of Certified Direct Entry Midwives.**

   Here are the numbers:

Total vaginal deliveries attended by CPM/CDMs	567
Percentage paid by Medicaid (DKC)	38%
Total Medicaid births by CPM/CDMs for 2022	215
Medicaid payment to CPM/CDMs	$982.74
Birth Center Facility Fee for CPM/CDMs	**$2603.19**
Medicaid payment for NSVD OB/GYN	$1130.15
Hospital Facility Fee for Vaginal Delivery	**$26,659.00**

(This is just for the location of the birth. This amount does <u>not</u> include professional or physician fees, pediatrician visits, newborn fees)

Total for Home Birth = $982.74

Total for Birth Center Birth = $ 3585.93

Total for OB Hospital Birth = $27,789.15

Cost savings for a home birth vs a hospital birth for 215 births

$982.74 x 215 births = $211, 289.10 vs $27, 789.15 x 215 births = $ 5,974,667.25

Saving Medicaid $5,763,378.15*

Cost savings for a birth center vs a hospital birth for 215 births

$3585.93 x 215 births = $813,289.10 vs $27,789.15 x 215 births = $5.974,667.25

Saving Medicaid $5, 161,378.15*

When averaged midwives saved the State Medicaid Program $5,462,378

It costs one hospital birth to pay for our Board yearly, and remember, WE, the midwives, pay for it, not the state. We SAVE the state money, we don't cost them anything. Please vote NO on EO 130.

3. There are demonstrated improved outcomes for women and infants under CDM care.

- **Significantly lower cesarean section rates** with the care of CDM/CPMs. (**6% vs 23%**)
- **CDM/CPMs have had 0 Maternal Deaths** vs the Hospital rates of 6-20 per year. (see Pregnancy – Associated Mortality in Alaska pdf)
- Significantly **fewer low birth weight babies and babies born prematurely** with the care of CDM/CPMs, all indicators for improved outcomes, especially for vulnerable populations.
- Significantly **higher breastfeeding rates (99% at birth and 99% at 6 weeks postpartum**) with the care of CDM/CPMs, with the accompanying demonstrated health benefits for mother and infants extending throughout lifetimes.
- **Higher rates of intact perineum** (without a tear or episiotomy); Lower rates of episiotomy.
- Lower unneeded medical interventions such as induced labor, continuous electronic fetal monitoring, and cesarean birth.
- **Better experiences with community birth with CDM/CPMs**. **Lower postpartum depression rates** due to being **more satisfied with the personalization of their care, their care environment, quality of their relationship with their midwife, their ability to have a physiologic birth.**The Board keeps costs down for families and the state by ensuring that midwives are practicing at and above national standards.

4. The Board keeps costs down for families and the state by ensuring that midwives are practicing at and above national standards.

Alaska Statute 08.65.030(a) authorizes the board to:

- examine and issue certificates and permits to qualified applicants;
- establish regulations for certification and practice requirements;
- order disciplinary sanctions when a person violates midwifery related statutes or regulations;
- approve curricula and adopt standards for basic education, training, and apprentice programs; and
- review and approve education, training, and apprentice programs
- Further, AS 08.65.030(b) states the board may, by regulation, require CDMs undergo a uniform or random period of peer review to ensure the quality of care.

5. *The Board is the only agency authorized to license midwives in the state and, as such, does not duplicate the efforts of other agencies.* - Alaska State Legislature, Division of Legislative Audit, 2022. This was decided and resolved by the legislature October 14, 2022 and can be found on page four of the report.

There are some areas of note that support keeping the Board of CDMs active that need to be known by the legislature. The prior 2020 audit of the Board of CDMs made three recommendations:

- The Board of Certified Direct-Entry Midwives (board) should recommend statutory changes that benefit the public, which the board did in 2021. **These have been waiting on legislative approval for three years.** Alaskan families are losing out on insurance coverage for their births because of this state level hold-up to the updating of our statutes. This is a staffing concern that affects Alaskan families greatly

regarding equitable access to care and choice in care. This is the first time the midwifery statutes have been updated in 40 years** and they now match and exceed national standards for practice certification and licensure while streamlining the licensing process without requiring state employee involvement.

It is IMPERATIVE that (HB 175) BE PASSED IMMEDIATELY BEFORE MARCH 31, 2024 to ensure that Alaskan families have the statute changes they need to access maternity care that is up to date per the Audit recommendations and guidance of NARM, the national credentialing body that governs North American Midwifery practice, as there are key changes to language in this bill that guarantee insurance coverage for birth choice for Alaskan families and help more rural families access the care that the need.

- The Division of Corporations, Business and Professional Licensing's (DCBPL) chief investigator should ensure investigations are completed timely. This was not done, at no fault of the Board. The report findings state *an investigation that concerned a threat to public safety was not addressed by DCBPL investigators in an efficient manner* and that d*uring the audit period, the case was reassigned to an investigator,* ***but no work was performed from March 31, 2021, to June 9, 2022 (435 days).*** **This alone should prove a State-run Department is NOT more efficient.** The Board has done its part to reduce all redundancies with statute changes and peer review updates that no longer allow this disregard by the State's staffing deficits to further risk Alaskan families and public safety.

- The board should improve oversight of the peer review process. This step was completed and has helped to keep costs down for the Board and the midwifery license fees due in full part to the fact that we were able to stop paying state employees unqualified in community healthcare provision to do jobs that require expertise that the state has not committed to training nor retaining. This lack of commitment has cost the Board of CDMs greatly in the past and this last audit recommendation compliance ensured the efficiency of keeping board costs down per the guidance of the Legislative Audit Committee. The board is now operating fully self-sufficient and posting a surplus.

"Overall, the audit concludes that the ***board operated in the public's interest*** *by conducting its meetings in an effective manner, by supporting statutory changes when deemed necessary, and by actively amending regulations…The Board is the only agency authorized to license midwives in the state and, as such, does not duplicate the efforts of other agencies."* - Results and Findings of the sunset review conducted on our Board October 14, 2022

6. Keeping the Board of Midwives saves money, and it saves lives.

Why do midwives have an autonomous board and why does that matter?

We have worked closely with state and legislative audit committees over the past 8 years to establish streamlined processes for licensing, peer review, investigative procedures, and more. This collaborative effort aimed to relieve the state of associated costs and responsibilities regarding the regulation of the practice of midwifery. By complying with legislative audit recommendations, we have strived to keep costs down for the State of Alaska, for new and practicing licensed midwives, and we have helped to ensure that Alaskan families receive the best possible care that their insurance will pay for, that exceeds national standards, and that delivers outstanding results. Our commitment to maintaining and exceeding national training and credentialing standards, as set by our certifying body, the North American Registry of Midwives and the credentialing

requirements of the Certified Professional Midwife, is reflected in the updated regulations and statutes that have been awaiting signature since 2021. This ongoing dedication by the Board of CDMs and the midwives of Alaska supports safe community healthcare care access and midwifery practice across the state while supporting efficient, economic practice regulation that is up-to-date and that continues to provide the best maternity care outcomes for families in the state.

The evidence is resoundingly clear: The Board of Certified Direct-Entry Midwives (CDMs) is not only self-sustaining, but it also saves the State of Alaska millions of dollars annually. Our collaborative efforts with state and legislative audit committees have consistently demonstrated that we are the most efficient and cost-effective option for regulating the practice of midwifery at a mere $28,000 yearly paid for completely by midwifery licensing fees.

The Board's commitment to maintaining and exceeding national training and credentialing standards, as well as the successful implementation of streamlined processes, is a testament to our dedication to ensuring that Alaskan families receive the best possible care. The exceptional outcomes for women and infants under CDM care, including significantly lower cesarean section rates, zero maternal deaths, and improved breastfeeding rates, speak volumes about the quality and safety of the care we provide.

It is imperative that the autonomy of the Board of CDMs is preserved to continue this vital work.

Therefore, we urge you to vote NO on EO 130 and to expedite the passage of the necessary statutes, by voting YES on HB 175, before March 31, 2024. By doing so, you will not only safeguard the economic interests of the state but also ensure the safety and well-being of Alaskan families. Keeping the responsibility in the hands of the Board of CDMs is the most efficient and effective choice for the residents and families of Alaska. We implore you to support our cause and help us continue to save lives across Alaska with safe practice and up-to-date board autonomy and regulation.

Sincerely,

The Board of Certified Direct Entry Midwives

Konrad Jackson

From: Mary Yanagawa <maryyanagawa@gmail.com>
Sent: Friday, January 26, 2024 8:47 PM
To: Senate Labor and Commerce
Subject: Please add to the permanent record
Attachments: IMG_7166.PNG

Follow Up Flag: Follow up
Flag Status: Flagged

I am reaching out as an Alaskan Midwife practicing in Wasilla.

I would ask that you, the members of Senate Labor and Commerce, take careful consideration in the governor's EO130 which will dismantle the board of midwives and absorb it into the administration via the Department of Commerce.

This move puts access to midwifery and women's health care options at risk.

We MUST maintain the autonomous Board of Midwives that understands the profession, understands consequences of losing access to care, and understands the ramifications to public health and safety that would surely be a downstream consequence.

Please, vote NO on the governor's executive order 130.

And please, vote YES on the currently midwifery bill being sponsored by Jamie Allard in the House: HB175 when it's counterpart makes its way to the senate.

Thank you for your time.
~Mary Yanagawa

Konrad Jackson

From: Michelle Bibbs <bibbs_michelle@live.com>
Sent: Tuesday, January 30, 2024 3:48 PM
To: Senate Labor and Commerce
Subject: Please don't take our Autonomy!

Follow Up Flag: Follow up
Flag Status: Flagged

To whom it may concern,

I'm writing this letter with tears in my eyes, I'm trying to wrap my head around how our autonomy as woman is always under attack! At 16 weeks pregnant with the hopes to have more children I cannot fathom my right to a natural home birth with my midwife being taken away!

Please hear our voice as we write in support of maintaining the Board of Midwives in Alaska. We are OPPOSED to the governors Executive Order 130 that would absorb this autonomous board into the Department of Commerce.

We would also ask that you vote YES on HB 175 this session as it makes its way through the committee process and ultimately will be voted on by the whole body.

We want to continue Alaska's strong history of access to midwifery care and protecting the autonomy of this profession.

Please look at the positive statistics that midwives have on the birthing world, and how much money they save the state with much less cost and fees! We need to have faith in the system that it CAN BE for woman's rights to choose!

Thank you for your time,

Michelle Bibbs
Anchorage, Alaska

Konrad Jackson

From: Mikaela Levy <mikaelalevy07@gmail.com>
Sent: Monday, January 29, 2024 2:45 PM
To: Senate Labor and Commerce; Rep. Andi Story; Rep. Sara Hannan; Sen. Jesse Kiehl; House Labor and Commerce
Subject: Opposition of Ececutive order #130

Follow Up Flag: Follow up
Flag Status: Flagged

Dear members of the Alaska State legislature,

I am a constituent living in Juneau, Alaska. I was born and raised here and am now raising my family in this community I love. I am writing in opposition of executive order #130 and support House bill #175. I had my first of four babies at the age of 18 and have seen the profound impact midwifery care can have not only for young families, but also the entire community they serve. I now have four children and all of my births were attended by midwives. The care I received from my incredibly skilled and compassionate midwives shaped the person I am today. I credit them with laying the foundation that allowed me to find success as a young parent. Their impact on my life allowed me to feel confident and secure in a system that viewed me as another statistic and stereotyped my future and ability to succeed. Without their care, support, and encouragement I would not be the person I am today.

Stripping direct entry midwives of their governing board denies their autonomy as clinical medical professionals. Assuming that an administrative clerk working with the state of Alaska can take over and manage not only licensing but also grievances and regulation around midwifery care in Alaska is not only harmful to the profession it is also harmful to families in Alaska. The board of direct entry midwives serves as a body of professionals who are knowledgeable of the unique needs of midwives in Alaska. They serve on the board as midwives themselves which means they also understand the nuances surrounding regulation of scope of practice for midwives. It is vital that direct entry midwives maintain a governing body that can advocate for the profession and keep midwifery care accessible and available to all Alaskan families.

Alaska is a unique state and the way we provide health care to families and communities is also unique. We are not immune to the maternal mortality crisis that the United States is facing. Midwifery care provides relationship, placed based, and culturally competent care. It also bridges the gap in care for communities where care is limited. Removing the governing body of direct entry midwives in Alaska leaves the profession without a board to advocate for appropriate regulation and scope of care. This opens the door for regulations that would hurt the profession and in turn Alaskan families.

An article by the Commonwealth fund outlines some of the major impacts expanding the role of midwives in the US could have on maternal outcomes. Below are some excerpts and a link to the full article.

“Maternal mortality rates are rising across all races and ethnicities in the U.S. — Black women are dying at nearly triple the rate of white women, and Native American women at double the rate. Additionally, data from maternal mortality review committees suggest that four of five pregnancy-related deaths are preventable.4”

“A recent analysis found that a midwife workforce, integrated into health care delivery systems, could provide 80 percent of essential maternal care around the world and potentially avert 41 percent of maternal deaths, 39 percent of neonatal deaths, and 26 percent of stillbirths.”

“Given the many benefits of midwives, and the profound maternal care inequities affecting Black and Indigenous families in the U.S., it’s important to understand how they could be better integrated into the U.S. health care system. This includes the intentional integration of midwifery across the complex health care ecosystem in order to ensure midwifery care is accessible, affordable, and equitable to all childbearing people.”

“states with highly integrated midwifery care — such as Washington, New Mexico, and Oregon — reported the best outcomes for mothers and infants, which included significantly higher rates of spontaneous vaginal delivery, vaginal birth after cesarean, and breastfeeding, and significantly lower rates of cesarean, preterm birth, low birth weight infants, and neonatal death (Exhibit 2). On the other hand, states with restrictive midwife laws and practices — including Alabama, Mississippi, and Ohio — were found to have worse outcomes.20”

“Research suggests that, in the relationship between midwives and childbearing people, patients deeply value time together, trust, the ability to ask questions, and emotional support.[21] To actualize these values, it is essential for midwives to be able to practice *autonomously*. Professional autonomy means midwives practice as independent providers that do not require physician “supervision.” To date, many state laws persistently require physician supervision and/or contractual practice agreements with physicians, ranging from supervision for all practice to supervision for prescriptive authority. States with laws that ensure autonomous midwifery practice have a more robust midwifery workforce that can attend more births and achieve better outcomes.[22]

Current hospital bylaws and other regulatory and legislative restrictions limit the growth of a robust midwifery workforce. Perinatal equity requires removing archaic laws and outdated policies designed to restrict midwifery practice and consolidate the power of physicians and hospital-based care.”

https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

Removing the board of direct entry midwives is the first step in allowing more regulation and less autonomy of midwifery care in Alaska. Please protect midwifery care in Alaska and oppose executive order #130 and support house bill #175
Mikaela Levy

Mendenhall valley resident - Juneau, Alaska

Konrad Jackson

From: Onica Sprokkreeff <homebirthalaska@gmail.com>
Sent: Sunday, January 28, 2024 9:10 AM
To: Senate Labor and Commerce
Subject: Executive Order No 130

Dear Senators,

I have sent each of you a copy of this email. However, I want to ensure the voice of Alaskan Midwives is solidified on the record in regards to Executive Order No. 130.

My name is Onica Sprokkreeff and I am the president of the Midwives Association of Alaska. As news of Executive Order NO.130 expediently spread throughout our Association's membership this past week, it was met with great alarm concerning the future of Midwifery in Alaska. The following letter is an expression of concern and is in opposition to Executive Order NO.130.

The use of Certified Direct Entry Midwives and autonomy for birthing options has been highly valued by many Alaskans for over three decades. Alaskans are known for valuing personal freedoms and self-sufficiency, and this mindset is inclusive in choosing their birth attendant. Alaskans are more than four times as likely as other Americans to choose a community birth supported by Midwives. Certified Direct Entry Midwives attend 60-80% of all out of hospital births in Alaska therefore; the issue of who oversees Midwives is an issue for the Alaskan way of life.

Maintaining the Board of Certified Direct Entry Midwives ensures Alaskan women and families who desire Midwives have the utmost autonomy over their birthing options and the profession, versus sole government control and dictation of Midwifery regulations which could restrict birth options for Alaskan families.

The current structure of the Board of Direct Entry Midwives consists of five members; 2 Certified Direct Entry Midwives, 1 Certified Nurse Midwife, 1 Obstetrician, and 1 public member. With their collaborative knowledge these five members set regulations in a manner that ensures public safety and reflects current provider standards in the field of Midwifery. Because of the specificity of the Midwifery field, it is difficult to glean how a state administrator will accomplish a similar quality of oversight for the profession. Ultimately, this may lead to restricted birthing choices for Alaskan women and families.

The Midwives Association of Alaska questions the Governor's decision in proposing this abrupt and dramatic change for our regulatory body. It is difficult to understand why this Administration would eliminate a self-sustaining board. The last Legislative Audit of the Board of Direct Entry Midwives completed in October 2022 determined the necessity of the Board of Midwives and recommended a four-year extension. Moreover; the audit recommendations highlighted the shortfalls of the departments' staffing challenges, in turn contributing to license processing delays as well as delays in addressing issues of public safety.

Staffing deficits within the Department of Community, Commerce, and Economic Development has been a long-standing issue, and it is not understood how eliminating the Board of Direct Entry Midwives, which is filled on a volunteer basis, would improve efficiency or maintain public safety.

The Midwives Association of Alaska requests additional transparency and reconsideration of Executive Order No. 130. We oppose the elimination of the Board of Direct Entry Midwives and government control of this important health care choice.

Kind Regards,

Onica Sprokkreeff, CDM, CPM, IBCLC
President on the Midwives Association of Alaska
907-444-1049

homebirthalaska@gmail.com
www.homebirthalaska.com

Dena'inaq ełnen'aq' gheshtnu ch'q'u yeshdu. (Dena'ina)
I live and work on Dena’ina land. (English)

Konrad Jackson

From: Rachel Pugh <rachel@traditionalrootsmidwifery.com>
Sent: Saturday, January 27, 2024 7:29 PM
To: Senate Labor and Commerce
Subject: Alaskan Midwife Information URGENT
Attachments: CPM_Fact_Sheet.pdf; Maternity-Care-Report-Alaska.pdf; Medicaid Cost Savings in 2022 for Midwives.pdf; MaternalMortality_2022.pdf; improving-our-maternity-care-now.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hello Senator,

I am attaching some important information regarding Alaska Midwives. I would appreciate it if you would take the time to look them all over and I would be more than willing to answer any questions you may have.

Vote NO on EO130 and vote YES on HB175

--
Traditional Roots Midwifery LLC
Rachel Pugh, CPM, CDM
Board of Certified Direct Entry Midwives
(907) 691-5991
traditionalrootsmidwifery.com

September 2020

Improving Our Maternity Care Now

Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies

Carol Sakala, Director for Maternal Health
Sinsi Hernández-Cancio, Vice President for Health Justice
Sarah Coombs, Director for Health System Transformation
Ndome Essoka, Health Justice Legal Intern
Erin Mackay, Managing Director for Health Justice

national partnership for women & families

The National Partnership for Women & Families dedicates this report to the millions of birthing people and their families who have been disrespected and mistreated by the U.S. health care system, the 700 women annually who have made the ultimate sacrifice birthing the next generation, and especially the families who have struggled this year to stay healthy and birth with dignity and safety during our dual national crises of the COVID-19 pandemic and racist injustice.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

This report was authored by the following National Partnership for Women & Families staff:

- Carol Sakala, Director for Maternal Health
- Sinsi Hernández-Cancio, Vice President for Health Justice
- Sarah Coombs, Director for Health System Transformation
- Ndome Essoka, Health Justice Legal Intern
- Erin Mackay, Managing Director for Health Justice

The following National Partnership for Women & Families staff contributed to this report (in alphabetical order):

- Stephanie Green, Health Justice Policy Associate
- Llenda Jackson-Leslie, Senior Communications Specialist
- Blosmeli León-Depass, Health Justice Policy Counsel
- Nikita Mhatre, Health Justice Policy Associate

We also acknowledge the following professionals who helped make this report a reality:

- Jorge Morales, Editor
- Nichole Edralin, Designer

This report was made possible thanks to the generous support of the Yellow Chair Foundation.

Improving Our Maternity Care Now: *Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*

OUR DIRE MATERNAL HEALTH CRISIS, WHICH HAS BEEN COMPOUNDED BY THE COVID-19 PANDEMIC, DEMANDS THAT WE MITIGATE NEEDLESS HARM NOW.

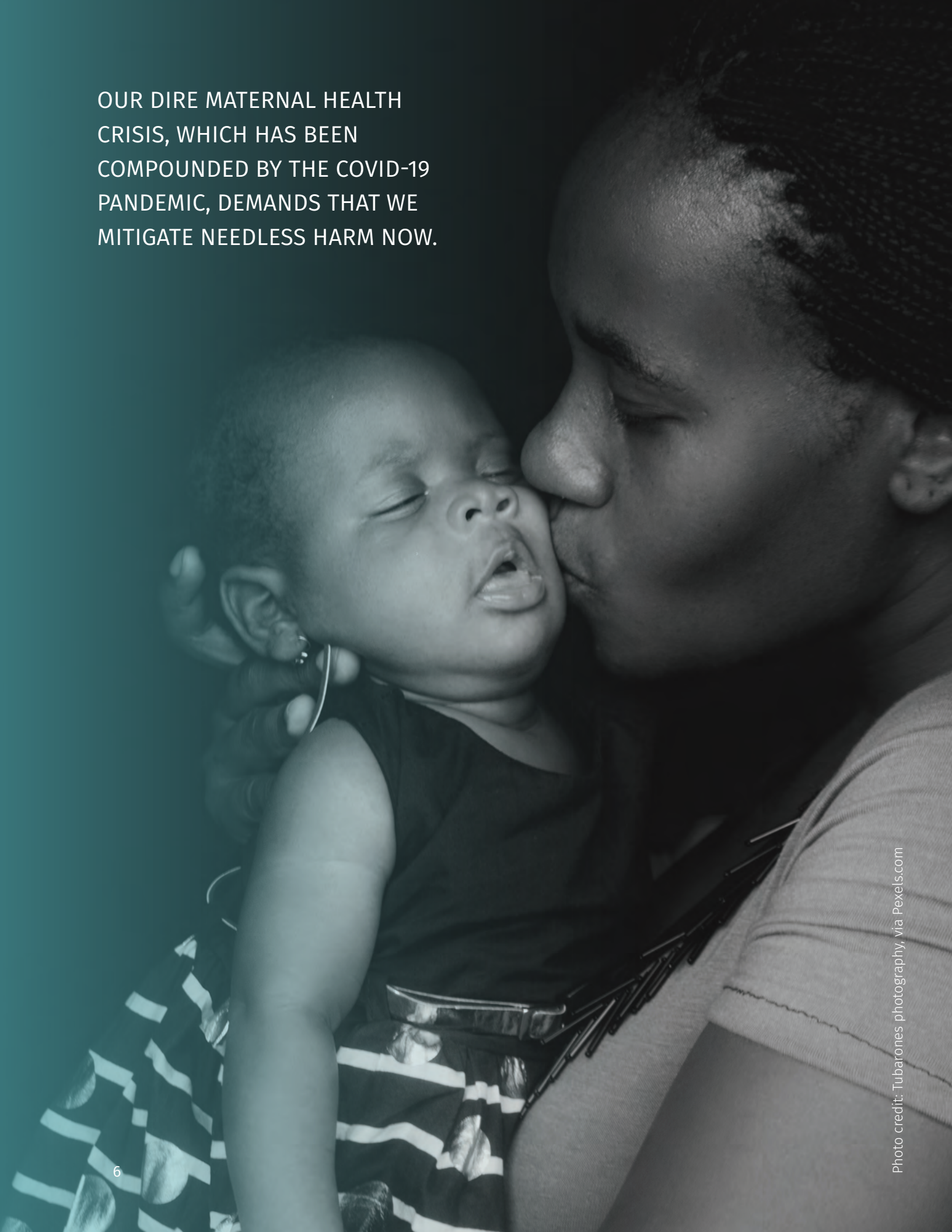


Photo credit: Tubarones photography, via Pexels.com

Improving Our Maternity Care Now: *Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*

Executive Summary

The U.S. maternity care system fails to provide many childbearing people* and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income country.

Our health care system spectacularly fails communities struggling with the burden of structural inequities and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.

In the long term, we must transform the maternity care system through multiple avenues: delivery system and payment reform, performance measurement, consumer engagement, health professions education, and modifying the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models lead to demonstrably better care, experiences, and birth outcomes. We just have to take steps to make them readily and widely available. We have identified three reliably high-quality forms of maternal and newborn care, as well as one promising, emerging model.

Clear evidence shows **midwifery care, "community birth" settings** (birth center and home birth settings), and **doula support** (including the extended model of prenatal, childbirth, and postpartum support) provide excellent and appreciated woman- and family-centered experiences, leading to improved birth outcomes. In addition, **community-led and -based perinatal health worker groups** are a newer, hybrid model of care that explicitly centers meeting community needs and priorities – particularly in communities of color – by providing a wide range of services, including in many cases some combination of midwifery care, community birth settings, and doula support. This model has emerged

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms such as "women" or "mothers" and gender-neutral terms such as "people," "pregnant people," and "birthing persons."

The terrible impacts of these inequities are unfair and unconscionable, considering that 60 percent of pregnancy-related deaths are preventable.

as a very promising practice in maternal care that has not been extensively evaluated as a unit, even as specific elements of care clearly have strong evidence of success, as already described. Given the strong focus on community-led services and the prominent role Black, Indigenous, and other women leaders of color have played in its creation and growth, it is likely that this last model is highly effective in reducing intractable racial inequities that have plagued many communities.

These four models of care share characteristics that distinguish them from the typical maternal care currently available in the United States. They provide highly appropriate care, minimizing both overuse and underuse. Care team members tend to be highly mission-driven and committed to meet their clients where they are. They holistically help meet families' physical, emotional, and social needs, providing individualized, respectful, trusted, relationship-based care. They tend to incorporate the skills and understanding to expertly support physiologic childbearing for the growing proportion of people interested in birthing in a less medicalized, more holistic way that avoids unneeded medical interventions. Their remarkable outcomes on key health indicators succeed for communities that are commonly left behind. Lastly, while demand for these services is great, too often women and families can't access and benefit from them.

This report describes each of these models, their current availability, and the evidence that supports their safety, effectiveness, and broader adoption to improve maternal and infant health. The report also provides recommendations for decisionmakers in the public and private sector to achieve this goal.

Models of Care Meriting Wide Adoption

Evidence shows that the first three models – midwifery care, community birth settings for medically low-risk pregnancies, and doula support – are highly effective and improve maternal and infant health. These results are especially notable given that usual maternity care continues to fail many birthing people and their families. We continue to have rates of preterm

birth, low birth weight, and cesarean births that are too high; rates of vaginal birth after cesarean and initiation and duration of breastfeeding that are too low; and extreme and unacceptable racial and ethnic inequities. Clearly, many more childbearing people and families could and should benefit from these higher-quality options.

The newer model comprises perinatal health worker groups headed by local community leaders. These multifunction groups are explicitly designed to meet the individual needs of childbearing people, families, and communities. They offer a wide range of services, often including one or more of the three evidence-based models described above. Frequently, they combine clinical and support services. They are particularly known for their expertise in offering respectful, trusted, culturally congruent care to communities of color. Such care acknowledges that women's cultural identity is central to the clinical encounter, upholds racial justice, fosters agency and practices cultural humility. In many cases, the groups also offer training programs that include national competencies such as comfort measures for doula support, as well as trauma-informed care to address the distinctive needs of marginalized communities and mitigate the harms of racism.

While evaluations of the perinatal health worker groups model are limited, available data show impressive results. And to the extent that these groups offer proven services such as midwifery care, community birth, and doula support, they are based on clear evidence. Given the urgency to mitigate the country's maternal health crisis, support for these groups should be prioritized along with evaluations of their impact.

As we work to transform the maternity care system, midwifery care, community birth, doula support, and the services of community-led perinatal health groups must be central to quality, value, and equity.

RECOMMENDATIONS

The ongoing maternal health crisis, compounded by the current COVID pandemic, underscores the urgency of taking concrete action now to improve birth outcomes for women and their families.

Congress and federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act, a bipartisan bill designed to increase the supply of midwives with nationally recognized credentials.
- Enact the Birth Access Benefiting Improved Essential Facility Services (BABIES) Act, a bipartisan bill to fund sustainable Medicaid demonstrations of birth centers for enrollees with low-risk pregnancies in underserved areas.
- Enact the Kira Johnson Act, which would improve Black maternal health by providing funding for community-based perinatal health worker organizations, especially those led by Black women; address racism and bias in all maternal health settings; and support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act, which aims to grow the maternal health workforce, to provide guidance to states for promoting diverse maternity care teams and centering culturally congruent care in improving outcomes, and to study the barriers to entry for low-income and minority women into maternity care professions.
- Ensure that Medicaid, CHIP (Child Health Insurance Program), TRICARE (military health care program), Veterans Health Administration (VHA), Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service (as appropriate) cover:
  - Certified midwives (CMs) and certified professional midwives (CPMs)
  - Licensed birth centers and midwife birth center providers with nationally-recognized credentials
  - Home birth attended by midwives with nationally-recognized credentials
  - Doula support
- Create programs to support and evaluate community-based multi-functional programs, such as through the Center for Medicare and Medicaid Innovation.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health (including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding).

State decisionmakers should:

- Enact necessary licensure in remaining jurisdictions for CMs, CPMs, and birth centers.
- Ensure that midwives with nationally recognized credentials are paid at the same level as physicians for the same service.
- Ensure that state Medicaid and CHIP programs pay for
  - Services provided by CMs and CPMs
  - Facility fees of licensed birth centers and professional fees of midwives with nationally-recognized credentials practicing in licensed birth centers
  - Home births attended by midwives with nationally-recognized credentials
  - Doula support
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice "at the top of their license" according to their full competencies and education.
- Ensure that doula training is tailored to the specific needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Pursue partnerships with community-based perinatal health worker groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments.

Private sector decisionmakers should:

- Educate employees and beneficiaries about the benefits of high-value forms of maternal health care, including midwifery care, birth centers, and doula support.
- Ensure that plan directories maintain up-to-date listings for available birth centers and midwives.
- Ensure that plans contract with birth centers and midwives with nationally recognized credentials in their service area and reimburse care in all settings provided by midwives with nationally-recognized credentials.
- Include extended model doula support as a covered benefit in health plans.
- Make the services of community-based perinatal health worker groups available to beneficiaries and evaluate the return on investment, including implications for quality of care, health outcomes, and women's experiences.

Conclusion

Our nation's terrible birth outcomes and unconscionable racial and ethnic inequities are driven by many separate yet interrelated factors and will require a multifaceted strategy to solve permanently. Nevertheless, we already know what to do to make concrete progress and achieve healthier mothers and babies. We must not accept the status quo of inequitable and expensive care that perpetuates avoidable harm. Concrete progress is within reach if decisionmakers are willing to act.

Introduction

The U.S. maternity care system fails to provide many childbearing people* and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income country.[1] It spectacularly fails communities struggling with the burden of structural inequities and other forms of disadvantage, including: Black, Indigenous, and other communities of color; rural communities; and people with low incomes.[2]

In the long term, we must transform the maternity care system through levers, including delivery system and payment reform, performance measurement, consumer engagement, health professions education, and modifying the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models make a demonstrable difference in better care, experiences, and birth outcomes. We must take steps to make these widely available. We have identified three reliably high-quality forms of maternal and newborn care, as well as one promising, emerging model. Clear evidence shows that **midwifery care, "community birth" settings** (birth center and home birth), and **doula support** provide highly effective care and excellent experiences, leading to improved birth outcomes. A newer model of **community-led and community-based perinatal health worker groups** has shown promise, especially in reducing glaring racial inequities in maternal health outcomes. Often, one setting or service provides some combination of these four models together. These combinations likely offer synergistic effects.

These forms of care share attributes that distinguish them from typical maternal care currently provided in the United States:

- They tend to have competence and reliability in providing highly appropriate services, avoiding both the underuse of high-value services and the overuse of unneeded care.
- The care team members tend to be exceptionally mission-driven and are ready to meet diverse needs of childbearing people and families where they are.
- They recognize and respond to the considerable physical, emotional, and social challenges that many families

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities, and do not always identify as "women" or "mothers." In recognition of the diversity of identities, this report uses both gendered terms such as "women" or "mothers" and gender-neutral terms such as "people," "pregnant people," and "birthing persons."

face (and their root causes), offering holistic services that build on the individual's and family's strengths to support better health, more confidence, and increased resilience.

- They tend to provide individualized, relationship-based care and support that are respectful, dignifying, trustworthy and trusted, and often culturally congruent. Culturally congruent care centers the needs of patients and families within their social, cultural, and linguistic needs and values. In the process, providers and clients collaboratively build a trusting, effective, high-quality care experience.[3]
- They tend to incorporate the skills and understanding to expertly support physiologic childbearing for the growing proportion of people interested in birthing in a less medicalized, more holistic way that de-emphasizes unneeded medical interventions. This type of care actively supports the innate capabilities of birthing people and their fetus or newborn for labor, birth, breastfeeding, and attachment, only employing medical interventions as needed to augment physiologic processes.
- The outcomes they achieve are remarkable, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.
- Surveys of childbearing women find that large proportions are interested in these forms of care. However, too often women and families cannot access and benefit from them.

The current maternal care crisis: Terrible outcomes and deep inequities

The United States lags behind every other high-income country, with the highest rates of infant and maternal mortality. Between 1987 and 2016, pregnancy-related deaths more than doubled – from 7.2 to 16.9 deaths per 100,000 live births.[4] Between 2006 and 2015, severe maternal morbidity, often reflecting a "near miss of dying," rose by 45 percent, from 101.3 per 10,000 hospitalizations for birth to 146.6.[5]

In communities of color, the crisis is far greater. Compared to white non-Hispanic women, Black women are more than three times as likely – and Native women are more than twice as likely – to experience pregnancy-related deaths. Black, Hispanic, and Asian and Pacific Islander women disproportionately experience births with severe maternal morbidity relative to white non-Hispanic women.[6] Additionally, there are geographic disparities: Rural residents have a 9 percent greater risk of severe maternal morbidity and mortality, compared with urban residents.[7]

Multiple factors contribute to maternal mortality and to racial, ethnic, and geographic disparities. These include: gaps in health coverage and access to care; unmet

social needs, like transportation and time off from paid work for medical visits, and safe and secure housing; poor quality of care, including implicit and explicit bias; and structural and institutional racism in health care and community settings.[8] The terrible impacts of these inequities are unfair and unconscionable, considering that 60 percent of pregnancy-related deaths are preventable.[9] One strategy to prevent maternal mortality and severe morbidity is to increase access to high-quality, culturally and linguistically congruent, evidence-based maternity care.

MATERNAL HEALTH INEQUITIES IN COMMUNITIES OF COLOR

The deep racial inequities in maternal and infant health outcomes in the United States must be understood in the context of our history of slavery and colonialism. In fact, the practice of gynecology and obstetrics in our country was built on abusive, inhumane experimentation on enslaved Black women, such as developing cesarean and other surgical procedures without anesthesia.[10]

Even after slavery ended, the Black female body continued to be inextricably linked to a complicated history of racism, discriminatory health practices, inhumane medical experimentation, eugenics, and forced sterilization. For example, Henrietta Lacks's cervical cancer cells were used by the medical establishment to help understand disease and develop treatments, without her or her family's knowledge, and certainly without recognition, until 2010.[11]

Key advocates for contraception, such as Margaret Sanger, the founder of what became Planned Parenthood, were motivated by racist, eugenic, population control principles.[12] Oral contraception – heralded as a tool for the liberation of middle-class white women – was tested on women in Puerto Rico, often without their knowledge or consent, even as many were also forced to undergo sterilization. In 1965, one in three married women in Puerto Rico between the ages of 20 and 49 were sterilized.[13]

The United States lags behind every other high-income country, with the highest rates of infant and maternal mortality.

In this country, access to maternity care depends on many factors, including availability of health insurance. However, for many communities across the country, particularly rural and low-income communities, having health insurance does not ensure access to care. There are many barriers to care even if you have insurance, including cost, lack of transportation, family caregiving responsibilities, inability to take time off from work, and cultural and linguistic factors.[14]

One of the most challenging barriers to accessing care is provider availability – either in your insurance network or at all. More than one-third of counties in the United States are "maternity care deserts," with neither a hospital maternity unit nor any obstetrician-gynecologist or certified nurse-midwife.[15] This means that most rural women have to drive more than a half-hour to the nearest hospital with maternity services.[16] Maternity care deserts are not limited to rural locations. For example, recent closures of maternity wards in the District of Columbia exacerbated ongoing maternity care provider shortages, despite the fact that D.C. has the second-lowest rate of people without insurance in the country. Unsurprisingly, D.C. also has one of the worst maternal mortality rates in the nation.[17]

Even when people have access to maternity care, it may not be the high-quality, culturally congruent care they need to promote healthy pregnancies, births, and babies. Quality care is often defined as the right care at the right time in the right setting for the individual.[18] Quality care aligns with the person's values, preferences, and needs. Efforts to promote and measure care quality often focus on better health outcomes, improved care coordination, the person's experience of care, and in some cases adherence to clinical treatment guidelines and best practices.[19]

Another foundational element of quality maternity care – and all care – is respect for people. In fact, half of the World Health Organization's standards for quality maternal and newborn care underscore "respect, dignity, emotional support, and a systemic commitment to a patient-led, informed decision-making process." Disrespectful maternal care can include withholding

or distorting information, coercion, and unfounded threats of harm to the baby to gain consent for unwanted and often unnecessary procedures. In some cases, there may even be physical or sexual abuse in the form of hitting, unnecessary restraints, and rough vaginal examinations.[20] Mistreatment is experienced more frequently by women of color, by those birthing in hospitals, and among those who experience social, economic, and health inequities in the United States. In addition, mistreatment can be exacerbated by unexpected obstetric interventions and by disagreements between birthing people and their providers.[21] Mistreatment during childbirth has a clear negative effect on the health and well-being of the birthing person, child, and family.[22]

The growing focus on the maternal health crisis in Black, Indigenous, and other communities of color, in the context of efforts to promote dignity in childbirth, has elevated the importance of culturally centered and culturally congruent care as a fundamental component of high-quality maternity care. The National Perinatal Task Force recently concluded that care "that does not also take into consideration the unique experiences of a woman/person, her/their community, and the specificities of her/their cultural background cannot produce the highest quality outcome."[23]

Yet our maternity care system regularly fails to provide birthing people of diverse backgrounds the culturally centered attention required to ensure high-quality care and promote healthy outcomes for mothers and babies. Even worse, this failure can cause additional harm to birthing people already shouldering experiences of ongoing racism, toxic stress, and trauma – from failing to mitigate the impact of Black women's lack of trust in the health care system, to disregarding Native women's traditional ways of caring for pregnant people.[24]

Fortunately, doulas, midwives, and community-based perinatal health worker organizations like Mamatoto Village in the nation's capital; Commonsense Childbirth in central Florida; Breath of My Heart in Española, N.M.; and Mama Sana Vibrant Woman in Austin, Texas, are leading the way in providing accessible culturally centered prenatal, birth, and postpartum care and support.[25]

Another foundational element of quality maternity care – and all care – is respect for people.

DISMANTLING RACISM AND MITIGATING HARM IN MATERNITY CARE

As our understanding of the terrible impact of racism on health has grown, there has been an increasing focus on not just preventing racist harm in health care, but also leveraging how care is provided to mitigate the harm caused by systemic racism and other forms of oppression. Providing culturally congruent care is especially important as a strategy to improve maternal and infant health in communities struggling with intractable racial and ethnic health inequities.

Over the last few decades, researchers, practitioners, and advocates have evolved the concept of "cultural competence," which focused on how health care systems could improve care delivery to diverse patients by tailoring care to meet their social, cultural, and linguistic needs,[26] to a more expansive concept of "cultural congruence." Culturally congruent care centers the needs of patients and families within their social, cultural, and linguistic needs and values. In the process, providers and clients collaboratively build a trusting, effective, high-quality care experience.[27]

Culturally congruent maternity care is foundational for improving quality and eliminating racial and ethnic inequities in maternal health outcomes, as well as those based on sexual orientation, gender identity, disability, and religious beliefs.[28] It is care delivery that takes into account a pregnant person's values, beliefs, preferences, and linguistic needs.[29] Culturally congruent perinatal providers strive to understand the broader social, environmental, and historical context of the childbearing person's family, community, and culture, and understand that these factors may influence the experience of pregnancy, birth, and parenting. Such care requires sensitivity, compassion, and deference to pregnant people's expertise about their own bodies and lives. While a provider cannot immerse themselves in every person's specific culture, they are responsible for having a basic understanding of their needs and communicating with them effectively, so people feel heard and respected, without judgment.

Culturally congruent care is indispensable in high-quality care because conscious or unconscious bias, stereotyping, and lack of cultural awareness and sensitivity can result in misdiagnosis, improper treatment, and mutual mistrust between providers and patients.[30] Pregnant people should have access to diverse providers and care that is rooted in equity and cultural congruency. Developing cultural congruency in the delivery of maternity care can improve trust between patients and providers, and has the potential to reduce maternal and infant health disparities, particularly among Black women and other women of color and their babies.[31]

One persistent and widespread failure of our maternity care system is that many beneficial practices are underused and ineffective or unneeded and potentially harmful practices are overused.

Clinical standards for quality maternity care are also based on the safety and effectiveness of specific practices, treatments, and interventions. One persistent and widespread failure of our maternity care system is that many beneficial practices are *underused* and ineffective or unneeded and potentially harmful practices are *overused*.[32]

Overuse happens when procedures that offer no clear benefit, and could potentially cause harm, are employed for no well-supported clinical reason – often in healthy women. For example, labor inductions happen with about four in 10 women.[33] Yet research supports few indications for inducing labor, which increases the risk of complications such as infection for both mother and baby, uterine rupture, and low fetal heart rate.[34] Another example of overuse is the steep increase in cesarean births, which today account for nearly a third of all births. This surge in cesarean rates has not been accompanied by any improved health outcome for women and babies. Instead, many have been needlessly exposed to the additional short- and long-term risks and complications of cesareans, including postpartum hemorrhage, blood clots, and infection.[35] This particular problem – providing more medical care than is needed or recommended, is also known as "over-medicalization."[36]

On the other hand, underuse happens when safe, beneficial, health-enhancing practices are not routinely available or employed. Examples among the many underused beneficial maternity care practices are smoking cessation interventions for pregnant people, manual manipulation to turn breech fetuses to the headfirst position, and treatment for perinatal depression.[37]

One response to over-medicalization, as well as birthing people's desire to retain more autonomy and control during pregnancy and childbirth, has been an increasing interest in physiologic childbirth. In the early 20th century, pregnancy and childbirth were reframed as medical – even pathological – conditions, rather than healthy physiologic life processes. Birthing moved from being attended by midwives of all backgrounds and traditions at home, to hospitals dominated by white men who saw childbirth as a medical problem to be solved with an array of drugs, treatments, and interventions.[38] Physiologic childbirth approaches birthing from a less medicalized, more holistic frame that avoids unneeded medical interventions. This type of care actively supports the innate capabilities of birthing people and their fetus or newborn for labor, birth, breastfeeding, and attachment. Medical interventions are used judiciously, as needed, and not as routine practices.[39]

Without detailed demographic data we cannot address the crisis and transform the maternity care system. This includes collection and public reporting of maternal and infant health data, broken down by race, ethnicity (including relevant subgroups), primary language, sexual orientation, gender identity, disability status, and socioeconomic status. Better demographic data collection and disaggregated reporting is critical to promoting understanding and advancing accountability for quality, equitable, and high-value maternity care.

Every birthing person should have access to evidence-based maternity care and be supported with high-quality information to make informed decisions about their care and birth experience. Unfortunately, this is not what usually happens.[41] In this report, we describe the four highlighted models of care, current access to these models, and summarize the evidence that supports their use as high-quality, high-value models. We include specific recommendations for decisionmakers to expand the reach and impact of these exceptional forms of care on childbearing families.

Selected Examples of Overused and Underused Maternity Practices[40]

OVERUSED PRACTICES

- **Labor induction**
- **Scheduled births**
- **Cesarean birth**
- **Repeat cesarean birth**
- **Continuous electronic fetal monitoring**
- **Healthier babies admitted to neonatal intensive care units (NICUs)**

UNDERUSED PRACTICES

- **Planned labor after one or two cesareans**
- **Smoking cessation interventions for pregnant people**
- **Continuous support during labor**
- **Hand maneuvers to turn a fetus to a headfirst position at term**
- **Intermittent auscultation with handheld device for fetal monitoring**
- **Being upright and mobile during labor**
- **Screening for and treating perinatal depression**

THREE HIGH-QUALITY, EVIDENCE-BASED MATERNITY CARE MODELS TO SPREAD AND SCALE NOW

Three evidence-based models exemplify the high-quality, high-value maternity care that is urgently needed to tackle our maternal and infant health crisis and reduce inequities. Models with strong evidence of success include **midwifery care, community birthing** in either birth centers or homes, and **doula support,** including the extended model of prenatal and postpartum support.

MIDWIFERY CARE

Photo credit: Diversity Photos, Photodisc Collection, via GettyImages.com

In nearly all nations, midwives provide first-line maternity care to childbearing people and newborns. However, in the United States, the vast majority of births are attended by obstetricians, while midwives attend only about 10 percent of births.[42] In general, midwifery is a high-touch, low-tech approach to maternity care. It is based on the core understanding that childbearing for most women is a healthy process that requires monitoring to identify when higher levels of care are needed. It centers the childbearing person and family. The midwifery model of care emphasizes a trusted relationship,

health-promoting practices, information that birthing people need to make their own informed care decisions, and personalized care tailored to individual needs and preferences. Many midwives have the skills and knowledge to support the physiologic model of childbearing, in contrast to the medicalized model that has become the norm in the United States. Although any type of maternity care provider can theoretically offer the midwifery model of care and can foster physiologic birth, midwives do so most consistently.[43] The midwifery model of care contrasts with medical approaches that are more pathology-focused and procedure-intensive for lower- as well as higher-risk women.

Hospital-based midwives have access to and use epidural analgesia and other technologies that are not available in birth centers and at home, according to women's needs and preferences. Influenced by hospital protocols and culture of practice, as well as the needs and preferences of women with hospital births, the overall style of practice of hospital-based midwives involves more interventions than midwives practicing in birth centers and at home.[44]

As in other countries, U.S. midwives holding nationally recognized credentials provide expert care for birthing people, and are trained to identify when higher levels of more specialized care are needed. Midwives may consult, share care, or transfer women to specialty care when higher risks and complications emerge.[45] Given that most women in the United States give birth in hospitals, it is no surprise that most midwives attend births in hospitals. However, nearly all maternity care providers in birth center and home birth settings are midwives.[46]

The United States has three nationally recognized midwifery credentials with education programs recognized by the U.S. Department of Education. Certified nurse-midwives (CNMs) have completed a nursing degree in addition to their midwifery training. They provide care in all three birth settings (hospitals, birth centers, and homes) and are licensed to practice, and be Medicaid providers, in all jurisdictions. In the 1990s, two additional credentials were created: certified midwife (CM) and certified professional midwife (CPM).

The CM educational program content and certification exams are the same as for CNMs, except that CMs are not required to hold a nursing degree. They also practice in all three settings. The CPM credential requires knowledge and experience in community birth, that is, care in birth centers or homes.[47] At this time, seven states regulate CMs, and 34 states and the District of Columbia have a path to CPM licensure, with ongoing efforts for legal recognition in remaining states and U.S. territories. Medicaid reimburses CMs in just one state and CPMs in 15 states.[48] The following table summarizes the three national midwifery credentials.

Midwives with Nationally Recognized Credentials: CNMs, CMs and CPMs[49]

Credential	Degree	Setting	Legal recognition	Medicaid coverage
Certified nurse-midwife (CNM)	RN + master's degree	Hospital, birth center, home	All states, DC, U.S. territories*	Yes, by federal statute
Certified midwife (CM)	Bachelor's + master's degree	Hospital, birth center, home	7 states: DE, HI, ME, NJ, NY, OK, RI	NY
Certified professional midwife (CPM)	High school diploma or equivalent; may earn certificate, associate's, bachelor's, or master's degree	Birth center, home	34 states + DC (all except CT, GA, IA, IL, KS, MA, MO, MS, ND, NE, NC, NY, NV, OH, PA, WV, and U.S. territories)	AK, AZ, CA, DC, FL, ID, MN (birth centers only), NH, NM, OR, SC, VA, VT, WA, and WI

Midwifery care provides equal or better outcomes compared to usual care

Several systematic reviews** have compared the care and outcomes of midwives and physicians. Compared to physician care, midwifery care resulted in:

- Less electronic fetal monitoring
- Less epidural or spinal analgesia
- Less use of pain medication overall
- Fewer episiotomies
- Increased spontaneous vaginal birth (with neither forceps nor vacuum)

* The US territories include: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

** A systematic review is a method of assessing the weight of the best available evidence about possible benefits and harms of interventions or exposures. An investigation by the Institute of Medicine found that this rigorous methodology is the best way of "knowing what works in health care." Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation.* (Washington, DC: The National Academies Press, 2008), https://doi.org/10.17226/12038

- More vaginal births after a cesarean
- Improved initiation of breastfeeding
- Better psychological experience (e.g., sense of control or confidence, satisfaction)
- Lower costs

Physicians and midwives produced the same results with regard to:

- Use of IV fluids in labor
- Maternal hemorrhage (excess bleeding)
- Signs of fetal distress in labor
- Condition of newborn just after birth
- Admission to a neonatal intensive care unit (NICU)
- Fetal loss or newborn death

For some indicators, systematic reviews varied in their conclusions. Compared to physicians, midwives had equal or better results for:

- Hospitalization in pregnancy
- Preterm birth
- Low birth weight
- Labor induction
- Use of medicine to speed labor
- Cesarean birth[50]

Other researchers have found that states that have more fully integrated midwifery care tend to have better maternal and infant health outcomes. More integrated states (measured by indicators such as regulation of the profession, Medicaid payment for their services, and the degree to which regulations allow them to practice autonomously) were more likely to report higher rates of physiologic childbearing, lower rates of cesarean and other obstetric interventions, lower risk of adverse newborn outcomes (preterm birth, low birth weight, and infant mortality), and increased breastfeeding both at birth and at six months postpartum.[51]

Similarly, the availability of midwifery care at the hospital level has been associated with less use of labor induction, medication to speed labor, and cesarean birth, and greater likelihood of vaginal birth, including vaginal birth after a cesarean, than hospitals with physician-only maternity services.[52] Higher percentages of midwife-attended births at hospitals have been associated with lower rates of cesarean birth and episiotomy.[53]

In light of the intractable maternal health crisis plaguing the country, investing more resources in training and supporting high-quality, high-value midwifery care is a powerful strategy for rapidly expanding access to effective maternity care services. Compared to the time and money it takes to train an obstetrician or family physician, midwives can be ready to serve pregnant people and their families more quickly and at a lower cost.[54] This is especially important given how racial and ethnic inequities in maternal and infant health mirror educational and economic inequities to a significant degree.

Spotlight on Success

MERCY BIRTHING CENTER

The Mercy Birthing Center illustrates the potential of a flourishing midwifery-led unit within a hospital. The center is a separate unit operated by CNMs within Mercy Hospital St. Louis. It was established in response to women's growing interests in receiving support for physiologic childbearing.[55] This approach mobilizes the capabilities of women's own bodies in tandem with the capabilities of their fetus or newborn.

The homelike center includes four birthing suites with tubs and showers, a central living room and kitchen, an area for classes, and rooms for prenatal and postpartum and newborn visits.[56] The center offers comfort measures as well as nitrous oxide ("laughing gas") to help women cope with labor. The midwives use handheld devices for monitoring the fetal heart status ("intermittent auscultation"). In contrast to many typical hospital settings, laboring women are free to eat, drink, and move about, according to their interest, and to give birth in their position of choice. If they need higher levels of care (for example, an epidural or continuous electronic fetal monitoring) or develop a complication or concern, their midwife can accompany them upstairs to the standard labor unit and continue to care for them there. Care by obstetricians and maternal-fetal medicine specialists is available if needed.[57]

The center's care and outcomes contrast sharply with standard hospital birthing care:

- Their **cesarean rate is 70 percent lower** than that national average (less than one out of 10 births, compared to one in three).
- Their **rate of vaginal births after a cesarean (VBAC) among women planning to have one is up to 40 percent higher** (84 percent compared to usual rates of 60 to 80 percent, depending on the study).[58]
- Their **episiotomy rate is only 0.4 percent,** compared to 6.9 percent among hospitals reporting in 2018 – more than 17 times higher.[59]
- Their **epidural rate was 6.4 percent,** versus 75 percent nationally in 2018.[60]
- Their **labor induction rate was 68 percent lower than national rates** reported on 2018 birth certificates (8.7 percent,).[61] However, birth certificate are known to greatly undercount inductions. For example, women in California who gave birth in 2016 reported a rate of 40 percent.[62]

Mercy Birthing Center Care

(Compared to Standard Hospital Care rates)

70%
fewer cesareans

Up to **40%**
higher VBAC success

More than **17x**
fewer episiotomies

Nearly **12x**
fewer epidurals

68%
fewer inductions

In addition to these excellent clinical outcomes, 100 percent of their clients reported they would recommend this care to friends.

Eligible lower-risk women with Medicaid or private insurance typically have coverage for prenatal, hospital birth, and postpartum and care with CNMs. Thus, when cost sharing is not onerous, financial barriers to access at the Mercy Birthing Center are minimal. However, very few hospitals offer comparable midwifery-led units.

Women's positive experiences with and strong interest in midwifery care

In recent years, concerns about disrespectful maternity care have come to the fore, and many childbearing people – including those with tragic outcomes – have reported being ignored, having their concerns dismissed, not having choices in care, and otherwise being mistreated.[63] Two systematic reviews found that people who received midwifery care were more likely to report feeling more control, confidence, and satisfaction than people who received physician-led care.[64]

Women's interest in midwifery care far exceeds their current access and use. For example, in the population-based *Listening to Mothers in California* survey, six times as many participants with 2016 births indicated an interest in midwifery care should they give birth in the future, compared to people who actually received midwifery care. A total of 54 percent indicated some level of interest, with 17 percent stating they would definitely want midwifery care, and 37 percent stating they would consider this type of care provider. Interest was especially high among Black women (66 percent), and

Midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.

In addition, midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.[65] Increasing the diversity of the midwifery profession would enable more women of color to obtain high-quality care that mitigates the racism embedded in maternity and other types of health care.[66]

interest of women with Medi-Cal (California's Medicaid program) was similar to that of women with private insurance.[67]

Access to midwifery care is limited

Despite the clear value of midwifery care, especially as a pathway to help solve the nation's maternal health crisis and obtain better outcomes for birthing people and infants, there are important limitations to the availability of midwifery care. One indicator of

limited access is the gap between the number of women who state an interest in midwifery care – the majority – and the number of those who actually use it, which is roughly one in 10. Another indicator of lack of access is that in 2016, 55 percent of U.S. counties did not have a practicing certified nurse-midwife. Moreover, roughly one in three U.S. counties in that year were considered maternity care deserts, meaning that the county had neither an obstetrician-gynecologist, nor a nurse-midwife, nor a hospital maternity unit.[68] The American College of Obstetricians and Gynecologists recommends increasing the number of midwives as an essential strategy to solve this access crisis.[69] The availability of midwifery care is influenced by the supply and distribution of midwives and birthing facilities. CMs are only licensed in a handful of states, and CPMs still are not licensed in 16 states and U.S. territories. A model legislation process undertaken by leading midwifery organizations points the way to robust, woman-centered midwifery legislation.[70]

A factor that limits the supply of midwives is the lack of consistent, systemic support for midwifery education and educators, including preceptors, parallel to Medicare's support for medical residencies. The burden on midwifery educators (as well as student tuitions) and on preceptors is thus great. This is also a limiting factor in the availability of midwives to share their distinctive knowledge and first-line approaches to maternal-newborn care with medical students and trainees, and nursing and other students.[71] The Further Consolidated Appropriations Act of 2020 included $2.5 million for this purpose, and a bill filed in the current Congress would greatly expand support for CNM, CM, and CPM education. Both initiatives have equity framing.

Adequate payment for a model of care that typically involves longer office visits and significantly more time waiting for labor to progress naturally, rather than accelerating it with medications and procedures, may also be a barrier to midwifery practice. Across states, Medicaid payment for CNMs ranges from 70 percent to 100 percent of physician payment for the equivalent service.[72] Medicaid payment levels vary widely and the average payment for CNMs is just 65 percent of the CNM Medicare fee schedule rate.[73]

Lastly, unnecessarily restrictive practice acts that, for example, require these independent professionals to have physician supervision, limit their prescriptive authority, or limit their reimbursement, are associated with reduced midwifery practice, and thus appear to limit women's access to midwifery care.[74]

RECOMMENDATIONS

INCREASE ACCESS TO MIDWIFERY CARE

Midwives have a distinctive, dignifying, person-centered, skilled model of care and an exemplary track record. They are an important part of the solution to the nation's shortage of maternity care providers. However, there are barriers to meeting this need and enabling more childbearing people and families to experience benefits of midwifery care.

Federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3849 in the 116th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (CNMs, CMs, CPMs) by supporting students, preceptors, and schools and programs. It would give funding preference to supporting students who would diversify the profession and who intend to practice in underserved areas.
- Mandate payment for services of CMs and CPMs recognized in their jurisdiction by Medicaid, the Child Health Insurance Program (CHIP), TRICARE (the military health care program), the Veterans Health Administration (VHA), the Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service.
- Mandate that hospitals cannot deny privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State and territorial policymakers should:

- In jurisdictions that currently fail to recognize them, enact CM and CPM licensure. For CMs, these include all of the territories, the District of Columbia, and all states except Delaware, Hawaii, Maine, New Jersey, New York, Oklahoma, and Rhode Island. Jurisdictions that have yet to recognize CPMs through licensure are: Connecticut, Georgia, Iowa, Illinois, Kansas, Massachusetts, Missouri, Mississippi, North Dakota, Nebraska, North Carolina, New York, Nevada, Ohio, Pennsylvania, West Virginia, and all U.S. territories.
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice "at the top of their license" in line with their full competencies and education as independent

providers who collaborate with others according to the health needs of their clients.

- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for services of CMs and CPMs licensed in their jurisdiction, mandate payment at 100 percent of physician payment levels for the same services. Currently, Delaware, Hawaii, Maine, New Jersey, Oklahoma, and Rhode Island recognize CMs but do not pay for their services through Medicaid. States that regulate CPMs yet fail to pay for their services through Medicaid are: Alabama, Arkansas, Colorado, Delaware, Hawaii, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota (does not pay for home birth services), Montana, New Jersey, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, and Wyoming.

Private sector decisionmakers, including purchasers and health plans, should:

- Incorporate clear expectations into service contracts about access to and sustainable payment for midwifery services offered by providers that hold nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.

COMMUNITY BIRTH: BIRTH CENTERS AND HOME BIRTH

While the vast majority of births in the United States occur in hospitals, demand is growing for alternatives outside of hospitals and within communities – both in birth centers and at home. Collectively known as "community birth," these two options safely serve people with medically low-risk pregnancies who wish to have a physiologic childbirth, avoid the overmedicalization that is common in hospitals, retain more autonomy and control, and receive more personalized care. It is important to note that these options are not appropriate for people with medically high-risk pregnancies who require specialized care, which are a smaller proportion of all births.

Birth center care differs in fundamental ways from care in hospitals. Birth centers are designed to provide homelike care, and many are in converted homes. Compared to typical maternity office visits, prenatal and postpartum visits in birth centers are generally much longer. In addition to the standard clinical checks, significant time is invested in building relationships and trust, providing support and education, and answering questions. During labor and birth, birth centers provide care options not typically available in hospitals, allowing birthing persons to experience more freedom and autonomy. Their companions of choice are welcome, which may include their

partner, family members, and doula. They are encouraged to eat and drink if they want, and to walk and change positions. The fetus is monitored with a handheld device to allow for freedom of movement and to prevent the elevated risks of electronic fetal monitoring (e.g., increased likelihood of cesareans). Non-pharmacologic tools for coping with the challenges of labor include using tubs and showers, hot or cold compresses, inflated exercise balls, and massage. After birth, skin-to-skin contact and early breastfeeding initiation are highly encouraged and supported. Discharge to home typically occurs several hours after birth, with midwife or nurse home visits likely one and three or so days after birth. If needed, birth center midwives manage first-line complications and consult or transport to hospital settings as appropriate.[75]

Home birth care also contrasts notably with hospital care, and it shares attributes with birth center care. While home births are a small fraction of births in the country, they are growing in popularity. About 85 percent of home births are planned. Most planned home births are attended by midwives, although some physicians attend home births. For most people, the values and preferences that guide their choice to birth at home are similar to those that move people to choose birth centers. In fact, some birth centers provide home birth as an option for their prenatal care clients.

Birthing at home in familiar surroundings can provide the maximum freedom and autonomy to have a physiologic birth. Midwives who attend home births bring needed tools and supplies to provide care similar to that provided in birth centers. Some women obtain inflatable birth pools for use at home. More detailed discussion of practices and precautions in both birth center and home birth settings is available in the National Academies of Sciences, Engineering, and Medicine's *Birth Settings in America* report.[76]

Community birth can also offer more opportunities for people of color to receive the additional benefits of racially congruent care that acknowledges a person's cultural identity as central to the clinical encounter, upholds racial justice, fosters agency, and practices cultural humility.[77]

Community births are a very small – but rapidly growing – fraction of births in this country. In 2018, most people in the United

Rates of Community Births Are Increasing (2004 to 2017)

85% Increase
COMMUNITY BIRTHS

77% Increase
HOME BIRTHS

More than **50%** Increase
BIRTH CENTER BIRTHS

States (98.4 percent) gave birth in hospitals, 1 percent gave birth at home, and 0.5 percent in a birth center.[78] Rates of community birth can vary greatly from state to state, ranging from 0.4 percent in Alabama to 7.9 percent in Alaska, while the national average is 1.6 percent.[79] However, the use of community birth is increasing. From 2004 to 2017, community births rose by 85 percent,[80] with home births growing by 77 percent and birth center births more than doubling. This likely reflects both increasing interest, as well as loss of hospital maternity units in rural areas. One 2018 study found that the loss of hospital maternity units in rural areas was associated with a rise in home births, either planned or unplanned.[81] More recently, there is much anecdotal evidence that the COVID-19 pandemic is spurring an interest in these settings,[82] as people become increasingly concerned about reducing opportunities for the virus's transmission and many hospitals have set hard limits on who birthing people can have with them during labor and birth.

Evidence supports equal or better outcomes with community birth

The *Birth Settings in America* report concludes that the overall results reflect both the self-selection of women who want this type of care and the contributions of the "wellness-oriented, individualized, relationship-centered approach of midwifery care."[83] In addition to being safe and promoting better health outcomes, community birth is also a good value. A review of the costs of birthing at home and in birth centers found that resource use was generally lower in community birth settings due to fewer interventions, shorter lengths of stay, or both.[84]

Evidence supporting birth center care

An integrative review comparing births in birth centers and those in hospitals, as well as national averages, found that birth centers provided equal or better maternal health outcomes. The review found that, compared to hospital births, birth center births averaged:

- Higher rates of spontaneous vaginal birth
- Higher rates of intact perineum (without a tear or episiotomy)
- Lower rates of cesarean birth
- Lower rates of episiotomy
- Equal rates of serious perineal tears.[85]

The main reasons for transfers from birth centers to hospitals were non-emergency conditions, such as lack of progress in labor. Serious maternal outcomes were extremely rare, and the reviewed studies reported no incidents of maternal death.[86]

A systematic review of newborn outcomes of birth center care found only one widely reported outcome, neonatal mortality. No included study found higher neonatal mortality nor a trend toward higher neonatal mortality in birth center versus hospital birth.[87] The *Birth Settings in America* report found that birth center care is associated with higher rates of breastfeeding initiation and exclusive breastfeeding six to eight weeks postpartum than hospital care.[88]

Evidence supporting home births

A systematic review comparing planned home and hospital birth found that, compared to women with hospital births,

women with home birth were less likely to experience:

- Epidural analgesia
- Medication to speed labor
- Episiotomy
- Birth with vacuum or forceps
- Cesarean birth
- Serious perineal tears
- Infection

Hemorrhage either was less likely at home or not different, and there were no reported maternal deaths.[89] *Birth Settings in America* found that home birth care is associated with higher rates of breastfeeding initiation and exclusive breastfeeding six to eight weeks postpartum than hospital care.[90]

A systematic review of studies in countries where home birth midwives are well integrated into the health system found that neither perinatal nor neonatal mortality differed across the home and hospital settings.

A systematic review of studies in countries where home birth midwives are well integrated into the health system found that neither perinatal nor neonatal mortality differed across the home and hospital settings.[91] However, *Birth Settings in America* identified a small increased absolute risk in neonatal mortality in U.S. studies of home versus hospital birth.[92] In reviewing the international literature, researchers found that home and hospital are equally safe for newborns in integrated systems with seamless transfer, ongoing risk assessment and selection for eligibility, and well-qualified providers. By contrast, in the United States, care is less safe due to "lack of integration and coordination and unreliable collaboration across maternity care providers and settings."[93] To facilitate such integration, a multidisciplinary team has developed "Best Practice Guidelines: Transfer from Planned Home Birth to Hospital" and accompanying model transfer forms.[94]

Given this evidence, the benefits of community birth for medically low-risk pregnant people are clear. First, compared to usual hospital care, community birth better aligns with optimal care. It limits unneeded medical interventions such as induced labor, continuous electronic fetal monitoring, and cesarean birth (curbing overuse), and more reliably provides beneficial care that is not widely used, such as encouraging birthing people to eat and drink and be upright and mobile during labor according to interest, and to choose their birthing position (curbing underuse). In addition, compared to the routinized care provided in hospitals, community birth is more likely to offer respectful, individualized, and person-centered care.[95]

Spotlight on Success

THE STRONG START FOR MOTHERS AND NEWBORNS INITIATIVE

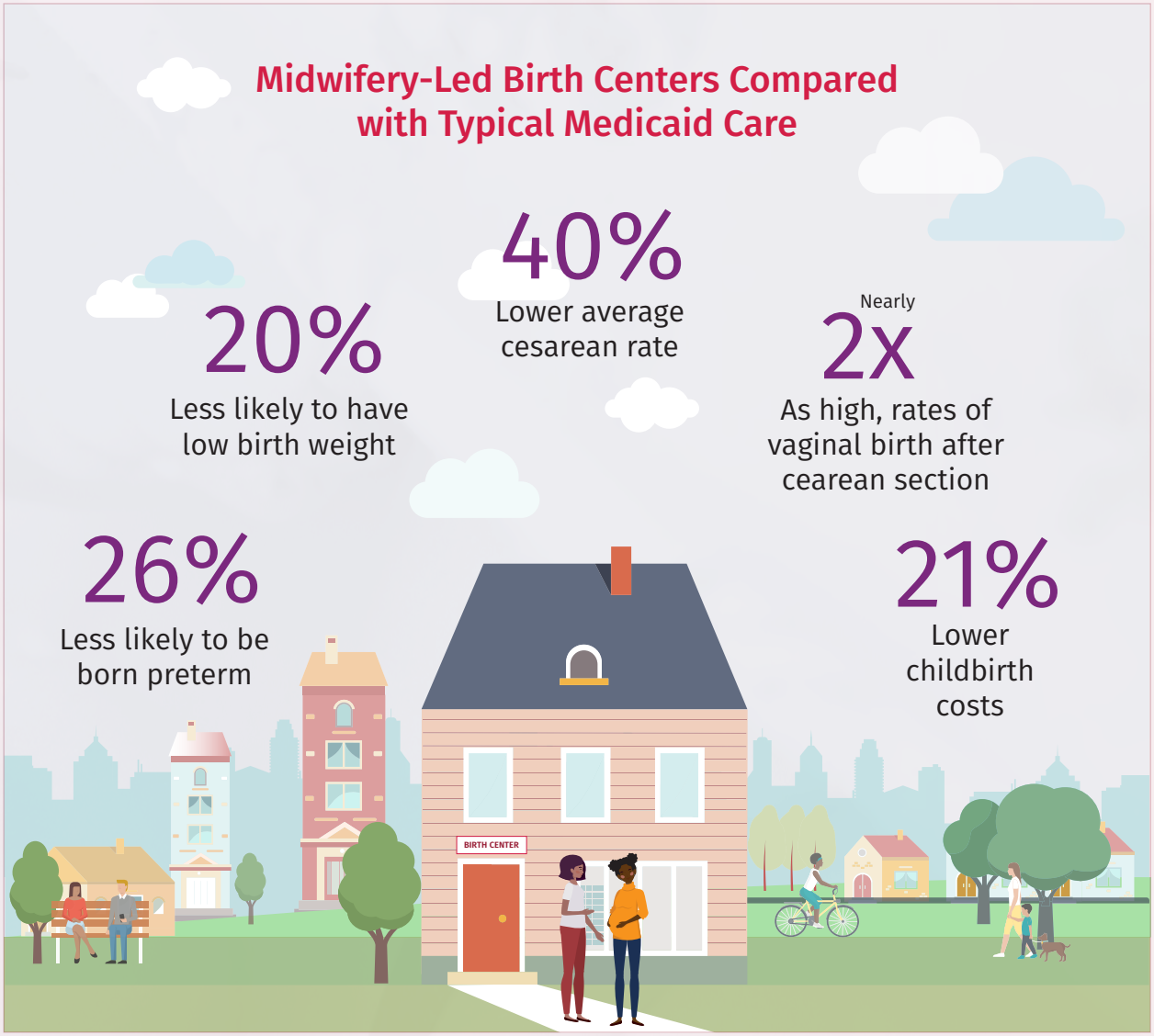
The Strong Start for Mothers and Newborns Initiative was a federal five-year, multi-site project to test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or the Children's Health Insurance Program (CHIP) who were at risk for having a preterm birth. One of the first Center for Medicare and Medicaid Innovation initiatives, it launched in 2012 to test three models of enhanced prenatal care among Medicaid beneficiaries: birth centers, group prenatal care, and maternity care homes.[96] Midwifery-led care in birth centers generated stellar results, whereas results of the other two care models were underwhelming.[97]

An independent evaluation compared women and infants in the midwifery-led birth center group with matched and adjusted women receiving typical Medicaid care in the same counties. The differences in outcomes between these two groups were compelling:

- Birth center infants were 26 percent **less likely to be born preterm** (6.3 percent versus 8.5 percent).
- Birth center infants were 20 percent **less likely to have a low birth weight** (5.9 percent versus 7.4 percent).
- The average **cesarean rate** in birth centers was **40 percent lower** (17.5 percent versus 29.0 percent).
- **Rates of vaginal birth after a cesarean** at birth centers were **nearly twice as high** (94 percent more likely: 24.2 percent versus 12.5 percent).
- **Childbirth costs** at birth centers were **21 percent lower** ($6,527 versus $8,286).
- At birth centers, **total childbirth and post-birth costs** up to one year after birth were **16 percent lower** ($10,562 versus $12,572).

All of these are statistically significant advantages favoring birth center care.[98]

In addition, Strong Start results were exceptional in reducing racial inequities. There were no differences by race for rates of cesarean birth and breastfeeding, or for the experience of care. Notably, participants reported feeling heard, being able to understand communications with the care team, having time for questions, being involved in decision-making, and being treated with respect.[99]



The midwifery-led birth centers succeeded in providing benefits to families, the health system, and taxpayers by improving a series of fundamental health outcomes relative to usual approaches to maternity care. Given that Medicaid covered 42 percent of the nation's births in 2018, including 65 percent of Black and 59 percent Hispanic births,[100] advancing this model for lower-medical-risk Medicaid enrollees could have an enormous impact on our nation's maternal and infant health crisis.

Women report better experiences with community birth

An integrative review of maternal outcomes in birth centers found that, compared to women birthing in hospitals, women birthing in birth centers reported greater satisfaction, greater likelihood of feeling that prenatal care elevated their self-esteem, and a desire to use this care model again. Specifically, they were more satisfied with the personalization of their care, their care environment, the quality of their relationship with their maternity care provider, their confidence, their ability to cope with life challenges, and their ability to have a physiologic childbirth.[101]

With regard to home birth, while we found no systematic reviews comparing satisfaction with hospital birth, women birthing at home perceived three interrelated themes regarding the benefits of not birthing in a hospital setting. First, giving birth at home contrasted with their perceptions or experience of hospital birth, which included too many interventions, too many disruptions, common use of pain medications, disrespectful care, and unfamiliar personnel. Second, they felt that they would have more control, be more able to make decisions, and be empowered in general. Lastly, the home was valued as being a peaceful, restful, and comfortable setting.[102]

Both forms of community birth can also offer additional benefits to birthing people of color because they enhance their opportunity to receive racially and culturally congruent care[103] and avoid the institutional racism of hospital care.

Access to community birth is limited

The many barriers to access to midwifery care, noted above, currently limit access to midwifery-led community birth. And also noted above, CPMs are specifically educated for these settings, yet are not legally regulated in 16 states and U.S. territories. And while the number of birth centers has been growing in the United States, 10 states and the U.S. territories do not have birth center licensure. Thus this care option still does not exist in many communities.[104] Payment of CPM services by private insurance and Medicaid is uneven, as is payment of other midwives when practicing in community settings.[105]

This lack of legal recognition and insurance coverage for community birth providers creates insurmountable financial barriers for many people who would otherwise choose to give birth in these settings. In 2017, only 3.4 percent of hospital births were paid out of pocket, but about two in three (67.9 percent) planned home births and one in three (32.2 percent) birth center births were self-pay.[106] Another reason for this mismatch between supply and demand is that Medicaid coverage pays for 42 percent of births in this country.[107] Medicaid payments are so low that operating a birth center with a large proportion of Medicaid clients is not financially sustainable. To extend the exceptional benefits of birth center care to the many eligible childbearing people who currently lack access will require new payment models.[108] As a result of

COMMUNITY BIRTH OFFERS ADDITIONAL BENEFITS TO BIRTHING PEOPLE OF COLOR BECAUSE IT ALLOWS THEM OPPORTUNITY TO RECEIVE RACIALLY AND CULTURALLY CONGRUENT CARE AND AVOID THE INSTITUTIONAL RACISM OF HOSPITAL CARE.

financial barriers, those with greatest interest and who might disproportionately benefit from this model of care may be least able to choose it.

There is a clear mismatch between the level of interest in community birthing options and their actual use. For example, in 2016 in California, less than 1 percent of births were in birth centers, and 1 percent were at home. However, *Listening to Mothers in California* survey participants who gave birth in hospitals that year reported much higher interest in birthing in these settings should they give birth in the future. A full 40 percent expressed interest in birth center births, including 11 percent who said they would definitely want a birth center birth. For home births, 21 percent expressed interest in this setting, with 6 percent stating they would definitely want to birth at home.[109]

RECOMMENDATIONS

INCREASE ACCESS TO COMMUNITY BIRTH

For many pregnant people, community birth options offer better care, more positive experiences, improved health outcomes, and potential cost benefits. The differences in care, experiences, outcomes, and costs are so striking that a leading international maternity care researcher has recently asked, "Is it time to ask whether facility-based birth is safe for low-risk women and their babies?"[110] Given this track record and the increasing use of, and unmet need for, these types of care, decisionmakers should act to make them more available to low-risk pregnant people who desire them.

Federal policymakers should:

- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and the Commissioned Corps of the U.S. Public Health Service for care in licensed birth centers and midwife providers in birth centers who hold nationally recognized credentials and are recognized in their jurisdiction.
- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and Commissioned Corps of the U.S. Public Health Service for home births attended by midwives with nationally recognized credentials who are recognized in their jurisdiction.
- Enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 5189 in the 116th Congress). This bipartisan bill would fund demonstrations of birth center models for improved maternity care access and quality for Medicaid beneficiaries with low-risk pregnancies in underserved areas, and develop sustainable approaches to payment for birth center care.
- Require the collection and public reporting of data related to health inequities, such racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State and territorial policymakers should:

- Enact birth center licensure in the 10 states that do not currently regulate birth centers: Alabama, Idaho, Louisiana, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, Wisconsin, and in the U.S. territories.
- Mandate payment by Medicaid and CHIP programs for care in licensed birth centers, for services provided by midwife birth center providers with nationally recognized credentials who are recognized in their jurisdiction, and for home birth with midwives with nationally recognized credentials who are recognized in their jurisdiction.

COMMUNITY BIRTH CAN ALSO OFFER MORE OPPORTUNITIES FOR PEOPLE OF COLOR TO RECEIVE THE ADDITIONAL BENEFITS OF RACIALLY CONGRUENT CARE THAT ACKNOWLEDGES A PERSON'S CULTURAL IDENTITY AS CENTRAL TO THE CLINICAL ENCOUNTER, UPHOLDS RACIAL JUSTICE, FOSTERS AGENCY, AND PRACTICES CULTURAL HUMILITY.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to and sustainable payment for community birth (birth center and home) settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of community birth settings and midwifery care.
- Mandate that plans contract with birth centers and midwives with nationally recognized credentials in their service area and pay for care in all settings provided by midwives recognized in the jurisdiction.
- Mandate that plan directories maintain up-to-date listings for available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of integrated maternity care with consultation, shared care, and seamless transfer from community birth settings as needed, and encourage adoption of "Best Practice Guidelines: Transfer from Planned Home Birth to Hospital," and accompanying Model Transfer Forms.

DOULA SUPPORT

Photo credit: birthbecomesher.com

The longstanding, widespread tradition of women providing comfort, emotional support, and information to women during childbirth was largely lost in the first half of the 20th century. At that time, childbirth was reframed as a medical condition – as opposed to a physiologic life process – and moved into the world of male-dominated hospitals. However, over the last half century, women have increasingly sought to birth without unneeded interventions, to exert more control over their birth experience, and to have supportive companionship in unfamiliar medical settings. These interests, supported by research studies showing the benefits of continuous support during labor, helped establish doulas as "new" non-clinical maternal support personnel.*

* Other types of doulas – including abortion, miscarriage, and stillbirth doulas, prison doulas, and end-of-life doulas – are beyond the scope of this report.

The doula role has been defined in various ways. Researchers have distilled four key attributes of doulas and other labor companions:

- They provide information about childbirth, fostering communication between women and members of the care team, and offering guidance for drug-free comfort during labor.
- They play an advocacy role, helping women to achieve their desired experiences.
- They provide practical support, through comfort measures and verbal and hands-on support.
- They provide emotional support for confidence and a sense of control.[111]

An extended model of doula support that begins during pregnancy helps build a trusting relationship, understand a woman's preferences, and prepare for birth.[112] Continued support after birth can help with myriad postpartum challenges, including recovery, newborn care, and changing family dynamics.

Initially, doulas focused on supporting women around the time of birth and were only available to women who could pay for their services out of their own funds. The private-pay postpartum doula role was also created to support women with recovery from birth, breastfeeding, household chores, and other needs after birth. Many private-pay doulas are certified through various national organizations.

More recently, as a response to the spiraling maternal health crisis and recognition of the extreme impact of racism on health, a community-based approach to doula support has been developed to help meet the particular needs of birthing people and families from communities of color and other marginalized groups. This model tends to provide culturally congruent, trauma-informed support that extends from pregnancy through birth and into the postpartum period. Myriad community-based organizations offer doula training that, in addition to covering the practical skills and knowledge needed to provide physical, emotional, and informational support, also focus on birth justice and mitigating the harmful effects of racism and systemic oppression. Financial support for this model varies, but rarely includes either public or private insurance. Some doulas offer their services on a sliding scale based on ability to pay. Services might also be paid by grants, donations, and other fundraising efforts of doula agencies. Some services are provided by volunteer staff, including by doula trainees who require experience with a fixed number of clients or births to attain certification. Bills have been filed in many states to provide more reliable financing, especially through Medicaid.[113] Bills filed in Congress include provisions to investigate Medicaid coverage of doula services and to cover doulas for TRICARE beneficiaries.[114]

Evidence supports the value of doulas

A systematic review[115] has rigorously evaluated the effects of continuous support *during labor* as given by three categories of people: those functioning in doula roles, hospital staff, and members of a woman's social network. The benefits of continuous support, compared to usual care, include

- Greater likelihood of vaginal birth with neither vacuum nor forceps
- Higher rates of satisfaction with the childbirth experience
- Reduced likelihood of using pain medications
- Lower rates of cesarean birth.

This longstanding, periodically updated review has never identified a downside of doula support.[116]

Of the three types of people offering continuous support, the doula model appears to offer the greatest benefit. Support from members of the hospital staff had fewer and weaker effects, and support from a member of the woman's social network was associated with increased satisfaction, but had no clinical benefits.[117] The well-documented outcomes of reducing use of pain medications and cesarean birth, with increased satisfaction, clarify why doulas are an important resource for people seeking physiologic childbearing experiences.

Individual studies have evaluated the "extended model" of doula support, which may begin in pregnancy and continue into the postpartum period. In addition to reduced likelihood of cesarean birth, the extended model has also been associated with reduced likelihood of preterm birth and increased likelihood of breastfeeding initiation and duration.[118]

Finally, evidence shows that doula support is a high-value service. A series of cost analyses have concluded that Medicaid coverage of doula services would likely yield a favorable return on investment.[119]

Midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.

Spotlight on Success

OPEN ARMS PERINATAL SERVICES

Open Arms Perinatal Services is an excellent example of how community-based doulas that provide an extended range of prenatal to postpartum care can dramatically improve the health of mothers and babies. This program has served women with low incomes in the Puget Sound region of Washington state since 1997. Open Arms hires doulas directly from the communities it serves. They provide about 300 pregnant women annually with doula services and, when possible, match women with culturally and linguistically concordant doulas. Open Arms has offered services in 17 languages.

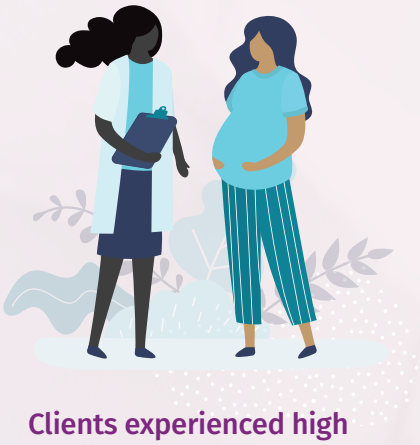
A less intense Birth Doula program supports women from the third trimester through birth and the first three postpartum months. The Community-Based Outreach Doula program provides home visits by the second trimester of pregnancy and through two years postpartum, in addition to continuous support at the time of birth.

Open Arms trains doulas, with an emphasis on equity and helping clients advocate for their needs. Open Arms works to provide doulas with a living wage and, as desired, a pathway to other health and social services jobs.[120]

An independent evaluation of all Latina and Somali mothers and babies enrolled in the Community-Based Outreach Doula program between 2008 and 2016 documented a broad range of benefits, including:

- Clients experienced high rates of **screening for depression and intimate partner violence** (more than 85 percent).
- Both Latina and Somali clients had **lower rates of preterm birth** than a comparable sample in King County, Wash.
- Somali clients had a **lower rate of cesarean birth** (25 percent) than the Black population in King County (35 percent).
- **99 percent of clients initiated breastfeeding,** exceeding the King County rate, and 94 percent were still breastfeeding at 6 months, by far exceeding the rate of state Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs (35.3 percent).
- Clients had **low rates of child developmental concerns.**

Open Arms Results



Clients experienced high rates of screening for depression and intimate partner violence (more than 85 percent).

99% of clients initiated breastfeeding. 94% were still breastfeeding at six months.

This evaluation concluded that rates of low birth weight, preterm birth, cesarean birth, and breastfeeding compare favorably to a broad range of possible comparators.[121]

Women value doulas' assistance during labor both as sources of information and in offering myriad nonpharmacologic approaches to comfort and coping. By explaining care options, doulas help women participate in their care.

Women's positive experience of doula support

Doulas help communicate women's preferences and needs to clinicians and in turn translate medical information to women, helping women feel heard and empowered. A qualitative synthesis found that women value doulas' assistance during labor both as sources of information and in offering myriad nonpharmacologic approaches to comfort and coping. By explaining care options, doulas help women participate in their care. They help women understand what is happening as labor progresses. They also help women feel confident in their ability to give birth and help them feel in control during labor. Continuous presence and support contribute to women's trust, sense of security, and a calm environment, and are buffers against the coming and going of clinical personnel. The support contributes to a positive birth experience and feelings of safety, strength, confidence, and security. Community-based doulas can be advocates for immigrant, refugee, and foreign-born women and help them feel confident and have a positive experience. Some women appreciate doulas' spiritual support during labor. By contrast, women without a labor companion may feel alone, vulnerable, stressed, afraid, and isolated. Women without a companion may be more vulnerable to mistreatment, neglect, and poor communication.[122]

Independent follow-up of participants in a community-based doula program found that 96 percent of clients would recommend the program or encourage other women to participate. Ninety-four percent felt well matched with their doula.[123] A study of teen moms who had experienced an extended model of community-based doula support identified their appreciation for a respectful relationship that imparted coping skills, confidence, and knowledge and skills for parenting.[124] A study of women from marginalized communities who received community-based doula services found that 91 percent felt that their labor and birth experience had been improved, and 87 percent would use a doula again. Large proportions rated many specific physical and psychosocial support strategies during labor as helpful and appreciated. The respondents appreciated a broad range of support strategies, including massage, hot

and cold compresses, eye contact, answering questions, verbal encouragement, and continuous presence.[125]

Doulas of color are well positioned and highly motivated to support women from their own racial, ethnic, and cultural communities, bringing cultural knowledge and enhancing women's experiences at this crucial time of transition. Some consider this work to be a calling.[126] Doulas of color recognize the biases incorporated into the health care system and can provide culturally congruent support that helps mitigate the impact of racism. They can also connect women with the social and community services they need.[127] In addition to helping women navigate maternity services, doulas who support marginalized women may help improve life circumstances, services that are not reliably available to women with usual care.[128]

Interest in doula support is greater than its limited access

Childbearing women appear to desire doula support out of proportion to their actual use. While recent national data on use and demand are not available, the third national Listening to Mothers survey found that 6 percent of women who gave birth in 2011 and 2012 reported having had a birth doula, and one in four women would have liked to receive doula support.[129] Additionally, an estimated 9 percent of respondents to the *Listening to Mothers in California* survey reported having had a doula in 2016. However, most respondents, 57 percent, indicated interest in doula support. Almost one in five (18 percent) stated they would definitely want a doula should they give birth in the future. Two-thirds of Black women expressed interest in doulas, with more than one in four (27 percent) reporting they definitely would want one.[130]

A major reason for this large unmet need is the failure of public and private insurers to reliably pay for doula services. Moreover, there are not enough doulas for a policy of a doula for every woman who wants one, and the demographic makeup of the doula population does not reflect the diversity of the nation's childbearing population.

RECOMMENDATIONS

INCREASE ACCESS TO DOULA SUPPORT

There is a strong evidence base to support the wider availability of doula services, particularly for women of color. Yet doula services are often out of reach for many pregnant people because insurance coverage for these services is rare. Given the ongoing maternal health crisis, especially in communities of color, doula care must be financially supported as a public policy.

Federal policymakers should:

- Mandate that all federally funded health insurance programs cover payment for doula support, including the extended model with prenatal and postpartum support, and for support for specific segments (e.g., birth doula) as desired by women, including Medicaid, CHIP, TRICARE, and IHS.
- Support research to more fully understand variations on this model, including effect of community-based and -led doula training and support programs for low-income, marginalized communities of color.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State policymakers should:

- Mandate payment for extended model doula support, and for support for specific segments (e.g., birth doula) as desired by women, in Medicaid and CHIP.
- Ensure that doula training is tailored to the specific to needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Provide payment for extended doula support at a level that sustainably provides them with a living wage, and can help attract and retain these critically important birth workers.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about sustainable plan payment for extended model doula services.
- Educate employees and beneficiaries about the benefits of doula support.
- Include doula support, including extended model with prenatal and postpartum support, as a covered benefit in health plans, ensure reimbursement levels that are able to sustain and expand the doula workforce, and promote this benefit among eligible beneficiaries.
- Ensure that plan directories maintain up-to-date listings for available doulas or doula agencies.

PERINATAL HEALTH WORKER GROUPS

Community-led and -based perinatal health worker groups are a newer, hybrid model of care that explicitly centers meeting community needs and priorities – particularly in communities of color – by providing a wide range of services, including in many cases some combination of midwifery care, community birth settings, and doula support. This model has emerged as a very promising practice in maternal care that has not been extensively evaluated as a unit.

A PROMISING, EMERGING HYBRID MODEL: COMMUNITY-LED PERINATAL HEALTH WORKER GROUPS

Standard approaches to maternity services are failing to deliver care that communities of color and other marginalized groups in the country reliably experience as safe, respectful, and trustworthy. Recognition of longstanding systemic inequities and unmet needs in their communities has motivated people to step forward and come together to build new tailored multifunction programs that center and support marginalized families affected by systemic racism and other forms of oppression.[131] A growing number of community-led and -based groups are filling this gap with services that directly address specific community needs.[132]

In general, women of color head these community-led perinatal health worker groups. Frequently, the groups combine clinical services, such as midwives offering birth center and/or home birth services, with a wide range of non-clinical support services. The latter may include doula support that often extends from pregnancy through the postpartum period, lactation support, mental health support, and health and social care navigation. Some of these community-led groups informally or formally poll community members, identify unmet community needs, and develop and implement programs to address them. For example, they may institute programs for young families that need long-term parenting support.[133]

Many of these groups develop and operate training programs for work within and

beyond the organization. Unlike much national training program content, the community-based programs typically are tailored to meet the specific needs of the communities they serve, including topics such as birth and broader social justice, the effects of systemic racism, and how to provide trauma-informed services.[134] Many community-based perinatal care leaders become active in state or other jurisdiction policy development and community advocacy. This might include advocating for CPM and/or birth center licensure legislation, for additional resources for the organization, and for social services needed by clients and communities. Less established groups may aspire to build capacity and add components such as clinical services, training programs, and policy advocacy down the line.[135]

Because of their multifaceted work, these groups play a major role in community development. They provide new services, educational opportunities, and employment; improve maternal and infant health; strengthen families, improve health literacy, and clients' sense of agency; and mitigate harmful effects of racism and other forms of oppression.[136]

Community-based perinatal health worker groups are a promising model

Of the four models featured in this report, community-led and -based perinatal health worker groups are the newest, and have not yet been evaluated to the extent needed to generate a solid evidence base. There is an urgent need to assess this model, which in theory is an ideal design from multiple perspectives. The community-based settings are geographically accessible, as they are located within the neighborhoods they serve. They strive to be financially accessible as well, and often provide care to people regardless of their ability to pay, insurance, and immigration status. Moreover, these programs are tailored to their local community and offer a range of services designed to center their diverse needs and build trust, including by offering cultural congruence and language accessibility. Additionally, their explicit focus on dignity and respect and on countering racism and discrimination enables them to recognize and support their clients' intersectional identities (such as race, ethnicity, gender identity, sexual orientation, and disability), so they can buffer the trauma that many of their clients experience, both in engaging with the health care system and in their daily lives.

To the extent that these groups offer proven services such as midwifery care, birth center care, and doula support, they are clearly providing evidence-based care. While the cumulative effect of combining these practices under a community-led, culturally congruent umbrella hasn't been fully evaluated, evidence about how a birth center versus a hospital allows the midwifery model to flourish to the benefit of childbearing people and families suggests a synergistic effect. To the extent that they offer more than one of these high-quality, high-value services, the synergistic effects may have an even greater positive impact on birthing people's health and well-being, and that of their families. Measuring effects of these models is an urgent research priority.

Spotlight on Success

COMMONSENSE CHILDBIRTH

Commonsense Childbirth is a midwifery-led practice in Orlando, Fla., that provides a range of clinical and support services to any pregnant person seeking care. Most clients come into the practice at risk for adverse outcomes in usual care settings, yet end up with much better health results than would be expected, thanks to an innovative community-led approach that combines respectful, dignifying, individualized services focusing on health promotion and building on assets of clients and families.

Jennie Joseph, a British-trained midwife, founded Commonsense Childbirth in 1998 in response to the maternal and infant health crisis she observed in central Florida. She is committed to providing a model of care that successfully supports healthy births for everyone. The model, known as the JJ Way®, is based on four pillars:

- Immediate unrestricted **access** to quality care and support, regardless of ability to pay;
- **Connections** among woman, care provider, baby, family, community, resources, and support systems;
- **Knowledge** of skillful, evidence-based care and support; leading to
- **Empowerment** of women, care providers and systems, agencies, and organizations.[137]

The program strives to serve low-income people who are un- or under-insured, come from marginalized communities, and are at risk of poor birth outcomes due to their life circumstances and unmet social needs – reflecting structural discrimination.[138] The services they provide include midwifery care, birth center care, childbirth education, birth doula support when available, lactation support, and social service navigation. Services are available in English, Spanish, and Portuguese.[139]

To advance birth equity, Joseph has pioneered the creation of "easy access clinics" and "perinatal safe spots" that offer safe harbor and respectful support to childbearing people who are often disrespected and poorly supported in "materno-toxic areas" within their broader communities and usual maternity care services.[140]

An independent evaluation of 256 Commonsense Childbirth clients found that this approach to care greatly reduced, and even eliminated, inequities that pervade our standard approach to maternity care.[141] Commonsense Childbirth outcomes for births between 2016 and 2017 were compared with

those for Orange County (where they are located) and the state of Florida in the same period. The results were remarkable:

- The preterm birth rate for Black clients in this program matched the white preterm birth rates for both Orange County and the state of Florida (9 percent in every case) and **eliminated the 4-percentage-point gap** at county and state levels: 13 percent Black versus 9 percent white in both cases.
- The low birth weight rate for Black clients in this program (9 percent) largely erased the broader community Black-white gap for this indicator: for both the county and state, **Black women had 13 percent low birth weight rates versus 7 percent for white women.**
- The **breastfeeding rate among Black women exceeded overall state and national rates of any breastfeeding.**
- Latina clients had a **preterm birth rate much lower** than their counterparts at the county and state levels. Whereas only 4 percent of Latina clients had preterm births, more than twice as many Latinas did at the county (9 percent) and state (9 percent} levels.
- **Only 1 percent of Latina clients had low birth weight babies,** compared to 8 percent at the county, and 7 percent at the state levels.
- Non-Hispanic white clients' **outcomes improved for preterm births** (5 percent compared to 9 percent at the county and state levels) and low birth weight (3 percent compared to 7 percent at both levels).[142]

In addition, the cesarean rate in this practice is 8 percent, in comparison with rates of about 30 percent to 50 percent in local hospitals.[143] These results are not even adjusted for risk; given that Commonsense Childbirth disproportionately serves clients from marginalized communities, these outcomes are even more impressive.

These results have major implications for the well-being of families. Considerable reduction in rates of preterm and cesarean birth have favorable cost implications for purchasers and payers.

Commonsense Childbirth also operates the Commonsense Childbirth School of Midwifery, with a three-year program to prepare midwives for the CPM exam and a four-month program to prepare foreign-trained midwives and some other U.S. midwives to obtain a Florida midwifery license. They also offer preparation for community-based childbirth education, doula, and lactation support.[144]

Women's experience of community-based perinatal health worker groups

At this time, understanding of women's experiences of receiving care and support from community-led, multifunctional perinatal groups appears to be limited to anecdotal sources. Research comparing women's experiences in these settings to similar women who lack access to such services is a research priority.

Access to community-based perinatal health worker groups is limited

There is no inventory of the number and location of community-based perinatal health worker groups across the United States. Many are located in urban areas, and some are available in remote areas. However, this is a relatively new service model, with no clear, reliable sources of financial support. If reimbursable clinical services are provided, payments for clinical services may be spread to also provide modest support to non-clinical services. But, given the high-touch, resource-intensive support they provide families, there are practical limits to how many families these groups can serve. At present, just a fraction of the childbearing families that might benefit from this model of care have access to it.[145]

Tailored to their local community, these programs offer a range of services that center clients' diverse needs and build trust, including providing culturally congruent and language accessible care.

RECOMMENDATIONS

INCREASE SUPPORT FOR COMMUNITY-LED AND -BASED PERINATAL HEALTH WORKER GROUPS AND FOR EVALUATIONS OF THIS MODEL

Given the extremely promising early evidence, community-led perinatal health worker groups have great potential for reducing racial and ethnic health inequities. Their frequent use of proven maternal care and support models is a strong asset. Decisionmakers should target support for and ongoing evaluation of these innovative, community-centered and -led groups.

Federal policymakers should:

- Create programs to support and evaluate new and existing community-led and -based multifunctional programs, including quality of services, health outcomes, women's experiences, and impact on equity, in comparison with similar women without access to such programs. One mechanism would be through a major program at the Centers for Medicare and Medicaid Services Center for Medicare and Medicaid Innovation.
- Enact the Kira Johnson Act (H.R. 6144 and S. 3424 Title II in the 116th Congress) to provide funding for community-based perinatal health worker organizations, especially those led by Black women, to improve Black maternal health; to address racism and bias in all maternal health settings; and to support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act (H.R. 6164 and S. 3424 Title IV in the 116th Congress) to provide guidance to states for promoting diverse maternity care teams and the role of culturally congruent care in improving outcomes, especially for minority women; establish and scale programs to grow the maternal health workforce (including doulas, community health workers, and peer supporters); and study barriers to entry for low-income and minority women into maternity care professions.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State policymakers should:

- Pursue partnerships with community-based perinatal health groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments, to support partnership efforts.
- Work to identify and establish inventories of community-based perinatal health groups, and support efforts to evaluate them.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to, and sustainable payment for, community-led perinatal health worker groups offering services of midwives with nationally recognized credentials, community birth, and/or doula services.
- Educate employees and beneficiaries about the benefits of midwifery care, community birth, and doula services.
- Make services of community-led perinatal health workers incorporating midwifery care, community birth, and/or doula services available to beneficiaries, and evaluate the overall multifunction model and return on investment, including implications of quality of care, health outcomes, and women's experiences, and possible synergistic effects.
- Mandate that plan directories maintain up-to-date listings for available community-led perinatal health worker groups whose services are paid for by plans.

Conclusion

The U.S. maternal and infant health crisis requires urgent action. The models of care featured in this report are examples of proven solutions to many of the failings of usual maternity care. Inequitable, disrespectful, inaccessible, costly approaches are not delivering on quality, experiences, and outcomes. Especially as the twin pandemics of COVID-19 and structural and interpersonal racism make birthing in this country even more risky for many people, we must invest in what we know works and quickly scale these models.

The evidence is clear: Moms and babies will be healthier if more families are able to access these types of care. We will have fewer premature and underweight babies. We will have fewer cesarean births, including for women with a history of cesareans. More babies and mothers will enjoy the emotional and health benefits of breastfeeding. We will see concrete progress toward eliminating our country's intractable racial and ethnic maternal and infant health inequities.

Less tangible, but no less important, is the models' potential to instill confidence, agency, and empowerment at this crucial time of transformation in women's lives. They are more likely to provide respectful, attentive, dignifying, relationship-based, culturally congruent care and invest heavily in health-promoting prenatal and postpartum care and support.

As we work to transform the maternity care system, midwifery care, community birth, doula support, and the services of community-based perinatal health groups must be central to solving for quality, value, and equity. Most importantly, they help us achieve healthier families.

We can't afford to wait. It is past time for federal and state policymakers, and private sector health care decisionmakers to take action.

The outcomes these models achieve are remarkable, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.

COMPLETE RECOMMENDATIONS

INCREASE ACCESS TO MIDWIFERY CARE

Midwives have a distinctive, dignifying, person-centered, skilled model of care and an exemplary track record. They are an important part of the solution to the nation's shortage of maternity care providers. However, there are barriers to meeting this need and enabling more childbearing people and families to experience benefits of midwifery care.

Congress and federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3849 in the 116th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (CNMs, CMs, CPMs) by supporting students, preceptors, and schools and programs. It would give funding preference to supporting students who would diversify the profession and who intend to practice in underserved areas.
- Mandate payment for services of CMs and CPMs recognized in their jurisdiction by Medicaid, the Child Health Insurance Program (CHIP), TRICARE (the military health care program), the Veterans Health Administration (VHA), the Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service.
- Mandate that hospitals cannot deny privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State and territorial policymakers should:

- In jurisdictions that currently fail to recognize them, enact CM and CPM licensure. For CMs, these include all of the territories, the District of Columbia, and all states except Delaware, Hawaii, Maine, New Jersey, New York, Oklahoma, and Rhode Island. Jurisdictions that have yet to recognize CPMs through licensure are: Connecticut, Georgia, Iowa, Illinois, Kansas, Massachusetts, Missouri, Mississippi, North Dakota, Nebraska, North Carolina, New York, Nevada, Ohio, Pennsylvania, West Virginia, and all U.S. territories.
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice "at the top of their license" in line with their full competencies and education as independent providers who collaborate with others according to the health needs of their clients.

- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for services of CMs and CPMs licensed in their jurisdiction, mandate payment at 100 percent of physician payment levels for the same services. Currently, Delaware, Hawaii, Maine, New Jersey, Oklahoma, and Rhode Island recognize CMs but do not pay for their services through Medicaid. States that regulate CPMs yet fail to pay for their services through Medicaid are: Alabama, Arkansas, Colorado, Delaware, Hawaii, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota (does not pay for home birth services), Montana, New Jersey, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, and Wyoming.

Private sector decisionmakers, including purchasers and health plans, should:

- Incorporate clear expectations into service contracts about access to and sustainable payment for midwifery services offered by providers that hold nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.

INCREASE ACCESS TO COMMUNITY BIRTH

For many pregnant people, community birth options offer better care, more positive experiences, improved health outcomes, and potential cost benefits. The differences in care, experiences, outcomes, and costs are so striking that a leading international maternity care researcher has recently asked, "Is it time to ask whether facility-based birth is safe for low-risk women and their babies?"[146] Given this track record and the increasing use of, and unmet need for, these types of care, decisionmakers should act to make them more available to low-risk pregnant people who desire them.

Federal policymakers should:

- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and the Commissioned Corps of the U.S. Public Health Service for care in licensed birth centers and midwife providers in birth centers who hold nationally recognized credentials and are recognized in their jurisdiction.
- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and Commissioned Corps of the U.S. Public Health Service for home births attended by midwives with nationally recognized credentials who are recognized in their jurisdiction.
- Enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 5189

in the 116th Congress). This bipartisan bill would fund demonstrations of birth center models for improved maternity care access and quality for Medicaid beneficiaries with low-risk pregnancies in underserved areas, and develop sustainable approaches to payment for birth center care.

- Require the collection and public reporting of data related to health inequities, such racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State and territorial policymakers should:

- Enact birth center licensure in the 10 states that do not currently regulate birth centers: Alabama, Idaho, Louisiana, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, Wisconsin, and in the U.S. territories.
- Mandate payment by Medicaid and CHIP programs for care in licensed birth centers, for services provided by midwife birth center providers with nationally recognized credentials who are recognized in their jurisdiction, and for home birth with midwives with nationally recognized credentials who are recognized in their jurisdiction.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to and sustainable payment for community birth (birth center and home) settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of community birth settings and midwifery care.
- Mandate that plans contract with birth centers and midwives with nationally recognized credentials in their service area and pay for care in all settings provided by midwives recognized in the jurisdiction.
- Mandate that plan directories maintain up-to-date listings for available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of integrated maternity care with consultation, shared care, and seamless transfer from community birth settings as needed, and encourage adoption of “Best Practice Guidelines: Transfer from Planned Home Birth to Hospital,” and accompanying Model Transfer Forms.

INCREASE ACCESS TO DOULA SUPPORT

There is a strong evidence base to support the wider availability of doula services, particularly for women of color. Yet doula services are often out of reach for many pregnant people because insurance coverage for these services is rare. Given the ongoing maternal health crisis, especially in communities of color, doula care must be financially supported as a public policy.

Federal policymakers should:

- Mandate that all federally funded health insurance programs cover payment for doula support, including the extended model with prenatal and postpartum support, and for support for specific segments (e.g., birth doula) as desired by women, including Medicaid, CHIP, TRICARE, and IHS.
- Support research to more fully understand variations on this model, including effect of community-based and -led doula training and support programs for low-income, marginalized communities of color.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State policymakers should:

- Mandate payment for extended model doula support, and for support for specific segments (e.g., birth doula) as desired by women, in Medicaid and CHIP.
- Ensure that doula training is tailored to the specific to needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Provide payment for extended doula support at a level that sustainably provides them with a living wage, and can help attract and retain these critically important birth workers.

Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about sustainable plan payment for extended model doula services.
- Educate employees and beneficiaries about the benefits of doula support.

- Include doula support, including extended model with prenatal and postpartum support, as a covered benefit in health plans, ensure reimbursement levels that are able to sustain and expand the doula workforce, and promote this benefit among eligible beneficiaries.
- Ensure that plan directories maintain up-to-date listings for available doulas or doula agencies.

INCREASE SUPPORT FOR COMMUNITY-LED AND -BASED PERINATAL HEALTH WORKER GROUPS AND FOR EVALUATIONS OF THIS MODEL

Given the extremely promising early evidence, community-led perinatal health worker groups have great potential for reducing racial and ethnic health inequities. Their frequent use of proven maternal care and support models is a strong asset. Decisionmakers should target support for and ongoing evaluation of these innovative, community-centered and -led groups.

Federal policymakers should:

- Create programs to support and evaluate new and existing community-led and -based multifunctional programs, including quality of services, health outcomes, women's experiences, and impact on equity, in comparison with similar women without access to such programs. One mechanism would be through a major program at the Centers for Medicare and Medicaid Services Center for Medicare and Medicaid Innovation.
- Enact the Kira Johnson Act (H.R. 6144 and S. 3424 Title II in the 116th Congress) to provide funding for community-based perinatal health worker organizations, especially those led by Black women, to improve Black maternal health; to address racism and bias in all maternal health settings; and to support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act (H.R. 6164 and S. 3424 Title IV in the 116th Congress) to provide guidance to states for promoting diverse maternity care teams and the role of culturally congruent care in improving outcomes, especially for minority women; establish and scale programs to grow the maternal health workforce (including doulas, community health workers, and peer supporters); and study barriers to entry for low-income and minority women into maternity care professions.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

State policymakers should:

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- Mandate that plan directories maintain up-to-date listings for available community-led perinatal health worker groups whose services are paid for by plans.

Resource Directory

This curated list of key publications and other resource provides additional information for decision makers, advocates, and community leaders

Reproductive and Birth Justice

- *Reproductive Justice*
  SisterSong Women of Color Reproductive Justice Collective, https://www.sistersong.net/reproductive-justice
- *Black Women Birthing Justice,* https://www.blackwomenbirthingjustice.org/what-is-birth-justice
- *Birth Justice Bill of Rights*
  Southern Birth Justice Network, https://southernbirthjustice.org/birth-justice
- *The Birth Equity Agenda: A Blueprint for Reproductive Health and Wellbeing*
  Joia Crear-Perry. National Birth Equity Collaborative, June 16, 2020, https://birthequity.org/birth-equity-agenda/
- *Building a Movement to Birth a More Just and Loving World*
  Haile Eshe Cole, Paula X. Rojas, and Jennie Joseph. National Perinatal Task Force, March 2018, https://perinataltaskforce.com/heads-up-maternal-justice-npt-2018-report-out-now/
- *2019 Birth Justice Fund Docket*
  Groundswell Fund. 2019, https://groundswellfund.org/birth-justice-fund/
- *A Black Mama's Guide to Living and Thriving*
  Mamatoto Village. 2020, https://www.mamatotovillage.org/viewguide.html

Physiologic Childbearing

- *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*
  American College of Nurse-Midwives, Midwives Alliance of North America, and National Association of Certified Professional Midwives. The Journal of Perinatal Education, Winter 2013, https://doi.org/10.1891/1058-1243.22.1.14
- *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care*
  National Partnership for Women & Families, 2015, http://www.nationalpartnership.org/physiology

- *Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*
  Melissa D. Avery, Amy D. Bell, Debra Bingham, Maureen P. Corry, Suzanne F. Delbanco, Susan Leavitt Gullo, Catherine H. Ivory, *et al.* National Partnership for Women & Families, June 2018, https://www.nationalpartnership.org/our-work/resources/health-care/maternity/blueprint-for-advancing-high-value-maternity-care.pdf

Midwifery

- *Midwifery*
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- *More Midwife-Led Care Could Generate Cost Savings and Health Improvements*
  Katy B. Kozhimannil, Laura Attanasio, and Fernando Alarid-Escudero. University of Minnesota School of Public Health, November 2019, https://www.sph.umn.edu/sph-2018/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf
- *Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes*
  Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, *et al.* Plos One, February 21, 2018, https://doi.org/10.1371/journal.pone.0192523
- *Midwifery = High Value Maternity Care*
  Every Mother Counts. May 2018, https://everymothercounts.org/wp-content/uploads/2018/10/Midwifery_High_Value_Maternity_Care_5_3_18_2-sided_Final.pdf
- *PBGH Midwifery Initiatives*
  Pacific Business Group on Health. https://www.pbgh.org/midwifery
- *Maximizing Midwifery to Achieve High-Value Maternity Care in New York*
  Nan Strauss. Choices in Childbirth, 2018, https://everymothercounts.org/wp-content/uploads/2018/10/MaxiMiNY_Final_5_3_18.pdf
- *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid: A Resource for State Medicaid Agencies and Medicaid Managed Care Organizations*
  Jennifer E. Moore, Karen E. George, Chloe Bakst, and Karen Shea. Institute for Medicaid Innovation, 2020, https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf

Doula Care

- *Doula Medicaid Project*
  National Health Law Program, 2020, https://healthlaw.org/doulamedicaidproject/

- *Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid*
  Chloe Bakst, Jennifer E. Moore, Karen E. George, and Karen Shea, Institute for Medicaid Innovation, May 2020, https://www.medicaidinnovation.org/_images/content/2020-IMI-Community_Based_Maternal_Support_Services-Report.pdf
- *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities*
  Asteir Bey, Aimee Brill, Chanel Porchia-Albert, Melissa Gradilla, and Nan Strauss. Ancient Song Doula Services, Village Birth International, and Every Mother Counts, March 25, 2019, https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf
- *Routes to Success for Medicaid Coverage of Doula Care*
  Amy Chen. National Health Law Program, December 14, 2018, https://healthlaw.org/resource/routes-to-success-for-medicaid-coverage-of-doula-care/
- *Building a Successful Program for Medi-Cal Coverage for Doula Care: Findings from a Survey of Doulas in California*
  Amy Chen and Alexis Robles-Fradet. National Health Law Program, May 21, 2020, https://healthlaw.org/resource/doulareport/
- *The Perinatal Revolution*
  HealthConnect One. 2014, https://www.healthconnectone.org/wp-content/uploads/2020/03/The-Perinatal-Revolution-CBD-Study.pdf
- *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*
  National Partnership for Women & Families and Choices in Childbirth, January 2016, https://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicaid-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf

Community-Led Birthing Solutions

- *Supporting Midwife-Led Independent Birth Centers Makes Sense*
  American Association of Birth Centers. 2016, https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/Insurers-Employers/Impact_Statement_-_rv8.16.pdf
- *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*
  Nora Ellman. Center for American Progress, April 14, 2020, https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/

- *Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches*
  National Partnership for Women & Families. 2019, https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf

Data Deep Dives

- *Continuous Support for Women During Childbirth*
  M.A. Bohren, G.J. Hofmeyr, C. Sakala, R.K. Fukuzawa, and A. Cuthbert. Cochrane Database of Systematic Reviews, July 6, 2017, https://doi.org/10.1002/14651858.CD003766.pub6
- *What Matters to Women: A Systematic Scoping Review to Identify the Processes and Outcomes of Antenatal Care Provision That Are Important to Healthy Pregnant Women*
  S. Downe, K. Finlayson, Ö. Tunçalp, and A. Metin Gülmezoglu. BJOG: An International Journal of Obstetrics and Gynaecology, December 24, 2015, https://doi.org/10.1111/1471-0528.13819
- *What Matters to Women During Childbirth: A Systematic Qualitative Review*
  S. Downe, K. Finlayson, O.T. Oladapo, M. Bonet, and A.M. Gülmezoglu. Plos One, April 17, 2018, https://doi.org/10.1371/journal.pone.0194906
- *What Matters to Women in the Postnatal Period: A Meta-Synthesis of Qualitative Studies*
  K. Finlayson, N. Crossland, M. Bonet, and S. Downe. Plos One, April 22, 2020, https://doi.org/10.1371/journal.pone.0231415
- *Perceptions and Experiences of Labour Companionship: A Qualitative Evidence Synthesis*
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- *Assessing Health Outcomes by Birth Settings*
  National Academies of Sciences, Engineering, and Medicine. https://www.nationalacademies.org/our-work/assessing-health-outcomes-by-birth-settings
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  Ian Hill, project director. Urban Institute, October 2018, https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf

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THE EVIDENCE IS CLEAR: MOMS AND BABIES WILL BE HEALTHIER IF MORE FAMILIES CAN HAVE ACCESS TO MIDWIVES, DOULAS, COMMUNITY-LED PERINATAL HEALTH GROUPS, AND BIRTH IN COMMUNITY SETTINGS.

Photo credit: Chalffy, E+ Collection, GettyImages.com

TAKEAWAYS

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Pregnancy-Associated Mortality in Alaska

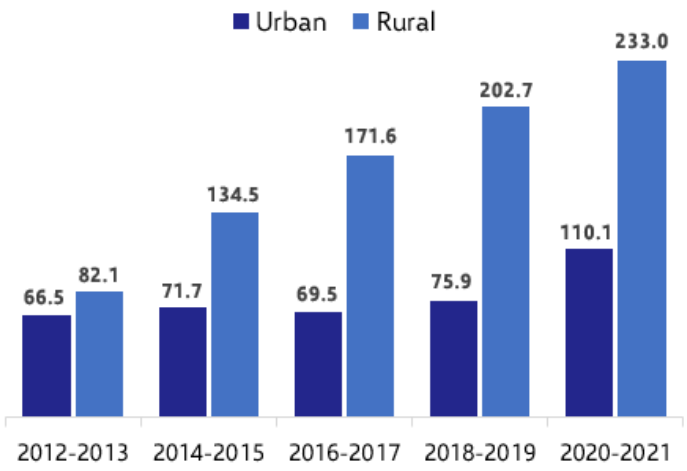
Pregnancy-associated mortality includes all deaths while pregnant or within one year of the end of pregnancy, due to any cause and regardless of the pregnancy outcome. This fact sheet reflects findings from the Alaska Maternal and Child Death Review (MCDR) committee.

Number of pregnancy-associated deaths in most recent 10 years

2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
10	6	9	11	12	8	10	14	8	20

Mortality Rates 2012-2021

(per 100,000 live births)

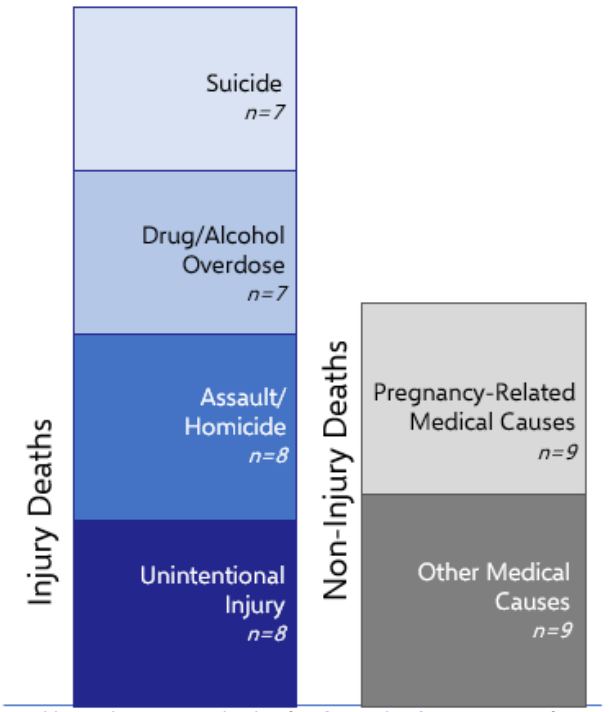


Rates of pregnancy-associated deaths from 2012-2021 increased by **184%** in **rural areas**, compared to an increase of 66% in urban areas.

- The overall pregnancy-associated death rate in 2021 exceeded the previous 5-year average by **109%**.

Death Categorizations 2015-2019

(Death Years finalized by MCDR)



*In addition, there were 7 deaths of **undetermined causes** (**12%** of cases).

MCDR Committee Findings

Among 57 deaths reviewed during 2016-2022:

- **88%** (n=50) were ***potentially preventable***.
- **Drug/alcohol use** or **substance use disorders** were documented in **72%** (n=38) of deaths.
- **71%** (n=40) of decedents had a history of being a victim or possible victim of **Interpersonal Violence (IPV).**
- **44%** (n=25) of deaths were associated with **barriers** to **health care access**.

Among deaths in 2015-2019:
17% were **pregnant at time of death**
6% occurred **within 7 days post-delivery**
4% occurred **8-42 days post-delivery**
73% occurred **>42 days post-delivery.**

The MCDR program works to reduce maternal mortality by understanding the causes and contributing factors of each death through a multidisciplinary committee review process. MCDR receives funding through the CDC ERASE Maternal Mortality grant program and through the Office on Women's Health to support data dissemination and prevention of maternal mortality from violence.

Contact: hss.wcfh.mcdr@alaska.gov
Updated December 2022

HEALTHY MOMS. STRONG BABIES.

WHERE YOU LIVE MATTERS: MATERNITY CARE IN ALASKA

INTRODUCTION

With over 3.5 million births in the United States annually, and rising rates of maternal mortality and morbidity, there is ample opportunity to improve maternal outcomes across the country.[1] More than 2 million women of childbearing age live in maternity care deserts, areas without access to birthing facilities or maternity care providers. Access to maternity care is essential for preventing poor health outcomes and eliminating health disparities. This report expands on the 2022 Nowhere to Go: Maternity Care Deserts Across the U.S. report[2] by taking a deeper dive into state level data and examining additional barriers that impact access to care. This data can be used to inform policies and practice recommendations in each state.

This report presents data on several important factors: levels of maternity care access and maternity care deserts by county; distance to birthing hospitals; availability of family planning services; community level factors associated with prenatal care usage as well as the burden and consequences of chronic health conditions across the state. While not an exhaustive list, each of these topics contribute to the complexity of maternity care access in each state. Working to improve access to maternity care by bringing awareness to maternity care deserts and other factors that limit access is one way in which March of Dimes strives to reduce preventable maternal mortality and morbidity for all pregnant people.

KEY FINDINGS

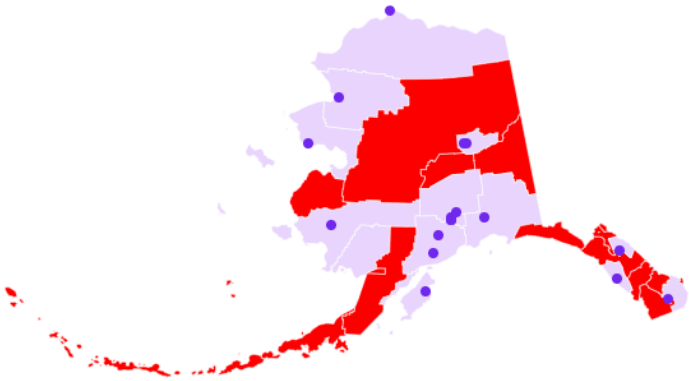
- In Alaska, 50 percent of census areas are defined as maternity care deserts compared to 32.6 percent in the U.S.
- 7.8 percent of women had no birthing hospital within 30 minutes compared to 9.7 percent in the U.S.
- Overall, women in Alaska have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.
- 17.9 percent of birthing people received inadequate or no prenatal care, greater than the U.S. rate of 14.8 percent.
- Women with chronic health conditions have a 53 percent increased likelihood of preterm birth compared to women with none.

ACCESS TO MATERNITY CARE IN ALASKA

Access to care during pregnancy and around the time of birth is not consistently available across the country. Hospital closures and a shortage of providers are driving changes in maternity care access, especially within rural areas and among Black, Indigenous and people of color (BIPOC).[3] The level of maternity care access within each census area (Alaska's county equivalent) is classified across Alaska by the availability of birthing facilities, maternity care providers, and the percent of uninsured women (see table). The map shows that in Alaska, 50 percent of census areas are defined as maternity care deserts compared to 32.6 percent of counties in the U.S. overall.

FINDINGS

- In Alaska, there was no change in the number of birthing hospitals between 2020 and 2019.
- 8% of babies born to Alaska Native women lived in a maternity care desert.
- In Alaska, there were 407 babies born to women living in maternity care deserts, 4.4% of all births.
- 30.1% of babies were born to women who live in rural census areas, while only 14% of maternity care providers practice in rural census areas in Alaska.



DEFINITIONS OF MATERNITY CARE DESERT AND LEVEL OF MATERNITY CARE ACCESS

Definitions	Maternity care deserts	Low access	Moderate access	Full access*
Hospitals and birth centers offering obstetric care	zero	<2	<2	≥2
Obstetric providers (obstetrician, family physician†, CNM/CM per 10,000 births)	zero	<60	<60	≥60
Proportion of women 18-64 without health insurance	any	≥10%	<10%	any

Maternity care desert | Low access | Moderate access | Full access | Hospital locations

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022; American Board of Family Medicine, 2017-2020; National Center for Health Statistics, 2021 final natality data.

Note: CNM/CM = certified nurse midwives/certified midwives.
*A census area is full access if it meets 1 or more of the criteria.
†Includes family physicians who provide obstetric care.

WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS AND THE CRISIS OF ACCESS AND EQUITY

March of Dimes recommends state policy actions that address access to care; see: **https://marchofdimes.org/mcdr-ak**

For details on data sources and calculations, see Technical Notes: **https://www.marchofdimes.org/peristats/maternitycaretechnotes**

ALASKA

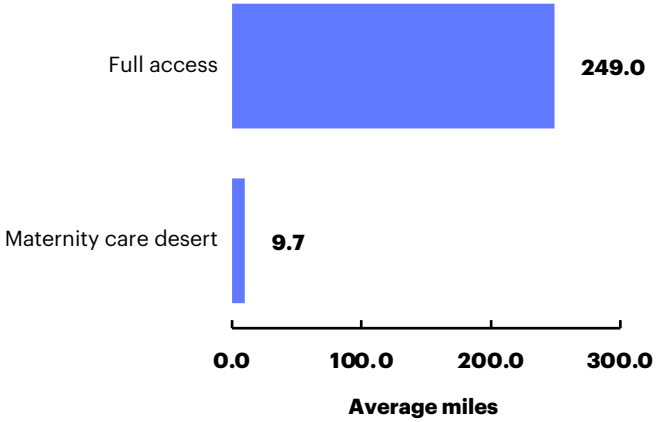
DISTANCE TO MATERNITY CARE

The farther a woman travels to receive maternity care, the greater the risk of maternal morbidity and adverse infant outcomes, such as stillbirth and NICU admission.[4,5] Furthermore, longer travel distances to care can cause financial strain on families and increased prenatal stress and anxiety.[6] The distance a woman must travel to access care becomes a critical factor during pregnancy, at the time of birth, and in the case of emergencies. Nationwide closures of birthing hospitals have contributed to increased distance and travel time to care, especially in rural areas.[6]

Alaska is especially unique because of its geography, extreme weather conditions and remote areas across the state which require travel by plane. To improve outcomes in areas with limited resources, birthing women living in remote areas often fly to larger cities, such as Anchorage, sometimes up to one month before birth and live in maternity care housing until the time of labor. Additionally, insurance may not cover all travel costs for a support person so some women must travel, live and birth without a known support person.

Mapping software was utilized to calculate distance, in miles and minutes, under normal traffic conditions and using real-world travel routes. The map indicates the average distance to the closest birthing hospital accessible by car or ferry throughout Alaska. Commonly used thresholds of 30- and 60-minute driving times were applied to measure the percent of birthing people with timely access to care.[4] This information can help identify areas where resources are needed to improve access to care. For zip codes in Alaska in which road or ferry travel is possible, the average distance women travel to their nearest birthing hospital is 16.2 miles, compared to 9.7 miles in the U.S. overall.

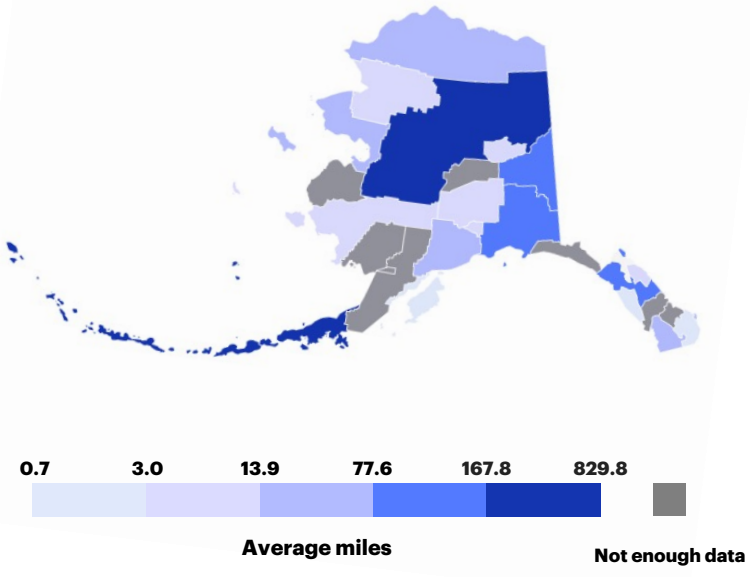
DISTANCE TO CARE BY MATERNITY CARE ACCESS



Sources: United States Census Bureau."S1301:Fertility." American Community Survey. 2017-2021. Web. 1 Nov 2022; American Hospital Association, 2021; American Board of Family Medicine, 2017-2020; U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022.

Note: Census areas with too few births and/or those without travel routes by car or ferry shown in gray.

DISTANCE TO BIRTHING HOSPITAL BY CENSUS AREA



FINDINGS

- Distance was not calculable for 8.7% of birthing women living in zip codes in Alaska, where plane travel is likely required at time of birth.
- In Alaska, women traveling by car or ferry commute 16.2 miles and 52.4 minutes, on average, to their nearest birthing hospital.
- Women living in census areas with the highest travel times (top 20 percent) could travel approximately 829.8 miles and 4,988 minutes by car or ferry, on average, to reach their nearest birthing hospital in Alaska.
- 7.8% of women in Alaska had no birthing hospital within 30 minutes.
- In rural areas across Alaska, 23.5% of women live over 30 minutes from a birthing hospital compared to 2% of women living in urban areas.
- Under normal traffic conditions, 5.7% of women live over 60 minutes from their nearest birthing hospital compared to 1.0% in the U.S.
- 1.7% of women live in census areas with the longest travel distance.

Note: Results represent geographic areas with calculable travel routes by car or ferry (no plane routes).

ALASKA

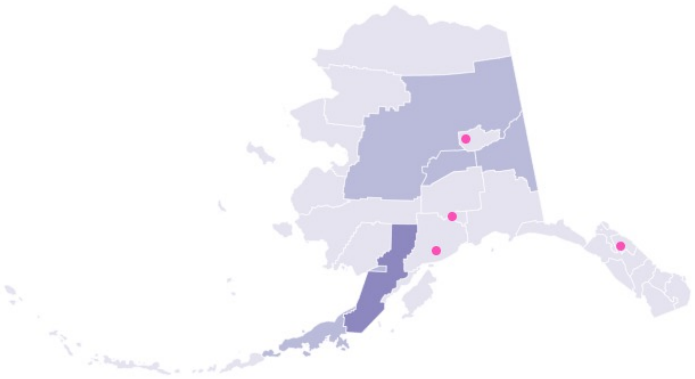
AVAILABILITY OF FAMILY PLANNING SERVICES

Access to family planning services allows for people to achieve their goals around having children, including the timing of and spacing between pregnancies.[7] An unexpected pregnancy or too little time between pregnancies can lead to serious health consequences, including preterm birth, depression, and anxiety.[8,9] Providing access to affordable contraceptives is a strategy to help people attain their family planning goals.[10] Title X clinics are federally funded healthcare sites that provide low-cost reproductive healthcare services including contraceptives, wellness exams, and breast and cervical cancer screenings.[11] The map displays Title X locations and areas where women are vulnerable to poor outcomes due to lack of access to reproductive health services. County-level risk data are derived from Surgo's U.S. Maternal Vulnerability Index (MVI), where a darker color indicates greater vulnerability.[12] Overall, women in Alaska have a very low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.

FINDINGS

- There are 2.6 Title X clinics per 100,000 women in Alaska compared to 5.3 per 100,000 in the U.S. overall.
- On average, people living in Alaska where car or ferry routes are available, travel 53.0 miles to reach their nearest Title X clinic.
- Women living in 91.7% of census areas in Alaska have a very low or low vulnerability to adverse outcomes due to the availability of reproductive healthcare services.

REPRODUCTIVE MATERNAL VULNERABILITY AND TITLE X CLINIC LOCATION



Sources: Surgo Maternal Vulnerability Index; U.S. Department of Health & Human Services, Office of Population Affairs. Title X Family Planning Directory (March 2023); United States Census Bureau. "S1301: Fertility." American Community Survey. 2017–2021. Web. 1 Nov 2022.

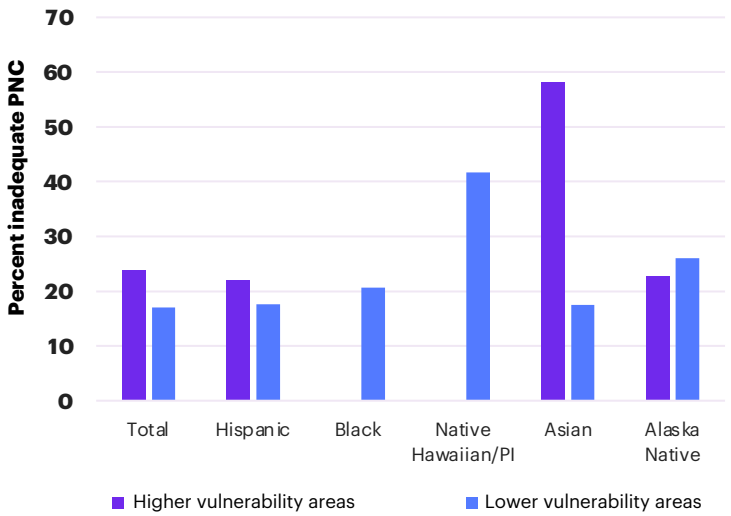
DISPARITIES IN PRENATAL CARE

Early and regular prenatal care (PNC) is an important strategy for reducing the risk of pregnancy complications and adverse birth outcomes.[13] Historically, BIPOC have lower rates of adequate PNC and may be less likely to receive services such as important health screenings and appropriate monitoring of baby's growth.[14,15] Socioeconomic determinants, including poverty, social support and education create barriers to care that can worsen the disparity in PNC usage among BIPOC.[16] The MVI defines areas where women are vulnerable to poor outcomes due to socioeconomic determinants. The impact of the socioeconomic determinants on PNC usage was assessed by examining the percentage of women receiving inadequate PNC in areas with higher and lower vulnerability. In Alaska, 17.9 percent of women received inadequate PNC compared to 14.8 percent in the U.S.

FINDINGS

- 0.9% of BIPOC did not receive PNC in areas of high socioeconomic vulnerability.
- Among BIPOC, those living in areas of high socioeconomic vulnerability have a 18% increased likelihood of inadequate PNC when compared to those living in areas of low socioeconomic vulnerability.
- Asian women living in areas of high socioeconomic vulnerability are 3.3 times more likely to receive inadequate PNC compared to those in areas of low socioeconomic vulnerability areas.

INADEQUATE PNC BY RACE/ETHNICITY AND SOCIOECONOMIC DETERMINANTS



Sources: National Center for Health Statistics, 2019-2021 final natality data; Surgo Maternal Vulnerability Index.

Note: Inadequate PNC is defined as no prenatal care or care that began during or after the fifth month of pregnancy or that included less than half of the appropriate number of visits for the infant's gestational age. PI=Pacific Islander. Missing groups are suppressed.

WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS AND THE CRISIS OF ACCESS AND EQUITY

March of Dimes recommends state policy actions that address access to care; see: **https://marchofdimes.org/mcdr-ak**

For details on data sources and calculations, see Technical Notes: **https://www.marchofdimes.org/peristats/maternitycaretechnotes**

ALASKA

CHRONIC HEALTH CONDITIONS AND PRETERM BIRTH

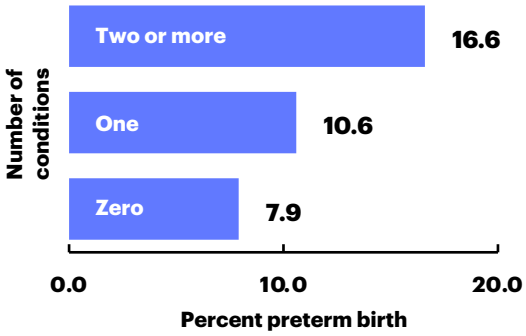
Having a chronic health condition before pregnancy increases the risk of pregnancy and postpartum complications. Preterm birth (PTB), a delivery before 37 weeks gestation, is one example of a complication that can lead to serious health impacts. The burden of chronic health conditions among birthing people is increasing across the U.S.[17,18] Access to healthcare before, during, and after pregnancy is important for appropriate management of chronic health conditions. At the time of birth, women with chronic conditions and their babies may need access to higher-level care, such as specialized providers, hospitals with the ability to perform a Cesarean birth, or hospitals with NICUs. Examining the chronic health burden (CHB) across Alaska and its relationship to adverse outcomes provides information needed to make important changes that can result in targeted resource allocation, prevention, and appropriate disease management.

The percent of birthing people with one or more chronic conditions was calculated for each census areas in Alaska and overall. The following conditions were included due to their availability in birth record data and established association with PTB: pre-pregnancy hypertension and diabetes, smoking, and being underweight or obese before pregnancy. The map describes the census area CHB in relation to the PTB rate. Areas shaded in purple have both a high CHB, greater than the overall state percent, and a high rate of PTB, defined as greater than the Healthy People 2030 target of 9.4 percent.[19] In Alaska, the PTB rate was 10.1 percent, compared to 10.5 percent in the U.S. overall in 2021.

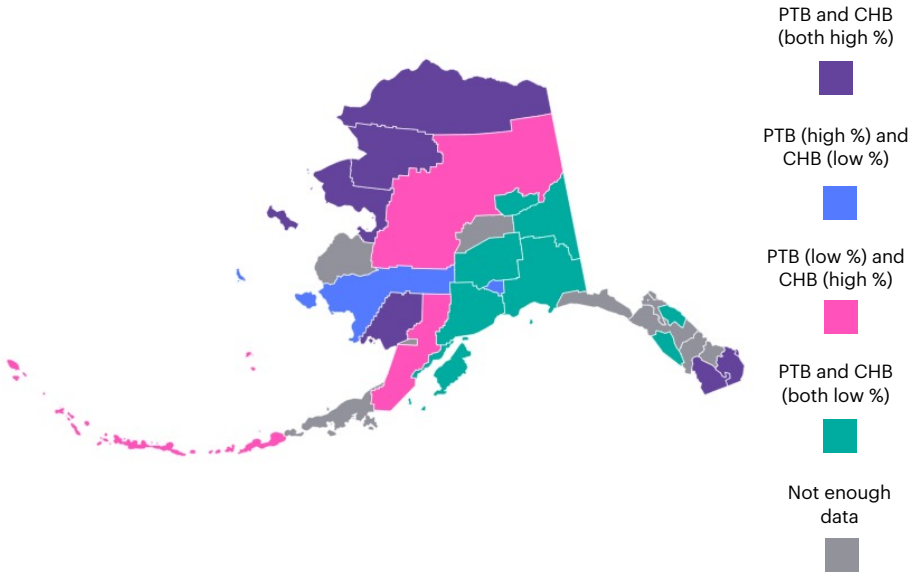
FINDINGS

- In Alaska, 39.6% of women had one or more chronic health conditions compared to 37.8% in the U.S. overall.
- Women with one or more chronic health conditions have a 53% increased likelihood of having a preterm birth compared to those without any chronic health conditions.
- 25% of census areas in Alaska have a high burden of chronic health conditions and a high rate of preterm birth.

PRETERM BIRTH BY NUMBER OF CHRONIC HEALTH CONDITIONS



CHRONIC HEALTH BURDEN (CHB) AND PRETERM BIRTH (PTB) BY CENSUS AREA



Note: The burden of chronic health conditions is the percent of birthing people in each census area with one or more chronic conditions. Census areas with less than 10 preterm births or women with chronic health conditions are excluded from the map.

Source: National Center for Health Statistics, 2017–2021 final natality data.

SUMMARY

All women deserve healthcare which is safe, effective, timely, efficient and equitable. Consistent and equitable access to maternity care helps women maintain optimal health as well as reduce the risk of experiencing complications during pregnancy and the postpartum period. Several factors influence maternity care access for women across the U.S. By assessing distance to care and the availability of maternity care providers, hospitals and family planning services, this report provides insight into several physical components that affect a person's ability to receive care. In addition, examining community level factors associated with access to care and identifying vulnerable populations provides greater context around barriers to receiving appropriate care. Together this information can lead decision makers, public health professionals, clinicians and researchers to advocate for policies and resources that increase maternity care access across each state.

By addressing these factors, states may move closer to eliminating pregnancy-related deaths and complications. Telehealth, through various platforms, equips maternal health providers with the tools to better facilitate care before, during and after pregnancy and has been shown to not only increase access but also improves patient engagement and treatment.[20] March of Dimes fully supports Congress, governmental regulating agencies and states to act and make telehealth provisions balanced and permanent. Evidence-based telehealth services and other innovative solutions are explored in greater depth on page 5.

ALASKA

POLICY SOLUTIONS AND ACTIONS

March of Dimes has long supported policies that improve access to maternity care, including Medicaid expansion and extension, improved integration of the midwifery model of care, reimbursement for doula care, and increasing the availability of telehealth services across a range of healthcare specialties. Telehealth is healthcare delivered using technology to replace or enhance in-person care and can save lives by providing high-quality care for pregnant and postpartum people.[21] Women who are underserved, vulnerable to poor health outcomes, and have limited access to high-risk care can greatly benefit from telehealth.[21]

To address the limited access to maternity care in the U.S., states must adopt and support telehealth and other innovative practices to expand access and provide more options for healthcare delivery. The current state of telehealth policies and innovative solutions in Alaska aimed at improving maternal health outcomes is explored in this report. By highlighting innovative solutions implemented across states, policymakers and healthcare professionals can identify policies and programs that can improve health for pregnant people in Alaska and ensure they receive the support and care needed before, during, and after pregnancy.

TELEHEALTH LAW

Due to the COVID-19 Public Health Emergency (PHE), states expanded access to telehealth services. While many of the policies increased access to telehealth for maternity care services temporarily, many states permanently expanded telehealth services. This policy measure identifies whether Alaska has passed laws to permanently provide Medicaid telehealth coverage for maternity care services.[22,23]

TELEHEALTH COVERAGE

Medicaid telehealth policies vary by state. States may cover all forms of telehealth services or restrict certain forms of telehealth services.[22] This policy measure identifies whether Alaska provides Medicaid reimbursement of the following telehealth services:

✓ Live video ✓ Remote patient monitoring ✓ Audio-only[22]

✓ Meets recommendations ✱ Progressing toward recommendations ✗ Needs improvement

POLICY AND PROGRAM INNOVATION

- The Alaska Native Tribal Health Consortium has a partnership with the University of Washington to provide clinical training and education in traditionally underserved healthcare systems. Physicians from the University of Washington's Global and Rural Health Fellowship partner with Tribal health systems in Alaska to provide direct clinical care in internal medicine and emergency medicine.[24]
- The Alaska Maternal and Child Death Review (MCDR) is a multi-disciplinary committee that uses a systematic case review model that is evidence-based and aims to identify causes and associated factors related to pregnancy-associated and infant deaths. The MCDR uses the data to perform statewide epidemiological surveillance, inform public policy, and improve public health initiatives and programs. The MCDR panelists include Tribal members and diverse individuals who have experience working directly with populations experiencing health disparities. The MCDR panelists promote equity by identifying and making recommendations to address systemic factors that contribute to maternal and infant deaths.[25]
- Project ECHO Alaska assists patients and primary care providers in rural settings by offering access to specialty care without the cost of travel. Project ECHO offers telehealth consultations by specialty providers to patients in rural and underserved areas.[26]

MARCH OF DIMES

ALASKA

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Medicaid Cost Savings in 2022 for Midwives (CPM/CDM) in the State of Alaska

Cost Savings

Total vaginal deliveries attended by CPM/CDMs	567
Percentage paid by Medicaid (DKC)	38%
Total Medicaid births by CPM/CDMs for 2022	215
Medicaid payment per birth for CPM/CDMs	$982.74
Birth Center Facility Fee for CPM/CDMs	$2603.19
Medicaid payment for NSVD OB/GYN	$1130.15
Hospital Facility Fee for Vaginal Delivery	$26,659.

(Does not include professional or physician fees, pediatrician visits, newborn fees)

Total for Home Birth = $982.74

Total for Birth Center Birth = $ 3585.93

Total for OB Hospital Birth = $27,789.15

Cost savings for a home birth vs a hospital birth for 215 births

$982.74 x 215 births = $211, 289.10 vs $27, 789.15 x 215 births = $ 5,974,667.25

Saving Medicaid $5,763,378.15*

Cost savings for a birth center vs a hospital birth for 215 births

$3585.93 x 215 births = $813,289.10 vs $27,789.15 x 215 births = $5.974,667.25

Saving Medicaid $5, 161,378.15*

Midwives (CPM/CDMs) saved Medicaid over $5 million dollars in 2022 in just birth fees.

Keep in mind that $5 million is only 6% of the births in Alaska. *This does not include the savings for prenatal care and postpartum care.

Sources: Medicaid Alaska Vital Statistics Annual Report, Medicaid Fee Schedules, Providence Hospital online insurance estimates for care.

The savings are similar every year I investigated starting in 2020.

Alaskan Midwives

Cost Savings with CPM/CDM Care Demonstrated by Alaska State Data:

- **Total Savings to Alaska Medicaid are approximately $5.4 million per year**. This estimate is based on low risk, vaginal birth and facility fees only.
- **Midwife (CDM/CPM) cesarean rate is on average 6%** vs the Alaska Hospital rate of 23%
- Cesarean sections are substantially more expensive than a low-risk birth, so **Midwives (CDM/CPMs) saved the Alaska Medicaid millions more when this is factored in.**
- According to the 2022 Legislative Audit, **the Midwifery Board Total Expenditures for FY2021 was $28,242, which was paid by our Boards incoming revenues from license fees and left the Board ending cumulative SURPLUS of $67,329.**
- **Cost savings to the State of Alaska** from the care of CDM/CPMs is approximately **192 times the cost of administrating the State Board of Certified Direct Entry Midwives.**
- **Cost savings achieved** with CDM/CPMs attending **6% of the births in Alaska**.

Improved Outcomes for Women and Infants with CDM/CPM Care Demonstrated:

- **Significantly lower cesarean section rates** with the care of CDM/CPMs. (**6% vs 23%**)
- **CDM/CPMs have had 0 Maternal Deaths** vs the Hospital rates of 6-20 per year. (see Pregnancy – Associated Mortality in Alaska pdf)
- Significantly **fewer low birth weight babies and babies born prematurely** with the care of CDM/CPMs, all indicators for improved outcomes, especially for vulnerable populations.
- Significantly **higher breastfeeding rates (99% at birth and 99% at 6 weeks postpartum**) with the care of CDM/CPMs, with the accompanying demonstrated health benefits for mother and infants extending throughout lifetimes.
- **Higher rates of intact perineum** (without a tear or episiotomy); Lower rates of episiotomy.
- Lower unneeded medical interventions such as induced labor, continuous electronic fetal monitoring, and cesarean birth.
- **Better experiences with community birth with CDM/CPMs**. **Lower postpartum depression rates** due to being **more satisfied with the personalization of their care, their care environment, quality of their relationship with their midwife, their ability to have a physiologic birth.**

2023 MAA (Midwives Association of Alaska) Stats Summary Report

528 Births

11% Transferred out of care during pregnancy due to risk factors

12% Intrapartum Transfer Rate

92% Intrapartum Transfers were NON EMERGENT

2% Neonatal Transfer Rate

0.02% Neonatal Mortality Rate

3% Postpartum Maternal Transfer Rate

0% Maternal Mortality Rate

17% of the mother/baby dyad who enter labor under the care of CDMs transferred from the community setting into the hospital

6% Cesarean Rate

99.6% Breastfeeding Initiation Rate

99% Breastfeeding rate at 6 weeks postpartum

64 Antenatal Transfers

57 Intrapartum Transfers Non-Emergent

5 Intrapartum Transfers Emergent

7 Neonatal Transfers Non-Emergent

5 Neonatal Transfers Emergent

1 Neonatal Death

8 Maternal Postpartum Transfers Non-Emergent

5 Maternal Postpartum Transfers Emergent

0 Maternal Deaths

Konrad Jackson

From: Robert Pugh <widad4015@yahoo.com>
Sent: Sunday, January 28, 2024 7:05 PM
To: Senate Labor and Commerce
Subject: Midwife Board and EO130

Follow Up Flag: Follow up
Flag Status: Flagged

I'm writing you to express my concern about the Governor's EO 130 to dissolve the Midwife Board into a state department of bureaucrats. This is a step backwards for midwives across the state. It will potentially lead to further restrictions of scope of practice and the ability for Alaskan families to choose this type of maternity care.
Furthermore it will have unknown consequences for public health and safety of birthing women in Alaska. Have you heard of a group calling themselves "Birthkeepers"? They are a group of untrained and unlicensed women already providing maternity care and assisting women in home births right here in Alaska. They are part of a nationwide group that are doing this due to the "high costs" and "too restrictive regulations" on licensed healthcare providers including CPM and CDMs in Alaska.
There has also been a rise in planned "unassisted" home births in Alaska for the same reasons.
Any further restrictions on Alaska's licensed midwives will undoubtedly increase the dangerous practice of women choosing this form of childbirth that will potentially lead to serious complications including infant and maternal mortality rates.
The current board members have been working diligently to address these issues over the past four years. The current board has also worked on updating the 40 year old statutes and regulations to update them to current national standards of midwifery as defined by NARM (North American Registry of Midwifes) that all states use as their standard for training and certifying credentials for midwifes.

As for fiscal responsibility and costs associated with the board, the board has ALWAYS BEEN SELF FUNDED through licensing fees. The board was in the red in past years but this board has also worked to remedy that and now has a surplus of funds as stated in the legislative audit 2022 page 9 (schedule of revenues and expenditures) and still has a surplus of funds that will be included in the current ongoing audit.

So the claims that the board is having "financial struggles" is false and misleading. If anyone from the legislature or the Governor's office would actually take the time to sit down and talk with the midwife board they would know this. They would also know that according to a 2022 Alaska midwife costs savings report they would know that CDM midwives in Alaska saved the state Medicaid over $5.4 million dollars in that year alone.
I find it most troubling that no one from the the Governor's office or the state legislature has reached out to the midwife board or the board of MAA (Midwife Association of Alaska) to discuss this matter. It is now my understanding there will be a legislative committee meeting on January 31 and not one single licensed midwife has been invited to comment. This doesn't sound like a democratic or transparent process!
I voted for Governor Dunleavy, I've supported him through some of his most difficult decisions and policies but it is my opinion he has missed the mark on this one. It is also my opinion that's due to a campaign of misinformation and defamatory comments and statements made by certain individuals that have a direct conflict of interests with midwives and maternity care in Alaska. It frustrates me that when such criticisms and accusations are made that our elected representatives do not take the time to research and verify these claims! Politics is a dirty game of "mudslinging" and politically motivated propaganda!

All I ask is to take the time to contact and listen to both sides of any and every issue. Look for the biased opinions and motives. After all isn't that what an elected "representative" of the people does? Are you in that office to represent the majority of your constituents or just the ones that have the most money, power and influence?

Respectfully (but frustrated)
Bob Pugh
Alaskan, Father, Grandfather, Veteran and most importantly REGISTERED VOTER Eagle River
907-691-5990

Konrad Jackson

From: Rose Hardesty <roselahatt@gmail.com>
Sent: Sunday, January 28, 2024 3:41 PM
To: Sen. Jesse Bjorkman
Subject: Opposition to Executive Order No. 130

Hi Jesse,

As a lifelong Alaskan and mother of four, I want to express my opposition to Executive Order No. 130. All four of my pregnancies and births were done under the care of midwives. The importance of them, with their training and experience, having their own board to govern themselves cannot be overstated. Midwives bring another option that in many cases is far different from what an OBGYN can offer. Not only has my experience with them been very personalized and compassionate feeling more like a friend than provider, but their training has provided every bit of medical information, care and options that I have needed for pregnancy and birth. For example, during my last pregnancy I was overdue. Instead of needing to go to the hospital my midwife successfully broke my water at my home, and I was able to give birth in my home with the highest level of peace and comfort possible. Not only did this eliminate extra time driving and taking up valuable space in the hospital, it saved so much money and stress!

As Alaskans, we are people who value our freedom of choice and independence. This includes having well organized options that fit what we want for birth as we grow our families. Numerous studies positively support the outcomes of Licensed Midwives including higher rates of physiological birth, lower intervention rates including lower Cesarean rates, higher rates of Breastfeeding initiation and continued breastfeeding at six weeks postpartum. Pregnancy and birth is a physiological thing that is benefited by having medical professionals. It is undeniable there is also a huge psychological part that goes along with this. Many people in Alaska (myself included) are most comfortable with the medical care provided by midwives. This encompasses the care physiologically and psychologically/emotionally for the well being of all the families who rely on midwives. Midwives know what midwives know unlike anyone else. They are qualified to make the decisions of how midwives should be operating. Please do not take this amazing resource away from Alaskans. Eliminate executive order No. 130.

Sincerely,
Rose LaHatt