Maternity Care Delivery and Payment Changes During COVID-19

Assessing Equity and Sustaining Innovation

This document reflects anecdotal information provided by maternal health stakeholders, including a survey conducted by the Health Care Transformation Task Force in Spring of 2020, and reported in the media and industry journals regarding maternity care and birth practice changes in the U.S. in response to the public health emergency caused by the 2019 Novel Coronavirus (COVID-19).

Introduction

Birthing people, health systems and practitioners had to alter their approach to furnishing care in significant ways in response to COVID-19. These care delivery changes evolved throughout the course of the pandemic, along with knowledge of the virus (including implications for childbearing people), with some exacerbating the underlying inequities in our health care system and others offering promising new innovations to improve care. This resource highlights examples of the ways birthing persons, practitioners, and health systems have driven innovations in maternity care, leveraged Medicaid and commercial payer reimbursement waivers in response to COVID-19, and worked to promote equity for Black, Indigenous, and People of Color (BIPOC) birthing people. Many of these findings underscore the need for more enduring payment reforms to support and sustain ongoing positive care delivery change and drive more equitable, higher-quality care.

The COVID-19 pandemic disproportionately impacted people of color, exacerbating existing systemic inequities in the United States. Racial and ethnic minority groups have borne an inordinate burden of COVID-19 related illness and death.[1] According to the Centers for Disease Control and Prevention (CDC), the identified COVID-19 death rate among Black persons is nearly two times that of white persons and Black persons are nearly three times more likely to be hospitalized. Further, American Indian or Alaska native and Hispanic persons are more than two times more likely to die from COVID-19 than white persons, and almost four times and three times more likely to be hospitalized, respectively, than white persons.[2]

Just as the COVID-19 pandemic has opened more eyes to troubling racial health disparities, maternal health outcomes in the U.S. have long signaled systemic inequities for pregnant and birthing persons of color, with birthing persons of color two to three times more likely to die in childbirth than white birthing

Terminology

Birthing persons is a term used to describe pregnant persons that is inclusive of all genders and gender identities. Not all birthing people identify as ***women*** or ***mothers***.

This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature.

Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.

See Appendix for additional definitions.

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persons.[3,4] In planning for the post-pandemic maternity care system, it is critical to evaluate the impact of all care delivery models with a health equity lens to determine whether birthing persons of color are benefited or harmed by the emergency innovation.

Early Care Delivery Changes in Response to COVID-19

Since the onset of the pandemic, pregnant and birthing persons have been faced with upended care plans and tremendous uncertainty when it comes to labor and birth, while providers have struggled to balance evidence-based care practices while keeping themselves, their patients and their families safe. In the early days of the pandemic, some hospitals started prohibiting partners and birth supports such as doulas from attending labor and delivery.[5] Some OB-GYNs advised and offered to induce labor for pregnant women at 39 weeks without medical indication, and some payers reversed prior payment policies to suspend reimbursement for early elective deliveries (EED) in response to the pandemic.[6] Anecdotal evidence indicates a potential increase in spontaneous birth as pregnant persons (some at the direction or requirement of their providers) delayed or avoided hospital admission for labor to minimize risk of COVID-19 transmission.

Lessons Learned from the Strong Start for Mothers and Newborns Initiative

Restrictions on businesses and public gatherings put in place to slow COVID-19 transmission resulted in an increase in unemployment. These job losses disproportionately impacted low income and minority communities further exacerbating the impact of existing inequalities. As the number of unemployed increased, so too did enrollment in Medicaid. Due to the public health emergency, State Medicaid programs adapted policies to allow for virtual care for routine prenatal and postpartum visits.[7] This improved access to care for some by eliminating traditional barriers to care (*e.g.*, transportation, childcare, etc.), but caused a new barrier to care for birthing persons without internet access and/or other technology. In a *Health Affairs* blog, authors applied lessons learned from the Strong Start for Mothers and Newborns Initiative[18] to offer policy and care improvement opportunities during the COVID-19 pandemic, including improving the medically focused model of care by investing in behavioral health and social support services, increasing reliance on non-physician health professionals and community health workers, and support for care delivery through value-based payment models.

Payers were also quick to expand coverage for durable medical equipment (DME), such as at-home blood pressure monitors to support virtual prenatal care visits. Yet, stakeholders found that modified benefit design had a large impact on access. Specifically, if the benefit was structured as a DME benefit rather than a pharmacy benefit, it proved much harder for pregnant persons to access given the tighter restrictions and limited access to covered DME. The strict regulations limit the number of suppliers available to provide the equipment to pregnant persons, creating an access barrier for pregnant persons with low-income and/or transportation limitations by requiring individuals to travel a significant distance to acquire monitors from authorized suppliers. A provider practice in California reported wildly different utilization of blood pressure monitors by pregnant women depending on whether their Medicaid Managed Care Organizations (MCO) plan made them available as DME or as a pharmacy benefit. When the blood pressure monitors were covered via a pharmacy benefit, providers saw significantly greater uptake, as pregnant women were able to acquire monitors at most local drug stores.

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The most noteworthy care delivery change has been the rapid scaling and uptake of telehealth. Experts noted that the industry "flipped the switch" on telehealth, mobilizing at a rate almost unthinkable prior to the pandemic, despite a decade-long industry investment in and implementation of electronic health records and digital health platforms. Resistance to telehealth both on the part of providers and patients was quickly overturned by the need to limit in-person visits to reduce opportunities for COVID-19 transmission. In moving towards the adoption of telehealth, stakeholders must ensure that telehealth does not further exacerbate existing disparities among people (disproportionately low-income and BIPOC) without access to reliable internet or the proper technology to connect with a provider.

As care delivery quickly shifted, experts noted conflicting policies and lack of clear guidance about various emergency-authorized payment changes, including billing for telehealth services, as a barrier to providing high-value maternity care. Early on, midwives who were providing and billing for telehealth services noted there was a lack of clarity regarding whether they would be reimbursed for the claims. In part, the confusion was due to inconsistent insurance coverage for services provided by birth center workers and other non-clinical birth workers including doulas and community health workers.

High-Value Equitable Maternity Care in the Time of COVID-19

Research conducted by the Urban Institute, as well as other anecdotal evidence, have found promising maternal telehealth practices resulting from the onset of the COVID-19 pandemic, including an increase in group prenatal care sessions and improved access to mental health counseling and postpartum care.[10]

Case Study: Prenatal Care Redesign at Michigan Medicine

Originally released in 1930, prenatal care guidelines remain largely unchanged,[11] recommending 12 to 14 in-person visits for a birthing individual which can total up to 40 hours (including travel time, wait time, labs, and appointments). To modernize the recommendations and adapt to people's needs, Michigan Medicine, an academic medical center at the University of Michigan, updated their prenatal care design to include fewer visits – both virtual and in-person – to create flexibility for birthing individuals. The project began in 2019 but was soon accelerated to account for a transition to more virtual health care services due to COVID-19.

Spotlight: One Medicaid program has seen significantly greater utilization of virtual group services – including group counseling/peer recovery groups for Medication-Assisted Treatment and women with Opioid Use Disorder – now that they are provided in a virtual setting and meeting pregnant persons where they are.

To change their system, Michigan Medicine began by thinking of prenatal care in two ways: the 'what' of services provided and the 'how' of delivery. The 'what' remained the same: prenatal care services do demonstrate improved maternal and infant outcomes. However, Michigan Medicine wanted to change the 'how' of delivery. In a literature review, the team found studies showing telehealth as a promising method of delivery with equivalent maternal and fetal outcomes, cost savings for the health system, and high patient satisfaction[12]. In conjunction with the literature search and before the start of the pandemic, Michigan Medicine surveyed 332 postpartum birthing persons admitted for childbirth and recovery in Michigan

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Medicine's health system, with a 90% response rate (300 responses). Two-thirds of respondents preferred fewer prenatal care visits than current standards recommend, and the majority preferred using telemedicine instead of some in person visits. With this feedback, Michigan Medicine moved forward with redesigning prenatal care around two principles: designing care around essential services and creating flexible services for anticipatory guidance and psychosocial support.

To achieve principle one, Michigan Medicine identified crucial prenatal services that could not occur remotely (such as ultrasounds, vaccinations, and physical exams), and grouped them based on recommended time of completion during pregnancy. The final pathway resulted in a "4-1-4" design: four in-person visits, one formal obstetrical ultrasound, and four virtual visits, interspersing virtual visits between in-person check-ups. To achieve principle two - providing anticipatory guidance and psychosocial support - Michigan Medicine created an online program to provide birthing individuals with social connection and peer mentoring in addition to their prenatal care visits. In the program, birthing individuals have the option to attend monthly small group sessions with other birthing individuals in similar gestational stages, communicate through private online chatrooms, and attend classes on coping skills and wellness led by social workers and psychiatrists. The program serves as a way for birthing individuals to gain access to critical guidance and psychosocial support, especially in a time where many in-person support networks are cancelled due to COVID-19.

In assessing the success of this new model, surveys found positive care experiences in access, quality, safety, and satisfaction. However, there are still gaps to be addressed including access to electronic devices and adequate bandwidth connectivity, the payment and quality structure for services, and ensuring delivery of equitable care to all populations served. Michigan Medicine continues to assess their program as COVID-19 continues.

Virtual Doula and Perinatal Support Services

Birthing persons with access to virtual services have shared positive feedback regarding these services – and perinatal support workers have noted that birthing persons seem more comfortable discussing mental health in a virtual setting and certain barriers like childcare and transportation have been eliminated with telehealth. The innovation of virtual doula and perinatal support services has helped to provide comprehensive support to all birthing persons.

The Pandemic's Effects on Doula Care

Despite challenges affecting doula care during the pandemic, including hospitals limiting the number of support persons allowed to accompany a birthing person during birth, community-based doulas have continued to provide valuable services to their clients.[1] Doulas have continued to meet the needs of birthing persons during the pandemic through community fundraising, providing essential supplies, and educating women on how to mitigate the spread of COVID-19. In a report, authors urge hospitals, as anchor institutions, to invest directly in community and community-based programs to promote health equity and adopt policies that recognize doulas as essential health care workers.[13]

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Case Study: Virtual Doula Services at Accompany Doula Care

Accompany Doula Care is a start-up that employs community-based doulas and contracts with Accountable Care Organizations (ACOs) to serve families on MassHealth Medicaid. Founded in 2016, the organization began a pilot program with one Massachusetts-based ACO in 2019 and is now in its third year of service delivery. In its second year (2020), the program successfully served 53 birthing persons and experienced a lower than state average preterm birth rate and an exceptionally low low-risk cesarean birth rate (11%). Along with positive health outcomes, Accompany Doula Care noted a unique patient satisfaction outcome: two clients who received doula services began training to become doulas themselves.

Advances in Virtual Programs

Located in one of the initial epicenters of the pandemic in New York City, the Center for Perinatal Education and Lactation at NYU Langone Hospitals, was required by state and local mandates to abruptly cancel all in-person educational sessions and support groups. In terms of challenges, determining how best to provide prenatal and postnatal lactation support was critical. NYU Langone quickly pivoted to remote programming – for example, virtual lactation education. They concluded that virtual platforms could continue to provide lactation support post-pandemic.

As doula services is a traditionally hands-on field, Accompany Doula Care had to make large adjustments to their care delivery during the COVID-19 pandemic to address the concerns of facilities, patients and doulas about COVID-19 transmission, while still offering high-quality, personalized doula support. Accompany Doula Care faced several challenges in delivering doula services during the public health emergency. These include hospitals preventing doulas from attending births in person, lower than projected reimbursements affecting the operating budget, wariness of doulas and patients of contracting COVID-19, and a lack of timely and readily accessible transparency and updates on hospital-based policies. Furthermore, there was a lack of knowledge within Accompany Doula Care about the transition to virtual doula care and varying levels of familiarity with technology among doulas and patients participating in the program.

Advances in Virtual Programs

Mamatoto Village, a nonprofit community-based organization in Washington D.C. that offers perinatal support services to birthing persons, pivoted to virtual services during the pandemic. The nonprofit offered services via both video and phone, as well as online childbirth education. In addition to virtual support via smartphones, tablets, and laptops.[14]

Accompany Doula Care saw an opportunity to be a trail blazer by offering virtual doula support. In response to concerns about COVID-19 transmission, doulas worked with patients to determine whether in-person or virtual support was right for them and their families. Because of the program's contracts with ACOs, many doulas were already integrated into hospitals and were able to continue giving in-person birth support following COVID-19 guidelines. Accompany Doula Care also began to reimburse for 'cumulative' time – reimbursing for every 45 minutes of calls, texts, or video interactions – instead of reimbursing for each typical appointment. Lastly, Accompany Doula Care purchased and distributed personal protective equipment (PPE) to all doulas, and provided training for them on COVID-19 safety practices.

In sum, throughout its care birth modifications during COVID-19, Accompany Doula Care encountered challenges and concerns. Moving to a virtual format requires a level of access to and familiarity with technology that is a barrier for some birthing people and doulas (including access to bandwidth and devices that support both audio and visual communication, as well as

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possessing the knowledge on how to properly use such devices). Doulas must navigate inconsistent hospital policies and opaque decision-making processes. Most recently, the program has been encountering hesitancy in the communities it serves regarding the COVID-19 vaccine due to trust issues emanating from a history of mistreatment by the medical care system. Accompany Doula Care continues to address the ongoing challenges as the public health emergency stretches on to ensure that all birthing persons in its program receive high-quality, patient-centric care.

Promoting Patient Self-Advocacy to Improve Outcomes

The shortage of BIPOC birth workers limits the promise of community-centered maternity care. Further, birth justice activists and scholars are still not usually found in positions of power to change the inadequate systems and policies in place in the medical industry. Self-advocacy is critical skill set for pregnant and birthing persons of color to reduce medical errors and other harm. Many perinatal support workers and organizations have resources to equip women with suggestions for how to advocate for themselves during pregnancy – whether there is a pandemic or not. With endless care delivery changes and upended birth plans amid COVID-19, the importance of self-advocacy is greater than ever.

Spotlight: Lamaze International, an organization that provides birthing persons with evidence-based information and guidance, suggests birthing persons know their options, ask questions, practice speaking up for themselves, be polite (to a point), and have a knowledgeable support person.[15]

Case Study: Community-developed, self-advocacy curriculum

Structural racism in the health care system has driven health inequities and negatively impacted maternal health outcomes for BIPOC individuals. A key strategy for combating health inequities is the adoption of person-centered care practices. Person-centered care is care that is respectful and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.[19] When applied to maternity care, person-centered care helps achieve birth justice – allowing all birthing individuals to have the freedom and support to make decisions with dignity.

Community-based, self-advocacy solutions offer a way for patients to help mitigate racism and other discrimination and foster dignity and respect in health care settings. For example, in New York city, the Sexual and Reproductive Justice Community Engagement Group made up of community leaders, activists and nonprofit organizations, worked with the New York City Department of Public Health to produce the New York City Standards for Respectful Care at Birth,[20] a resource that educates and encourages birthing individuals to know their human rights

Resources to help counter racism in the medical profession and support diversity in the midwifery field include:

- **Black Women's Blue Print:** Provides anti-racism training in the workforce[16]
- **National Black Midwives Alliance:** Provides mentorship for Black women training to become midwives[17]
- **Health and Human Services:** Provides free courses in culturally and linguistically appropriate services in maternal health care[18]

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and be an active decision maker in their care. Similarly, the National Association to Advance Black Birth (NAABB) released a Black Birthing Bill of Rights[21] to give birthing individuals the tools to understand and confidently exercise their rights. The NAABB resource also serves as guidance for government programs, hospitals, and maternity providers as they inform policies, procedures, and practices to meet the needs of Black birthing people.

The Black Coalition for Safe Motherhood, founded in July 2020, seeks to promote health care advocacy and holistic support of birthing families in Black communities. To do so, the Coalition created the ACTT curriculum:[22]

- **A**sk questions until you understand the answer,
- **C**laim your space,
- **T**rust your body,
- **T**ell you story.

During ACTT workshops, birthing people and supporters practice forming questions and statements to challenging situations, actions to take when feeling dismissed or disrespected, and responses to feeling in danger. The program sends participants home knowing their rights in a maternity care setting, including their entitlement to informed consent, and with the ability to vet maternity care services and advocate for themselves.

Patient-self advocacy is an important tool for patients to receive care that is respectful, culturally congruent and aligned with their needs in the short term. The resources mentioned above provide ample opportunity for birthing individuals to become proficient in self-advocacy to improve their birthing experience. However, longer-term solutions such as delivery system and payment reform, performance measurement, and work force development are also necessary to ensure maternity care is more equitable, respectful, effective, and affordable.

Black Women led birthing centers, operating or in formation, include:

- **Birth Sanctuary**[23] in Gainesville, Alabama addresses the needs of the immediate rural birthing community while offering comprehensive care for women and non-binary health care for healthy non-pregnant persons as well.
- **Birth of a Nation Birthing Center,**[24] located in Cleveland, Ohio. Their mission is to provide a cost efficient, safe and low risk alternative for the birthing process. They are champions forequitable healthcare for all women.
- **Birthing Place Bronx,**[25] in New York, New York. BIPOC local doulas and birthing professionals came together with a dream: to create The Birthing Place, serving families in search of a safe, serene, and deeply supportive alternative to birthing low-risk pregnancies in hospitals.
- **Birth Supporters United**[26] in Montgomery County, MD wishes to open a birthing and support facility in a predominantly black community so that families will have access to the help and support that they need.
- **Kindred Space**[27] in Los Angeles
- **Birth Center Equity Fund,**[28] supporting and networking BIPOC-run facilities and healthcare providers.

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Conclusion

Now is the time for providers and policymakers to evaluate maternity care innovations borne out of necessity due to COVID-19 to determine what innovations should be made ubiquitous once the public health emergency is over. The promising care delivery changes discussed above represent preliminary findings, and significant work remains to rigorously evaluate the maternity care delivery and payment changes with outcomes stratified by race and ethnicity. Emerging data on racial disparities in certain states and localities has prompted public health officials to call on the federal government to provide more comprehensive COVID-19 data stratified by race and ethnicity, and the Centers for Disease Control and Prevention (CDC) leadership has publicly acknowledged the agency's "inadequate" data on racial disparities among COVID-19 cases, deaths, and hospitalizations.[29] Similarly, the data collected must identify pregnancy and lactation status to better understand COVID-19 related cases, symptoms, hospitalizations and deaths for the childbearing population to help reduce inequities, and improve care and outcomes. This natural experiment may provide an opportunity to make permanent policy changes that advance high-value maternity care and eliminate racial disparities in maternal morbidity and mortality, but only if the right questions about disparate health outcomes are asked and answered.

Acknowledgments

The Health Care Transformation Task Force (HCTTF), with support from The Commonwealth Fund, convened the Maternal Health Hub Learning Community, which informed the development of this resource. The Learning Community comprises maternal health stakeholders – including providers, payers, patient advocates, purchasers, community-based organizations, policymakers and others – that are committed to advancing high-value maternity care by sharing their experience, best practices, and challenges with others. Special thanks to those members of the Learning Community who contributed to this resource, HCTTF Director Joshua Traylor, HCTTF Associates Anna Kemmerer and Megan Zook, and Carol Sakala of the National Partnership for Women and Families. We also thank former HCTTF Senior Director and Maternal Health Hub Project Lead Clare Pierce-Wrobel and former HCTTF Senior Associate Katie Green for their early contributions.

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Definitions

Birthing persons: A term used to describe a pregnant, laboring, birthing or postpartum person that is inclusive of all genders.

> *Note: Not all birthing people identify as "women" or "mothers." This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature. Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.*

Doula: A trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible. (Adopted form DONA)[30]

Perinatal support workers: An umbrella term used to describe someone who graduated from a specialized program which allows them to provide physical, emotional and educational support through a birthing person's pregnancy and into the infant's first year of life. (Adopted from the Global Perinatal Support Worker Inc.)[31]

Birth center: The birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. Birth centers are an integrated part of the health care system and are guided by principles of prevention, sensitivity, safety, cost-effectiveness, and appropriate medical intervention. The birth center respects and facilitates a pregnant person's right to make informed choices about their health care and their baby's health care based on her values and beliefs. (AABC Standards for Birth Centers – revised 2017)

Strong Start: The Strong Start for Mothers and Newborns Initiative, an effort by the Department of Health and Human Services, was launched in 2012 to reduce preterm births and improve outcomes for newborns and pregnant women. The initiative was made up of two streams: the first encouraging providers to use best practices to reduce the rate of early elective deliveries. The second stream tested three evidence-based maternity care service approaches among Medicaid beneficiaries: Centering/Group Visits, Birth Centers and Maternity Care Homes. The program was in operation for four years and is no longer active. (Adopted from the CMS)[8] In a rigorous evaluation, results of birthing people who participated in the birth center model were very favorable relative to those receiving typical Medicaid care.

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