

Expanding certified professional midwife services during the COVID-19 pandemic

Jeremy Applebaum MD 

Department of Obstetrics and Gynecology, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, USA

Correspondence

Jeremy Applebaum, 3400 Spruce Street, 5 Dulles, Philadelphia, PA 19104, USA.
Email: jeremy.applebaum@pennteam.upenn.edu

Abstract

Given concerns of coronavirus disease 2019 (COVID-19) acquisition in health care settings and hospital policies reducing visitors for laboring patients, many pregnant women are increasingly considering planned home births. Several state legislatures are considering increasing access to home births by granting licensure and Medicaid coverage of certified professional midwife (CPM) services. In this commentary, issues surrounding the expansion of CPM services including safety, standardization of care, patient satisfaction, racial and income equity, and an overburdened health care system are discussed. Lawmakers must account for these factors when considering proposals to expand CPM practice and payment during a pandemic.

KEYWORDS

birth location, certified professional midwife, COVID-19

The coronavirus disease 2019 (COVID-19) outbreak has changed hospital admission patterns for non-COVID-19 conditions. During spring 2020, American hospitals experienced upward of a 34% reduction in general admissions, and nearly half of Americans report postponing medical care during the pandemic.^{1,2} Similar trends have been noted in pregnancy care with increased interest in home births, which has been a lively topic for discussion throughout various news and social media outlets.³⁻⁸ Between 2019 and 2020, planned home births in the United States increased by 23.3%.⁹

Certified professional midwives (CPMs) participate in the majority of community births (planned home and birth center births), and the CPM is the only United States credential with required out-of-hospital childbirth experience.¹⁰ CPMs differ from certified nurse-midwives (CNMs) in that they are not required to hold a nursing license before midwifery training. CNMs are educated in university-based programs, accredited by the Accreditation Commission for Midwifery Education, and certified by the American Midwifery Certification Board (AMCB).¹⁰⁻¹³ CNMs have nationwide licensure

and prescription privileges with universal Medicaid and most private insurance coverage.^{10,14} Although CNMs may attend home births, the overwhelming majority attend only hospital births.¹⁰ CPMs are educated by means of an apprenticeship or a vocational education program, many of which are accredited by the Midwifery Education Accreditation Council (MEAC).¹⁵ CPMs are certified by the North American Registry of Midwives (NARM). CPMs are licensed or regulated in only 35 states, are without prescriptive authority in many states, and have mandated Medicaid coverage in only 14 states.¹⁰ Certified midwives (CMs) are another direct-entry midwifery credential, also certified by AMCB, and with similar scope of practice to CNMs in the states where they are licensed.^{10,14} CMs, however, are only recognized in 10 states and have more restrictive third-party reimbursement.^{3,16} Notably, AMCB and NARM are similarly accredited through the National Commission of Certifying Agencies, an independent agency that establishes standards for professional certification programs.¹⁰

Expanding CPM licensure and insurance coverage during ongoing surges of the COVID-19 pandemic may

increase opportunity for low-risk pregnant women to deliver at home. Doing so may have important impacts on access to pregnancy care during the pandemic, including easing the strain on the current health care system and providing access to CPM services to low-income families. Several state legislative bodies that currently do not regulate CPMs have recently introduced bills to provide temporary CPM licensure throughout the pandemic. A bill has been introduced in the Pennsylvania House of Representatives to offer temporary licensure to CPMs or out-of-state licensed CPMs, aiming to encourage insurance coverage for such practitioners.¹⁷ Similarly, the Licensed Certified Professional Midwife Practice Act was signed as Illinois law in December 2021, providing licensure to CPMs in the state.¹⁸ These bills would increase access to community-based birthing, particularly among low-income families, and reduce the burden on hospital systems during successive waves of the COVID-19 pandemic. They also prevent pursuit of criminal action against midwives who were otherwise practicing without state-recognized licenses.¹⁹ Other states have eased restrictions on midwifery care during the pandemic, including expediting licensure of midwife-led birthing centers and practice privileges for midwives licensed out of state.^{3,20,21} Notably, the Governor of New York, after large midwife-led advocacy efforts, issued an executive order to allow out-of-state licensed midwives to practice in New York.^{3,21}

The issue of providing CPM licensure and insurance coverage during the COVID-19 pandemic, however, is complex and requires important considerations before expanding midwifery services.

Maternal and neonatal safety must be weighed in increasing home birth access. Planned home births are associated with fewer maternal interventions, including labor induction and augmentation, operative vaginal delivery, and cesarean birth.^{22,23} Home births are also associated with fewer higher-order lacerations.²³ These outcomes are important for the many women who report reduced medicalization of birth as a reason for pursuit of home birth.³ Conversely, some United States investigators have suggested that delivery at home is associated with adverse neonatal outcomes, including low Apgar scores, neurologic dysfunction, and overall mortality.^{22,24,25} However, these poor associations with home births are largely mitigated by appropriate selection of low-risk pregnancies and maternity care system integration. Large prospective United States trials demonstrate that midwife-accompanied, low-risk planned home births are associated with maternal and neonatal morbidity and mortality similar to those of low-risk births at United States hospitals.^{26,27} This aligns with many international studies in countries with robust availability and integration of midwifery services in the maternity care system that report fewer maternal

interventions and similar perinatal outcomes in low-risk home births.^{23,28-31} Criteria for a low-risk home birth may include the absence of significant maternal or pregnancy-associated disease, the absence of fetal anomalies, a term, cephalic-presenting singleton fetus, no prior history of cesarean birth, and labor that is spontaneous.^{30,31} Home births with higher-risk pregnancies, however, are associated with a higher incidence of both maternal and neonatal morbidity.²⁶

Although planned CPM-accompanied home births are overall low-risk, CPM education is not uniform and students can earn certification through either an accredited institution or an apprenticeship with a demonstrated portfolio of experiences.^{10,11} The American College of Obstetricians and Gynecologists supports the provision of care from midwives certified by AMCB, or those whose education aligns with the International Confederation of Midwives (ICM) standards.³² MEAC-accredited programs and competencies required for NARM certification are in alignment with the ICM standards.³³ NARM also notably offers a Midwifery Bridge Certificate, a continuing education program specific to core competencies from the ICM.³⁴

Though home births cost less than hospital deliveries, approximately two-thirds of home deliveries are self-pay.^{9,26,35} An additional quarter of home births are covered by private insurance.²² Home births have long been cost-prohibitive for many women, especially if they live in a state without Medicaid or private insurance coverage of CPM services. Despite similarly expressed interest in home birth among black and white women, black women comprise less than three percent of home birth participants.^{26,27,36} Women who are Medicaid-eligible are also far more likely to report feeling safer delivering at home than women who are privately insured.³⁶ Cost of home birth may now be more poignant, especially as 1 in 6 Americans are unemployed during the COVID-19 pandemic.³⁷ Temporary state-mandated Medicaid coverage of CPM services may make home birth more accessible to low-income communities and women of color.

The psychosocial stress of a hospital delivery is another important consideration. Concerns over infectious exposure to visitors, patients, and health care workers have led to hospital policies restricting the number of visitors in labor and delivery and postpartum units. Laboring with reduced support may isolate or disempower the pregnant patient. These policies may also limit the partner involvement in the first days of the newborn's life. At-home delivery may also reduce concerns over poor quality of care from overburdened health care systems and nosocomial exposure to SARS-CoV-2.⁵ For instance, the transition of many prenatal appointments to a virtual format has promoted the impression that health care settings are a site of contagion.³ There are similar incentives for health care systems to consider

reducing the number of low-risk individuals in the hospital, including decreasing potential exposure of SARS-CoV-2 to patients and staff and shifting hospital resources to a growing number of COVID-19 patients.^{38,39}

This is of particular importance for women of color who are already at higher COVID-19-related and pregnancy-related morbidity.^{3,40,41} There have been similar calls to enhance collaboration between midwives and obstetric units during the pandemic, increasing low-risk births in community settings and improving intrapartum transfer practices when a hospital birth is recommended.⁴²

Regulating CPM involvement in home births during the COVID-19 pandemic is a topic of both harm reduction and health equity. For low-risk women opting for home delivery, providing provisional licensure to CPMs allows for involvement of a health care worker without worry of legal consequence. Regulation may also provide CPMs with increased resources and equipment and improved coordination of transfer to higher levels of care if necessary. Similarly, offering temporary Medicaid coverage may provide health care support for women opting for home births who were previously financially restricted from such services. Home births also allow both the patient and the newborn increased access to individualized support, while reducing strain on hospital systems burdened with COVID-19-specific needs and staffing shortages.

Since home births may have both maternal and neonatal safety concerns for women of certain risk profiles, expanding CPM licensure would enable more access to reliable guidance from credentialed midwives who are well prepared to properly counsel women toward a safe birth location. The absence of sufficient numbers of regulated professionals may otherwise make it difficult for women who have higher risk pregnancies to ascertain whether their pregnancy could benefit from institutional birth despite COVID-19 exposure concerns. Although the perceived risk of in-hospital SARS-COV-2 exposure may cause patient worry, the true risk of nosocomial versus community exposure also remains unknown.

As our knowledge of the pathophysiology of COVID-19 on maternal and neonatal health evolves, so must our health policy response. As states propose expanding CPM licensure and insurance coverage, several factors must be taken into consideration, including safety, cost, patient comfort, social justice, and the larger impact on health systems. During an ongoing pandemic in which hospitals are cyclically burdened with fluctuating numbers of COVID-19 patients, increasing home birth access through CPM licensure and public insurance coverage may be an appealing means of promoting a safe, comfortable, and equitable delivery for low-risk women. Expanding CPM services also contributes to the decriminalization of midwives, providing opportunity to enhance the safety

network for community births. Doing so may contribute to ongoing conversation about the integration of CPMs in the United States maternity system even beyond the COVID-19 pandemic.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ORCID

Jeremy Applebaum  <https://orcid.org/0000-0002-6732-7417>

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