April 2, 2020

Dear Governor Polis,

Colorado Organization for Latina Opportunity and Reproductive Rights and Elephant Circle are working together to ensure that pregnant and laboring people and their providers are included in pandemic orders, protocols, and planning, and to ask that directly-impacted people and community-engaged experts in physiologic and non-hospital birth be included in planning and communications. We invite you to join us.

Birthing people are not only at risk of contracting COVID 19 but are also at risk of experiencing harms caused by the secondary effects of the virus including the slow and inadequate response of the government resulting in hospitals being overwhelmed. Nationally, 23% of people discharged from U.S. hospitals are childbearing people and newborns. Not only is childbirth a major component of hospital services that cannot be delayed during a pandemic, but prenatal and postpartum care also require ongoing clinical attention.

About 65,000 people are born in Colorado every year, 97% in hospitals, 1.6% at home, and about 1% in birth centers.[1] Colorado's rate of community birth is 2.6% and recent Elephant Circle Colorado survey data demonstrate this could increase by at least 25% just using existing infrastructure. The adoption of several of the changes described below could increase the capacity for community birth in Colorado by 50%.

Physicians deliver the vast majority of babies in hospitals (90%), Certified Nurse Midwives attend 8.7%, in Colorado the majority of home births are attended by Certified Professional Midwives (CPMs, also called Direct-Entry Midwives, DEMs, in Colorado), and due to staffing rules, the majority of birth center births are attended by CNMs. Certified Nurse Midwives and Certified Professional Midwives are independent providers in Colorado and both credentials meet the International Confederation of Midwives standards.

Depending on the trajectory of the virus in Colorado, hospital beds and providers could become overwhelmed in the coming weeks making it necessary to divert and adapt provision of care. We urge you to think outside the current system to both defend against transmission of disease and protect those receiving antepartum, intrapartum and postpartum care. Midwives, especially

[1] MacDorman MF, Declercq E. Trends and state variations in out-of-hospital births in the United States, 2004-2017. Birth. 2019;46(2):279–288. doi:10.1111/birt.12411

those who practice in home and birth centers have not historically been included in emergency planning, and that needs to change to best protect pregnant and birthing people.[2]

Colorado's response to COVID 19 should include the following hospital policies, provisions for access to hospital alternatives, and insurance requirements. We also recommend that these variables that pregnant people face be carefully considered in hospital policies, access to hospital alternatives, and insurance provisions (see attached).

Hospital policies

- Require hospitals to accommodate laboring people having at least one support person with them during hospital care; supporters can be required to help mitigate risks of transmission through restrictions based on testing, symptoms, age and other risk factors.
  - Include doulas as essential health care workers in addition to support people and factor in protective equipment for these providers.
  - Prohibit restrictions on use of technology in the hospital to accommodate virtual doula support.
- Prohibit policies that separate babies from parents at birth, except as a last resort when the infant needs care in the NICU.
- Require that the informed consent and refusal processes be honored even in extraordinary conditions; prohibit pressure to consent to interventions, require information be provided about alternatives (including alternatives to hospital care), ensure access to requested/needed interventions (including epidural anesthesia), distinguish between provider risk-priorities and family risk-priorities.
- Anticipate and plan for the lack of continuity of care, sudden changes to plans and policies, shifting of care providers or locations impact on families, and make plans for communications and notifications that ensure families have as much timely information as possible.
  - Factor in that families do not have equal access to the internet.
  - Provide information about accountability, including information about how to make complaints and what the process is for handling complaints.
  - If executive orders are made that protect hospitals and providers more than usual from liability for harm, make sure that information is shared with all patients, especially pregnant patients, in advance of their arriving in labor.

[2] States like Washington are leading the way and we can take their lead to create a more robust and responsive emergency response that values pregnant and birthing people (more information is coming soon).

Access to hospital alternatives:

- Preserve hospital personnel and beds for pandemic response by encouraging hospitals and hospital-based providers to refer low-risk patients to **all** midwives for antepartum, intrapartum and postpartum care.[3]
- Include **all** midwives in emergency health care workforce planning.
    - Executive Orders modifying or waiving licensing requirements and scope of practice limitations should include **all** Colorado midwives (CNMs and Registered Midwives, also known as CPMs along with CNMs), student midwives and birth centers.
    - Create a way for previously licensed midwives to become active whether through expedited renewals or waivers.
    - Waive licensing requirements for student midwives who want to assist during the pandemic.
    - Waive licensing requirements for midwives licensed in other states or countries (as New York state has done).
    - Include **all** midwives as essential workers, ensure they are excepted from stay-at-home orders and have the ability to travel and access to emergency equipment, including but not limited to personal protective equipment.
    - Fast track the ability of CPMs to run and staff birth centers.
    - Expedite birth center licensing and renewals.
- Waive facility requirements for expedited birth center licenses and renewals.
- Establish requirements and protocols for hospitals to accept transfers from homes to medical facilities during the pandemic and require best-practices for interprofessional collaboration.[4]

Insurance:

- Require insurance companies to accommodate needed changes in providers and facilities as a result of the pandemic.
    - People may need out-of-network care, or people may want to switch from a hospital-based provider to a home birth midwife or birth center.
- Require insurance companies to pay equitable rates to all providers of maternity care services, including site-neutral payments.
- Include Colorado Registered Midwives (also known as CPMs) as Medicaid and CHIP providers and reimburse them at equitable rates.
- Require insurance companies to adjust billing codes to fit changing circumstances (telemedicine versus an office visit, or antepartum care versus intrapartum).
- Include **all** midwives in exceptions to liability.

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[3] Unfortunately, we have to emphasize *all* because existing leadership locally and nationally consistently fails to acknowledge the existence of the Certified Professional Midwife.

[4] See, The Birth Place Lab, Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers. Available at: https://www.birthplacelab.org/best-practice-guidelines-for-transfer-and-collaboration and The Birth Place Lab, Best Practice Guidelines: Transfer from Planned Home Birth to Hospital. Available at: https://www.birthplacelab.org/best-practice-guidelines-for-transfer-and-collaboration/

- Prohibit malpractice policies that constrain responsiveness to the crisis, like policies that prohibit collaboration between providers or exclude certain "procedures" (like VBAC).

These recommendations have been created in consultation with pregnant consumers, community birth providers (including CNMs and CPMs), community doulas, reproductive justice and birth justice organizations, and non-profit organizations serving families with small children. Please don't hesitate to reach out to us for more information.

Sincerely,

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- Health outcome disparities based on bias may worsen during a crisis; implicit biases may become explicit (*e.g.* existing provider distaste for high-BMI pregnant people may evolve into an institutional policy to deny such patients ventilator access, based on a biased understanding of risk), institutional processes established to mitigate implicit bias may be considered non-essential and abandoned, and stress placed on providers by the stress of the emergency can amplify any existing bias in their treatment of patients.
- Child protective service agencies often judge families for their risk-benefit calculations. Risk analysis becomes all the more intense and morally charged during a pandemic. The involvement of CPS in a pregnant person's care, particularly when using a punitive approach to patients' non-hospital birth, refusal of medical recommendations, choice to bedshare, or substance use during pregnancy, may affect outcomes for pregnant people, who are already vulnerable to judgment, and their newborns.
- Pregnancies may be affected by other stressors, including a lack of accommodations for pregnant workers (especially health care workers), xenophobia based on misperception of immigrants as primary viral carriers, loss of employment/income, and lack of access to shelter, food or other essentials.
- Pregnant people who receive medication-assisted treatment (typically methadone or buprenorphine) often need in-person, daily access to clinics, a challenge during a pandemic. The federal government is allowing states to apply for exceptions to the usual limit of take-home doses, but states and providers must first be aware of this opportunity and then take action to implement these new exceptions.
- Incarcerated pregnant people already experience limited access to information, options, and care; these shortcomings are likely to be intensified during a pandemic both in their correctional facility and in any clinic- or hospital-based care.
- Undocumented pregnant people already experience both structural and individual exclusions from programs and health system responses and a pandemic may magnify this exclusion,causing even more extreme consequences, especially for people detained in immigration facilities where exposure to the virus and other secondary harms are higher.
- Pregnant people in general are at heightened risk of domestic violence. The isolation that accompanies social distancing and sheltering in place may increase the risk of harm from domestic violence even more.
- LGBTQ people in general face increased economic risks and lack of access to health care; pregnant people who are LGBTQ may be uniquely impacted because LGBTQ-specific-responses may not include or consider pregnant people.