

Improving Patient and Provider Experiences to Advance Maternal Health Equity

Strategies to Address Inequity During the COVID-19 Pandemic and Beyond

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Alarming high and climbing rates of maternal mortality and severe maternal morbidity, especially among Black and indigenous women, have drawn attention to disparities in patient experiences with maternal health care in recent years. Affecting all aspects of maternal care, the COVID-19 pandemic has amplified these concerns, revealing as well as exacerbating inequities in mothers' experiences.

Part of a larger [series](#) on maternal health equity, this report draws on literature reviews and interviews with maternal care stakeholders (Box 1) to explore how the pandemic is contributing to inequitable patient and provider experiences with maternal health care during the prenatal, delivery, and postpartum periods. We also explore the following promising strategies providers, states, advocates, and communities could consider both during and after the pandemic to improve maternal outcomes and reduce inequities:

- › Enabling expanded access to remote care, such as through expanded insurance coverage of virtual health monitoring equipment, smartphones, and internet access, so pregnant and postpartum women can receive care safely at home.
- › Ensuring women have the support they need during birth, such as through expanded visitor policies at birthing locations.
- › Valuing the mother-infant relationship while incorporating culturally appropriate, patient-centered care strategies in which mothers are fully involved in decisions made around their care and the care of their infants (e.g., not automatically separating COVID-19-positive mothers from their newborns).
- › Linking pregnant and postpartum women to community-based organizations and social service providers to reduce pandemic-related material hardship, which is disproportionately affecting families of color.
- › Directly addressing racial and ethnic inequities, such as through provider education, implicit bias training, and accounting for disparities when measuring quality of care.
- › Meeting providers' needs for adequate personal protective equipment and virus testing capacity, staffing, and support, as well as expanding workforce capacity to integrate and reimburse nonphysician providers, such as doulas, midwives, lactation consultants, and nurse practitioners.

Inequities Before the Pandemic: Implications of Structural Racism for Access to and Quality of Care

Before the COVID-19 pandemic, U.S. maternal morbidity and mortality was markedly higher than in other wealthy countries, and worsening. In the United States, about 700 women¹ die from pregnancy-related causes each year during pregnancy or birth or within a year after—a rate that has nearly doubled in recent decades—and many more experience severe maternal morbidity.^{2–6} Inequities persist in maternal outcomes, too; nationally, Black and American Indian/Alaska Native women are two to three times more likely to die from pregnancy-related complications and are more likely to experience severe maternal complications compared with non-Hispanic white women, with even larger disparities in some states.^{6–9}

Systemic inequality affects both access to care and health care experiences among women of color, as manifest in their relatively low health insurance coverage rates, access to transportation, and geographic availability of care, as well as their socioeconomic disadvantages, higher rates of underlying chronic conditions, greater exposure to environmental hazards and violence, and greater likelihood of facing biased treatment when receiving care.^{5,9–16} Many Black women, for instance, report

not being encouraged to make their own decisions about childbirth or not being believed when they report complications or pain.^{5,15,17} Though the drivers of racial and ethnic inequities in maternal care are numerous, providers' cultural competence, communication abilities, and implicit bias can affect the patient-clinician relationship and contribute to variation in health outcomes.¹¹ Other disparities, such as those related to socioeconomic status, immigration status, disability, sexual orientation, and geographic location (e.g., residency in rural or underserved areas), can contribute to inequitable patient experiences, especially for patients facing multiple disparities.¹⁵

Maternal health inequities have gained attention in recent years, leading policymakers to establish maternal mortality review committees and propose legislation to address disparities, including increasing implicit bias training to improve the dignity and respect with which women are treated.^{18–20} But, disparities in patient experiences persist and have implications for quality of care.⁹ For instance, stakeholders we interviewed described the adverse consequences of underserved patients seeing different providers each time they access care, which can be especially harmful for women with risk factors for pregnancy complications or those with mental health challenges, who may particularly need to develop trust and rapport with providers.

BOX 1. RESEARCH METHODS

In spring and summer 2020, we conducted individual and small-group interviews with 40 maternal health experts, perinatal care providers, consumer advocates, philanthropic funders, and frontline health workers serving pregnant women to identify and examine key concerns about maternal health equity and challenges raised by the pandemic. We also conducted, and periodically updated, a comprehensive scan of publicly available information on maternal health equity during the pandemic from national policy and research organizations, professional and provider trade organizations, and leading maternal and infant health advocacy groups. Our findings primarily reflect insights into and responses to the pandemic that emerged between March and September 2020.

Because of social distancing requirements and the urgency of this topic during the pandemic, this analysis has some limitations. We could not interview mothers directly, and though we interviewed provider and advocate stakeholders, we recognize they do not represent mothers' viewpoints. In addition, our interviewees were predominantly on the East Coast, but we acknowledge community needs and realities differ by location and understand the importance of authentic community voice, partnership, and engagement as solutions are developed, implemented, and evaluated.

We center this work, part of the Urban Institute's larger Transforming Health and Health Care Systems project, around the Center for Social Inclusion's definition of racial equity:* when "people, including people of color, are owners, planners, and decisionmakers in the systems that govern their lives" and society "[acknowledges and accounts for] past and current inequities and provides all people, particularly those most impacted by racial inequities, the infrastructure needed to thrive."

* What is racial equity? Center for Social Inclusion website. <https://www.centerforsocialinclusion.org/our-work/what-is-racial-equity/>. Accessed October 19, 2020.

Inequities Exacerbated by the Pandemic: Separation Worsening Patient Experiences

The pandemic has revealed existing inequities even more starkly while likely exacerbating them. Recent evidence suggests pregnant women who contract the virus might be at greater risk for severe illness than nonpregnant women.²¹ Moreover, emerging research on variation in virus exposure and incidence indicates health risks may be higher for pregnant women of color than other pregnant women.²² Effects of the pandemic and resulting economic crisis, however, extend beyond medical concerns, increasing stress, anxiety, and financial insecurity while reducing community and family support that can affect all mothers, especially those already at risk of problematic experiences and poor outcomes.^{23–25} The available evidence indicates the pandemic is worsening inequities in several ways:

› New health and economic problems are adding to burdens for mothers already at higher risk for maternal complications.

Existing disparities across racial and ethnic groups affect disease risk. People of color are more likely to have jobs with higher virus exposure (e.g., as essential workers, who must be present at work or lack paid-leave access) and to have underlying health conditions that can cause complications among those who contract COVID-19.^{14,26,27} And these same communities are also experiencing larger economic fallout: Black and Hispanic adults are more likely than white adults to report that the pandemic has affected their families' finances.^{28,29} These pandemic-related shifts are therefore disproportionately adding to the burdens for already marginalized and/or underserved women, contributing to the psychosocial, financial, and medical difficulties they are experiencing.²³ In May 2020, about half of Black and Hispanic adults in families who lost work or income during the pandemic reported unmet needs for medical care due to concerns about costs or coronavirus exposure.³⁰

› Social distancing requirements mean mothers are increasingly separated from providers, infants, partners, advocates, support people, and other mothers during prenatal, delivery, and postpartum periods—with disproportionate effects on women of color.

The pandemic has necessitated converting many patient-provider interactions to telehealth. And though the shift to remote connection with providers can be positive for some patients, the physical separation from providers and support givers has been detrimental for others, according to stakeholders. Moreover, separation can disproportionately harm some mothers and/or add to existing barriers some mothers face, such as those who lack reliable internet service or access to necessary technology, have limited English

proficiency, are immigrants, are experiencing homelessness, or are already experiencing postpartum depression or other mental health challenges. Though most adults overall report owning smartphones, and rates are similar across racial and ethnic groups, gaps in broadband internet access at home and other disparities across groups remain (e.g., lower rates of smartphone access among Hispanic adults born outside the United States).³¹ Moreover, unable to conduct face-to-face exams in a private setting, providers are reportedly struggling to build trust with patients and ensure they have a safe space to share their concerns—especially those related to other areas of their lives, like intimate partner violence. Adapting to pandemic routines can also mean missed opportunities to educate patients; to protect women from the virus and keep hospital capacity stable, hospital discharge after delivery may be earlier than usual and rushed, reducing access to postpartum recovery and infant care education, or may be too focused on health, especially for COVID-19-positive patients, with less attention to psychosocial needs.^{25,32}

In response to the pandemic, some hospitals have begun separating some mothers who have COVID-19 or related symptoms from their infants.³³ Given that research has documented the importance of skin-to-skin contact after birth, which affects bonding and breastfeeding in the longer term,³⁴ such policies undermine mothers' and infants' health. They also exacerbate existing disparities. For example, policies that penalize mothers with substance use disorder disproportionately affect mothers of color.³⁵ And if separation policies vary by hospitals' COVID-19 testing infrastructures, existing disparities in maternal risks across hospitals could widen.^{9,36}

Given the importance of continuous support during labor,³⁷ visitor restrictions that exclude labor support people, partners, and advocates (e.g., restrictions to just one visitor or only allowing partners to be present if they sign a release form) could especially worsen outcomes for Black mothers. Because Black mothers are already more likely to experience discrimination or report feeling mistreated, having supportive advocates during labor and delivery is critical.^{5,15,17,38} Providers we interviewed also expressed concerns about the effects of visitor restrictions on women who are immigrants or do not speak English, who may be more likely to rely on family support both during birth and postpartum.

› Providers have inadequate resources, affecting their experiences and their abilities to provide care.

Providers reported that budget and personnel shifts to cover needs for patients with COVID-19 can reduce maternity care resources. Inadequate supplies—personal protective equipment, testing for in-person staff, and telehealth equipment and child care for staff working from home—

both reduce providers' productivity and morale and increase infection risks for patients, providers, and providers' families and other contacts.^{5,32} Providers' stress and trauma have increased during this period, and these challenges may be even greater for Black practitioners.^{24,32,39}

Stakeholders also indicated that staffing problems during the pandemic have also laid bare existing provider shortages. Some providers described not feeling safe providing care under current conditions without adequate staffing. And though some workforce challenges can be solved more easily now because of relaxed rules regarding nonphysician providers or licensing,^{40,41} challenges could grow if these rules are rescinded when the crisis ends. And without federal financial aid, the viability of maternity care practices may also be threatened.⁴²

Emerging Solutions to Address Inequities: Fostering Connections

Our research identified several strategies that providers, states, advocates, and communities could consider to help reduce inequities in maternal care patients' and providers' experiences. No one strategy can fully address existing inequities, but with forethought and coordination, the following could support meaningful improvement:

➤ **Health systems, payers, and providers could work together to ensure mothers remain connected to their care providers and other supports during and after the crisis, relieving pressures both related to and predating the public health emergency.**

As patient-provider interactions are increasingly conducted virtually, patients could be better connected to providers. Pregnant and postpartum women may need to conduct some health monitoring at home, which would require ensuring that insurance coverage pays for the necessary equipment and related services, patients know how to use them, and internet access is widely available. Our research identified some initiatives to maintain connection, including virtual tools like the Babyscripts app, which links home monitoring with providers, the Shades of Blue Project,⁴³ which provides online mental health support to mothers of color, and Penn Medicine's Healing at Home program, which offers support after hospital discharge.⁴⁴ Interviewees also suggested ways communities can help, such as through providing adequate internet access in underserved areas. Combining at-home monitoring with patient education and provider engagement can improve care, especially for women who may already be underserved in maternal health

care settings or face access challenges, such as those living in rural areas. Developing robust systems for remote care could have positive implications for health care access even after the pandemic.

Hospitals and other birthing locations could also expand visitor policies to allow partners, doulas, and other people who support women to be present during labor. Executive orders in states such as Michigan, New York, and Oregon have deemed support people essential for laboring mothers,⁴¹ and a recent New Jersey law, S. 2394, requires hospitals to permit a pregnant woman at least one support person during childbirth. The American College of Obstetricians and Gynecologists recognizes such policies can specifically benefit communities who historically face more mistreatment when receiving care:⁴⁵ "Labor, delivery, and postpartum support may be especially important to improve outcomes for individuals from communities traditionally underserved or mistreated or harmed within the health care system. In considering visitation policies, institutions should be mindful of how restrictions might differentially and negatively affect these communities, which in many areas are also disproportionately affected by COVID-19."

Connecting mothers with their social networks or with other mothers facing similar challenges could also improve their experiences before, during, and after delivery. Financing devices for virtual social connectedness could help support mothers during delivery if support people cannot be physically present, and virtual prenatal or postpartum groups could not only help with treatment but reduce isolation caused by social distancing.⁵ Models for patient care, such as CenteringPregnancy, can improve patient experiences, address isolation, and reduce disparities,^{46,47} but only nine state Medicaid programs covered group prenatal care programs in 2019.⁴⁸ For programs that can be conducted virtually during the pandemic, including such benefits in Medicaid could improve patients' access and experiences.

The Centers for Disease Control and Prevention has also provided new guidance discouraging automatic separation of mothers with COVID-19 from their infants, calling for a mutual decision between the family and providers that considers the mother's and infant's clinical condition, breastfeeding plans, facility capacity, and plans for infection control.^{24,49} Hospitals and other birth settings could adopt this new guidance to help preserve patient autonomy and foster bonding and attachment at birth.

► **Hospitals, health systems, and managed-care organizations could cultivate improved patient-provider relationships by meeting providers' needs and promoting practices that prioritize respectful care of and shared decisionmaking with patients.**

Giving both patients and provider staff the tools they need to make informed decisions together, including sound scientific advice, is more important now than ever. And improving patient-provider communication, such as through shared decisionmaking, helps center the patient and reduce inequities.¹¹ A toolkit by Black Mamas Matter Alliance, a national organization promoting Black mothers' health, rights, and justice, suggests additional ways for clinicians to enhance communication and education: "Tools like patient decision aids, patient-centered birthing plans, clinical conversation guides, and the participation of doulas or patient advocates may help. Providers may also need additional training to meaningfully obtain consent, especially where power differences between a woman and her provider are substantial."⁵⁰

Moreover, interviewees reported the need to give provider staff what they need to work safely, such as a sufficient supply of protective gear. Supporting clinicians through adequate staffing and stress-management support would improve their abilities to care for patients and maintain their own health and well-being under challenging and changing conditions.³²

► **Policymakers, health systems, foundations, and communities could improve connections to supportive services provided by community-based organizations and social service providers to reduce the stresses and material hardship many pregnant and postpartum mothers experience.**

With large socioeconomic disparities in social determinants of health (e.g., neighborhood safety and access to housing, food, and transportation), screening mothers for social needs and connecting them with local social service providers could reduce material hardship and ameliorate economic inequities—especially as needs grow from the pandemic and associated recession.^{15,51,52} Stakeholders we interviewed recommended strategies to reach mothers and inform them about available resources, such as using social media to inform families of events where needed items (e.g., diapers) are distributed, during which families could learn about other available resources. And such events can not only address material needs but unique social needs arising from isolation, too.

Providers and other stakeholders reported that they have expanded their efforts to learn more about social service resources in their communities because of the pandemic, which will also serve their patients after the crisis. They also reported that diverse institutions, including public, academic, and nonprofit organizations, have been working together more closely. But to serve their communities, social service providers require adequate staffing and funding, attention to staff safety, and virtual accessibility.

Policymakers, health systems, and providers could work to develop stronger, more formal connections between health and community-based social service systems to better address social determinants of health and reduce the stresses pregnant and postpartum women face. Legislation may be needed to advance such goals: a coalition of health care professionals and patient advocates recently recommended that Congress consider promoting increased access to nonclinical supports, such as peer supporters, lactation consultants, and social workers, especially among women of color and those with public insurance coverage.⁵³

► **Governments, health systems, and hospitals could require implicit bias and other training and commit to a "culture of equity."**

Our interviews and literature review revealed multiple steps providers, governments, and payers could take to directly address racial and ethnic inequities in patient experiences with maternal health care and thereby promote a culture of equity. Sources suggested health systems could promote and implement implicit bias training to educate providers about disparities, which payers could reimburse as an administrative cost; build stronger public-private partnerships; use quality-of-care measures that account for disparities; and promote clear, straightforward messages about the role of structural racism in patients' experiences and the importance of a culture of equity.^{9,11,14,15,26,52}

Some state and local governments have increased efforts to address racial disparities and target resources to groups most at risk during the pandemic: The governor of Michigan established the Michigan Coronavirus Task Force on Racial Disparities and expanded implicit bias training in the state's medical schools.^{54,55} And San Francisco's Abundant Birth Project pilot is a public-private partnership aiming to reduce preterm births among Black and Pacific Islander communities through direct payments to mothers during the prenatal and postpartum periods.⁵⁶ Stakeholders also reported greater awareness and attention to inequities among those working in maternal health care, with some reporting acting to directly address racial inequities for the first time.

► **Payers, such as state Medicaid programs, could increase workforce capacity to integrate and reimburse nonphysician providers, including doulas, midwives, lactation consultants, and nurse practitioners.**

Expanding workforce capacity to include more nonphysician providers could expand access to care, especially in light of budget cuts and staff reductions during the crisis. This could also potentially increase workforce diversity, which could help build patient-provider trust. For instance, some Black midwifery practices report growing interest from Black patients during the pandemic.⁵⁷ Such patient-centered provider options can increase support for women, improve their birth experiences and outcomes overall, and help reduce inequity.⁵⁸

To address maternity care provider shortages and maximize positive outcomes for mothers,³⁸ more states could follow the lead of states such as Maine, New Jersey, New York, Pennsylvania, Tennessee, and Texas, which have tried to address maternity care shortages through midwifery expansions.⁴¹ As of 2019, only six states covered doulas in Medicaid,⁴⁸ but additional states are expanding such coverage during the pandemic,⁵⁴ which could increase doula access among low-income women. States could also choose to maintain expanded coverage of nonphysician providers after the pandemic, which would give patients more autonomy and choice to select the caregivers and settings most appropriate for them. Hospitals could also consider employing staff doulas to increase access to labor support.³²

However, expanding workforce capacity also presents new challenges regarding integration of care across providers; as one key informant explained, challenges transferring care plans and medical records between hospital and nonhospital systems have exposed weaknesses in care coordination, despite collegial relationships between various groups of providers. Policymakers could also take several steps to improve access to out-of-hospital births for low-risk deliveries, which could both reduce virus risks for women and their infants and lessen burdens on hospital systems.⁵⁹

Moving Forward

Existing inequities in maternal care experiences have been highlighted and likely exacerbated during the COVID-19 pandemic, disproportionately harming women already at risk of worse maternal outcomes. Because most maternal deaths are considered preventable,⁶ efforts to improve patient

experiences could increase quality of care, improve outcomes, and reduce inequities. Stakeholders we spoke with identified several emerging solutions that could be implemented now by governments, health systems, providers, and payers: fostering better connections with providers and support people throughout pregnancy, during labor, and after delivery; incorporating shared decisionmaking opportunities; and connecting mothers with social service resources in their communities. Other more long-term priorities include improving provider education and diversifying the perinatal workforce. At a minimum, more work is needed to establish the specific practice, policy, or administrative steps necessary to sustainably support any of the proposed strategies. Moreover, given that staffing, funding, and implementing needed changes will add to states' already strained budgets, improving maternal health equity will require sustained commitment from policymakers and other stakeholders.

Medicaid, in particular, could play a significant role in addressing inequities and improving outcomes for mothers and infants, because it pays for nearly half of all U.S. births, including more than 6 in 10 births among Black mothers.^{60,61} State Medicaid coverage of joint mother-baby models of prenatal and postpartum care or doula services could help mitigate disparities by providing care that is patient centered, supportive, and culturally appropriate.^{61,62} But, federal action could also be critical. For instance, pregnancy-related Medicaid coverage, which typically expires 60 days after delivery, has been temporarily extended through the public health emergency period under the Families First Coronavirus Response Act, but this extension will end when the emergency period expires. Thus, adoption of a 12-month postpartum Medicaid extension, already under consideration by Congress (and in several states), could close coverage gaps among new mothers, especially because Black and Hispanic new mothers are more likely to be uninsured than white new mothers.^{13,63} Adoption of other federal legislation, such as the Black Maternal Health Momnibus Act of 2020 (H.R. 6142) and the Maternal Health Quality Improvement Act of 2019 (H.R. 4995), could help reduce disparities and improve outcomes.^{53,64}

Healthy People, part of the U.S. Department of Health and Human Services, defines health equity as the "attainment of the highest level of health for all people" and asserts that achieving it "requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."⁶⁵ Though health equity in maternal care has not been reached in 2020, the pandemic has highlighted the need to ensure all mothers and infants can thrive.

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