Office of the
Bronx Borough President
Vanessa L. Gibson

# Delivering Change

## Establishing a Birthing Center in The Bronx

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Dear Neighbors,

When I was sworn in as your borough president three years ago, I pledged to tackle the health challenges plaguing The Bronx. We are facing numerous health issues, from the lingering effects of the COVID-19 pandemic to chronic illnesses like diabetes and other ailments stemming from environmental injustices. One of these issues is ensuring birth equity and ensuring that women are able to receive culturally competent maternal healthcare in an environment of their choosing. We are experiencing a maternal mortality and morbidity crisis that is a result of several factors, including women of color's access to care.

Women's voices must be centered in conversations around birthing care and patients must be given more autonomy over their bodies. Achieving true birth equity in The Bronx will involve embracing a holistic approach to maternal care that focuses on patients' mental, emotional, and physical well-being and that their voices, especially those from marginalized communities, are heard and respected.

This will include expanding the involvement of midwives, doulas, and other birthing professionals whose roles have not been fully incorporated into the birthing care continuum in our borough. One way that we can achieve these goals for pregnant women in The Bronx is through the creation of a birthing center. There are only two birthing centers in New York City, both in Brooklyn, and there has not been a birthing center in The Bronx in over a decade. Establishing a new birthing center will provide women with resources to have more preparation, education, and control over their pregnancies, their labor, and their bodies. Women who utilize the supportive services of a birthing center before, during, and after a delivery have better health outcomes, have more control of their birthing process, and are able to give birth in a more supportive and patient-centered environment.

I stand with the robust and growing community of birth workers, advocates, and activists in our borough in their push for decreasing the high rates of maternal mortality and morbidity we are seeing in our communities. Together we can achieve greater birthing options for all Bronxites.

I am proud to release the following report, which details the current state of birthing care in The Bronx, explores the feasibility of opening a new birthing center, and describes our path forward. I am strongly committed to supporting efforts to establish a birthing center in The Bronx, and I hope that you will join me in making this a reality.

Sincerely,

Vanessa L. Gibson

Bronx Borough President

# EXECUTIVE SUMMARY

Amidst soaring maternal mortality rates nationwide, the county with one of the highest rates of pregnancy-related deaths in New York State finds itself at the intersection of health inequities and historical disinvestments. According to the New York City Department of Health and Mental Hygiene (DOHMH), from 2001 to 2019, Black women had a pregnancy-related mortality ratio nearly **9.2 times** that of White women, a stark contrast that highlights the need for equitable access to maternal healthcare and a call to action.

In recent years, New York City and New York State have spearheaded numerous efforts to increase access to maternal health services in underserved communities. While these initiatives promise to improve outcomes, it may still be difficult for expectant mothers to navigate and access separate entities. There is an unmet need for a hub with comprehensive, coordinated, and culturally competent maternal health services and social support in The Bronx. A birthing center would address this gap in interconnected services.

Birthing centers provide health services before, during, and after birth through a midwifery and wellness model. Birthing individuals can determine their preferences for delivering their babies and can receive patient-centered guidance from healthcare professionals to create an individualized birthing plan. As the concept of birthing outside of a hospital has gained favor over the past decade, the number of birthing centers has increased across the United States. In New York, however, the number of birthing centers has declined to just three statewide, with only two in New York City. The Bronx's only birthing center, the Childbearing Center of Morris Heights, opened its doors in 1988 and closed them in 2012. Restoring a birthing center like the Morris Heights Childbearing Center to The Bronx would provide a welcoming place for multidisciplinary, equitable, culturally competent, and affordable birth care.

Bronx Borough President Vanessa L. Gibson is committed to advocating for the establishment of a birthing center in The Bronx to serve as a community resource and a health hub. The birthing center would follow a midwifery model and exist in a dedicated space, separate from a hospital but near or within a medical facility. An independent facility would welcome families into an environment that is fully immersive and oriented to supporting the physical, psychological, cultural, and social needs of pregnant women, as well as offering screening, education, coaching, and all labor-related services.

Labor and delivery services could be provided for low-risk pregnancies, and referrals to the adjacent hospital could be made for other levels of care or in case of complications. Additionally, women with high-risk pregnancies and other maternal challenges can also benefit from a birthing center through a host of prenatal, postpartum, and educational services that could be used by women with any level of pregnancy risk. These services are critical to managing both high- and low-risk pregnancies. Such diversification of services provides essential preventative care that can decrease the number of high-risk pregnancies and complications at birth across the borough.

Establishing a birthing center in New York State is a complex and rigorous process. Our research shows that one of the biggest challenge is the Certificate of Need (CON) application, which is approved by the New York State Department of Health. Freestanding birthing centers are typically small, community-based practices that serve low- and middle-income families and operate on thin margins and low capital. This makes it challenging for birthing centers to meet the financial requirement needed to obtain a CON which is, for the most part, only within reach for large health centers and hospitals with significant capital and institutional resources. The CON process and funding requirements thus pose barriers to highly qualified clinical providers who cannot meet the financial requirement needed for entry-level investment. For small midwife- and physician-led practices, this makes opening birthing centers in vulnerable neighborhoods like The Bronx unfeasible. Maintaining existing birthing centers in New York State is no easier. Despite their great value to expectant mothers, New York City's birthing centers struggle tremendously due to delayed and low insurance reimbursement rates for their services and insufficient staffing. These challenges forced the only birthing center in The Bronx to shut its doors in 2012.

**In this report, "mothers," "expectant mothers," and "birthing individuals" will be used to refer to all individuals with the ability to give birth.**

To support a public birthing center, Borough President Gibson recommends that the City of New York and the State of New York increase public funding to support midwife-driven birthing care, mandate suitable insurance reimbursement rates, make the CON process more streamlined and equitable, and integrate interest-free loans for those working towards establishing a birthing center.

New York City has vast resources, committed providers, and high-quality services available to support maternal health. What is lacking is the cohesive infrastructure needed to leverage these strengths to meet the complex health needs of underserved communities. A birthing center located in The Bronx could be the beginning of a strategic transformation of maternal care in New York City. While a birthing center will not singlehandedly solve the racial and systemic issues contributing to poor maternal and infant health outcomes, its establishment will be a foundational and tangible step towards providing expectant mothers in The Bronx with safe, respectful, and culturally competent care.

## CONTRIBUTORS

**The data, expertise, and policy recommendations put forth in this report are the culmination of rigorous fact-finding efforts and data collection, supported by invaluable contributions and cooperation from experts and stakeholders across New York City and State.**

Bronx Borough President Gibson would like to thank the New York City Department of Health and Mental Hygiene Neighborhood Health Action Centers, the Doula Consortium of The Bronx, The Bronx Health Link, the Bronx Maternal Health Consortium, Dr. Jennifer Dohrn, Trinisha Williams, Rosie Hernandez, Myla Flores, and Dr. Norma Veridiano for contributing their time, insight, and expertise. The information and testimonies provided by these individuals have been combined with public reports, studies, news articles, and surveys cited throughout this report. Some direct quotes have been slightly edited for clarity, and all edits were approved by the interview subjects.

# INTRODUCTION

In the past decade, demand for out-of-hospital births has risen across the United States. According to the American Association of Birthing Centers, there has been an **82%** increase in the number of free-standing birthing centers across the United States since 2010.[1] However, in stark contrast to the national trend, New York State has seen a net loss of birthing centers over the same time period.[2] The State of New York only has three birthing centers, two in New York City and one in Buffalo. This is considerably lower than peer states. California has over **70** birthing centers, while Texas has nearly **40**.

To address the ongoing maternal healthcare crisis at the borough level, including lack of care options and an elevated rate of maternal mortality, former Bronx Borough President Ruben Diaz Jr. assembled a task force of policy experts and healthcare leaders in 2020 to discuss challenges and propose solutions. The Bronx Black Maternal Mortality Task Force ultimately published the Black Maternal Mortality Task Force Report in March 2021.[3]

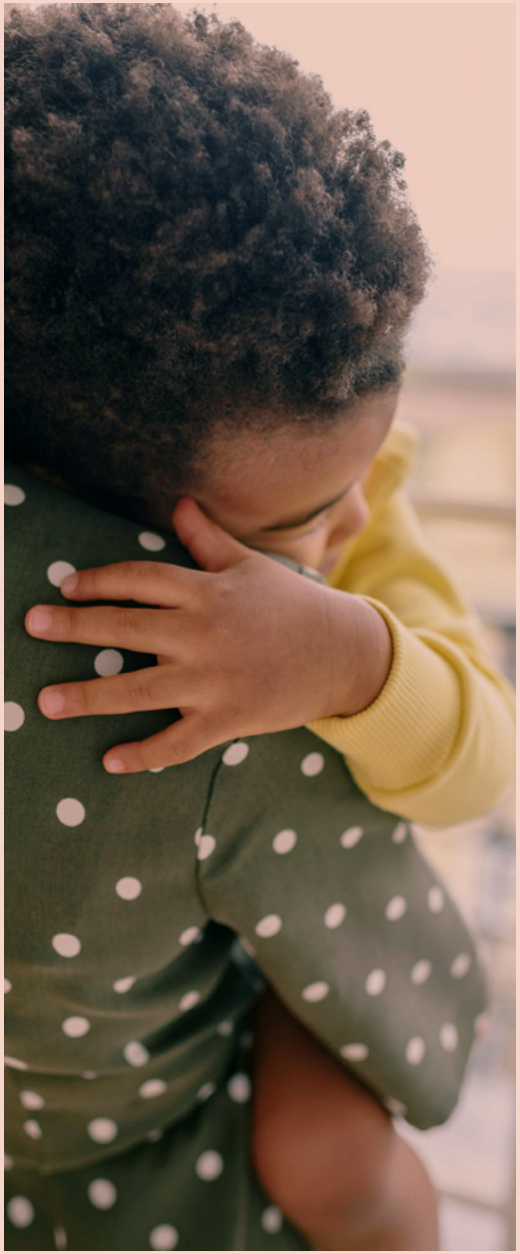
This report articulated the status of maternal health in The Bronx, as well as policy proposals and action steps for improving maternal health, including a recommendation to establish a birthing center in The Bronx. The report also proposed the creation of a long-term Bronx Maternal Health Consortium, which was launched in 2022 by Borough President Gibson.

Ongoing efforts by the Consortium include targeting racial bias in maternal healthcare services, increasing access to health coverage and care services, expanding doula access, addressing communication barriers within and between hospitals, establishing a Bronx-based Fetal and Infant Mortality Review, and increasing patient health literacy. This report, *Delivering Change*, aims to provide context for the alarming decline in birthing centers in New York City through an economic, sociocultural, policy, and public health lens.

This includes an analysis of why several birthing centers have closed and new centers have not opened in recent years. The report will also recommend solutions for the lack of birthing centers by identifying potential opportunities and avenues for opening a birthing center in The Bronx. This report is the culmination of research conducted by The Bronx Borough President's Health and Human Services Division and Policy Division. It combines the knowledge of experts and lived experiences of those working in maternal healthcare in New York City.

This report will define birthing centers and the professionals who staff them. It will lay out an understanding of the birthing community in The Bronx, the worsening maternal and infant health indicators in New York City in recent years, and will examine recent efforts to expand maternal healthcare, the current regulatory environment, and explain the absence of new birthing centers despite public demand.

The report's final section will propose how a public birthing center would operate and will lay out policy recommendations for bringing one into operation in The Bronx. The continued operation of many existing birthing centers and the opening of new ones have been rendered unfeasible by a confluence of financial and regulatory factors involving the health insurance system, hospitals, and government actors. Solving these issues will require significant changes in the landscape of maternal healthcare in New York City, involving medical stakeholders and various levels of government committing to greater investment in maternal health options for expectant mothers and families.



## DEFINITIONS

The Bronx Borough President's Office recognizes that the birthing community includes individuals across the spectrums of biological sex and gender identity. This includes but is not limited to individuals who identify as female, intersex, nonbinary, cisgender, and/or transgender. In this report, "mothers," "expectant mothers," and "birthing individuals" will be used to refer to all individuals with the ability to give birth. When presenting or referring to data, appropriate terms that reflect the demographics of the study sample will be used. Furthermore, this report will use terminology to describe racial and ethnic groups in alignment with the vocabulary used by the New York City Department of Health and Mental Hygiene. Bronx Borough President Vanessa L. Gibson and her Office are committed to equity in all forms, including gender identity,

sexual orientation, race, ethnicity, and ability, and to advocating for the reproductive rights of all people.

Additionally, a low-risk pregnancy is defined as one in which there are no underlying health conditions that would put the birthing individual or fetus at risk for complications. A high-risk pregnancy involves a greater risk of complications for the expectant mother or fetus. This may be due to age, a pre-existing health condition such as diabetes, high blood pressure, or a mental health disorder, pregnancy-related conditions such as poor fetal growth, and lifestyle factors, including, but not limited to, smoking, alcohol consumption, or substance use.

### Birthing Centers

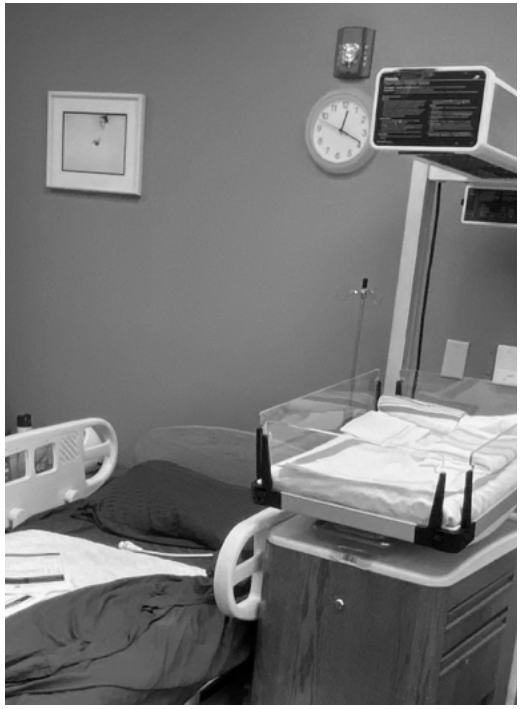
A birthing center is a healthcare facility that provides health services to expectant mothers before, during, and after birth where care is provided through a midwifery, wellness, and collaborative care model.[4] A birthing center is not a hospital, meaning that it has autonomy in policy formation and operational management. There are more than 350 birthing centers in the United States, including three in New York State: the Brooklyn Birthing Center and the Birthing Center of New York, both located in Brooklyn, and the Birth Center of Buffalo.[5]

A birthing center is a facility that is close to a hospital and equipped to provide routine care and perform initial emergency procedures. Birthing center services can include but are not limited to, prenatal care such as preventative screenings, physical exams, routine laboratory tests, health counseling,

and 24-hour telephone access to care providers. Birthing centers also offer care by midwives or physicians who are readily present for active labor, postpartum/newborn care, required newborn laboratory screening tests, postpartum/newborn follow-up, support in parenting and breastfeeding, planning the participation of family members, educational programming that includes components of self-care and self-help, and planning payment for services.

Birthing centers are designed to be an integral part of the local healthcare system that maintains relationships with hospitals and community health agencies for wraparound health and social services, referrals to other levels of care, and access to an acute care obstetrical and neonatal unit.[6]

Although prenatal and postpartum services can be provided to all expectant mothers, only individuals anticipating a low-risk pregnancy and birth can give birth in a birthing center. Despite this, research has shown that there are many positive maternal health outcomes and financial benefits associated with the use of birthing centers.[7] For low-risk births, birthing centers are just as safe as hospitals and are much less likely to have adverse outcomes among their clients.[8] Additionally, births at birthing centers are associated with fewer cesarean sections, which, public health experts argue, increase health risks and financial stress when performed unnecessarily, but are nonetheless performed too often in the United States.[9] Among individuals who birth in a birthing center, only 6% have a cesarean section after transferring to a hospital, much lower than the 26% of low-risk pregnancies that are delivered by cesarean section at hospitals in the United States overall.[10] Proponents contend that one primary reason for this difference is that birthing centers allow more time for childbirth to occur naturally. Advocates therefore say that those with uncomplicated and low-risk pregnancies may experience greater health benefits in birthing centers compared to in hospitals because they are less likely to be subjected to unnecessary treatments. However, it should be noted that those with complicated pregnancies or other health risks often need access to the medical treatments offered by hospitals.



*Birthing room at The Birthing Center of New York*

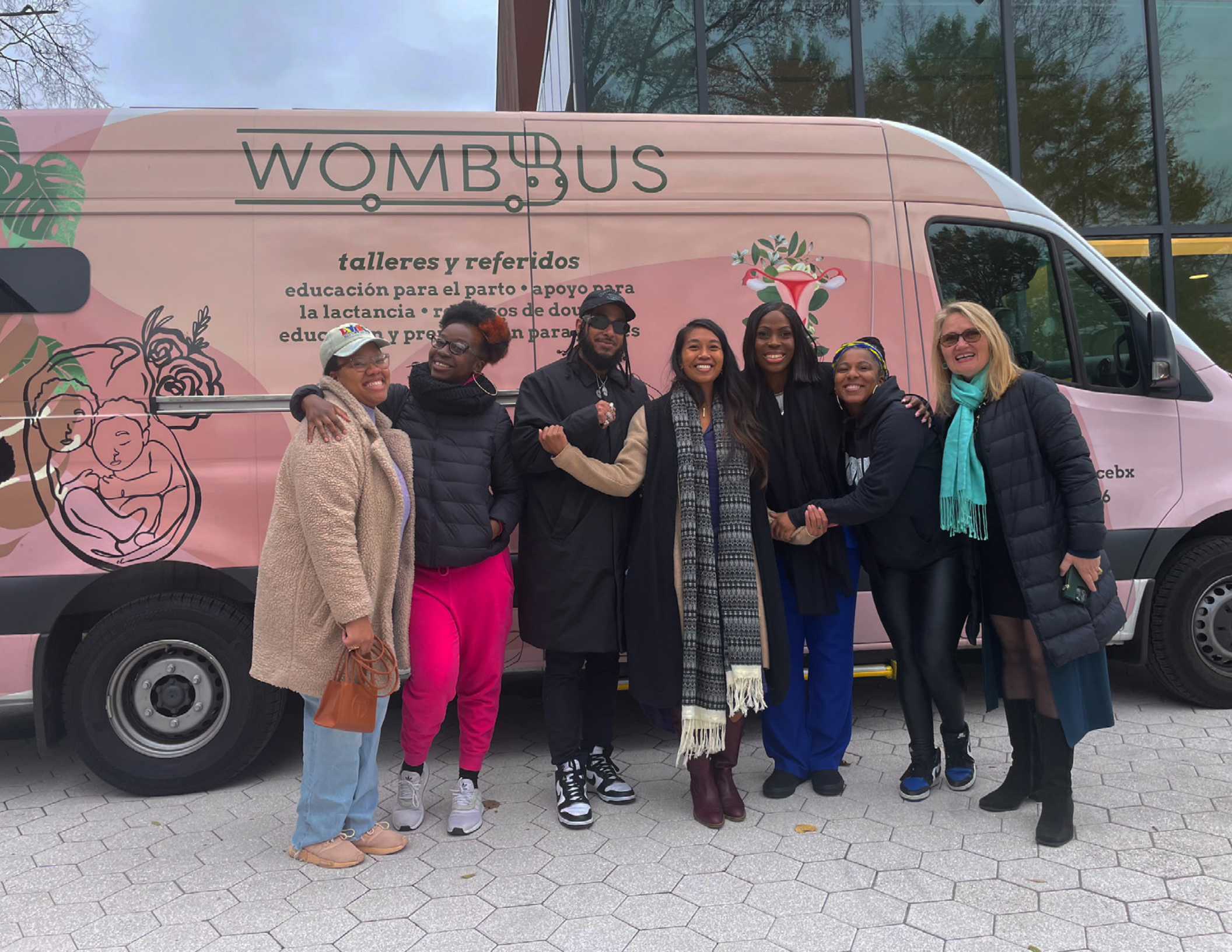
Cost is another differentiating factor between a birthing center and a hospital. While there are a range of prices associated with both sectors, the cost of delivering a child at a birthing center is on average lower than at a hospital. The average cost of delivering a child at a birthing center in the United States ranges from **$3,000** to **$4,000**.[11]

Interviews with New York City's birthing centers suggested the price ranges in the city are closer to **$5,000**. This is still considerably cheaper than the average cost of birth at a hospital, which is over **$14,000** by some estimates.[12]

Furthermore, birthing centers are staffed by qualified professionals, including, but not limited to, midwives, nurses, social workers, case managers, and physicians. Doulas are usually hired externally by expectant mothers but can also be part of a birthing center staff. In either capacity, doulas are key members of the birthing team. Equipped with an interdisciplinary team of health and wellness professionals, birthing centers are characterized by a commitment to patient preferences and holistic care.

This commitment to comprehensive care is often associated with a "collaborative care" model of maternal healthcare. This model is not based on a single obstetrician but rather a team of healthcare professionals who all work together to provide comprehensive and personalized care to expectant mothers throughout the prenatal, birth, and postpartum periods.[13] New York State and New York City government officials are striving to transition maternal care towards a collaborative care model, with a greater focus on midwifery, and birthing centers fit well in this landscape.

These health and financial benefits have caused the demand for birthing centers in the United States to increase in recent years. The number of birthing centers in the country has roughly doubled since 2010.[14] According to the Pew Research Center, births in hospitals decreased in 2020 as more expectant mothers opted for home births and birthing centers.[15] While births in birthing centers make up only **0.6%** of total births, the number of births in birthing centers increased by **65%** between 2011 and 2021.[16]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# CLASSIFICATION OF BIRTHING CARE PROFESSIONALS

Prenatal care, labor and delivery care, emergency birthing care, and postpartum care are administered by a wide variety of birthing care providers and professionals. The following table presents brief definitions of the types of birthing care professionals. Though this table may not include all birthing care professionals, it includes those identified as potentially employable in a birthing center. All medical professionals listed below are required to maintain active licensure. Complete definitions and descriptions, including required certifications and licensures, can be found in the appendix.

| Category | Title | Scope of Practice and Services |
|---|---|---|
| Doula | Birth Doula | • A non-medical birth coach who assists a woman during the prenatal period, labor, delivery, and post-childbirth<br>• Works in a nonclinical capacity to provide continuous physical, emotional, and informational support to pregnant people and their families before, during, and shortly after childbirth<br>• Helps clients navigate hospital policies and costs and encourages respectful communication between families and health providers and staff<br>• May not diagnose medical conditions or give medical advice, perform any clinical task or conduct any physical or behavioral assessment or exam, or provide or interfere with medical treatment<br>• May not deliver babies or perform surgery |
| | Postpartum Doula | • Same scope of practice as a birth doula<br>• In addition, can provide evidence-based information on physical recovery from birth, emotional well-being, infant feeding, and parent-infant bonding |
| Midwife | Certified Nurse-Midwife | • Can assess, diagnose, and treat women in the areas of sexual and reproductive health and gynecological health<br>• Can provide primary care to healthy newborns during the first 28 days of life, adolescents, and adults<br>• Can deliver babies, but may not treat high-risk pregnancies or complications during delivery<br>• May not perform surgery |

| Legal Status and Prescriptive Authority | Education | Payment/Insurance Coverage in NY |
|---|---|---|
| • No formal authorization required to provide services<br>• May not prescribe medications | • No mandated education<br>• Usually, completes courses and private certifications, ranging from a few days to a few months in length | **Medicaid**<br>**TRICARE**<br>**Out-of-Pocket** |
| | | **TRICARE**<br>**Out-of-Pocket** |
| • Authorized to practice in all 50 states, D.C. and most territories<br>• Can prescribe medications in all 50 states, D.C. and most territories | • Bachelor of Science degree in Nursing<br>• Master's degree in Midwifery | **Medicaid**<br>**Medicare**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |

| Category | Title | Scope of Practice and Services |
|---|---|---|
| Midwife | Certified Midwife | • Same scope of practice as a Certified Nurse-Midwife |
| | Certified Professional Midwife | • Can assess, diagnose, and treat women in the areas of sexual and reproductive health, gynecological health, and family planning<br>• Can provide maternal and well-baby care through the 6–8-week postpartum period<br>• Can deliver babies, but may not treat high-risk pregnancies or complications during delivery<br>• May not perform surgery |
| Physician | Obstetrician/ Gynecologist | • Practices allopathic (MD) or osteopathic (DO) medicine<br>• Provides all medical services of a licensed physician and specializes in female reproductive health<br>• Can deliver babies and can perform surgery |
| | Family Medicine Physician | • Treats patients of all ages<br>• Treats chronic conditions, evaluates symptoms, offers preventative care, and lets patients know when they need to see a specialist<br>• Often provides routine checkups, including well-baby and child visits<br>• Can deliver babies and perform surgery |
| Advanced Practice Registered Nurse | Certified Nurse-Midwife | • See Certified Nurse-Midwife under Midwife Category |

<table>
<tr><th>Legal Status and Prescriptive Authority</th><th>Education</th><th>Payment/Insurance Coverage in NY</th></tr>
<tr><td>• Authorized to practice in 9 states, including New York, and D.C.<br>• Can prescribe medications in 5 states, including New York, and D.C.</td><td>• Bachelor of Science degree<br>• Master’s degree in Midwifery</td><td rowspan="2">Medicaid<br>Private Insurance<br>Out-of-Pocket</td></tr>
<tr><td>• Authorized to practice in 37 states, including New York, and D.C.<br>• May not prescribe medications</td><td>A certificate, an Associate’s, Bachelor’s, Master’s or Doctoral degree in midwifery<br>Total Years of Education: 2-3 years<br>Total Clinical Training: 500-1,400 hours</td></tr>
<tr><td rowspan="2">• Authorized to practice in all 50 states, D.C., and all U.S. territories<br>• Can prescribe medications in all 50 states, D.C., and all U.S. territories</td><td>• Bachelor’s Degree<br>• Doctor of Medicine Degree or Doctor of Osteopathic Medicine Degree<br>• OB-GYN Residency Program<br>• Optional additional fellowship in subspecialty</td><td rowspan="2">Medicaid<br>Medicare<br>TRICARE<br>Private Insurance<br>Out-of-Pocket</td></tr>
<tr><td>• Bachelor’s Degree<br>• Doctor of Medicine Degree or Doctor of Osteopathic Medicine Degree<br>• Family Medicine Residency<br>• Optional additional fellowship in subspecialty<br>Total Years of Education: 9-15 years<br>Total Clinical Training: 5-8 years</td></tr>
</table>

| Category | Title | Scope of Practice and Services |
|---|---|---|
| Advanced Practice Registered Nurse | Certified Registered Nurse Anesthetist | • Can provide all medical services of a licensed registered nurse<br>• Can provide anesthesia in collaboration with surgeons, dentists, podiatrists, physician anesthesiologists, and other qualified healthcare professionals<br>• Can assist in delivering babies, but may not independently deliver babies<br>• Can assist in surgeries, but may not independently perform surgery |
| | Clinical Nurse Specialist | • Can provide all medical services of a licensed registered nurse<br>• Can provide care in a specialty of choice, including women's health<br>• A Women's Health Clinical Nurse Specialist can offer consultation, education, research, and leadership in maternity care and childbirth<br>• Can assist in delivering babies, but may not independently deliver babies<br>• Can assist in surgeries, but may not independently perform surgery |
| | Nurse Practitioner | • Can provide a full range of primary, acute, and specialty healthcare services<br>• A women's health nurse practitioner can provide preventive care such as well gynecological exams, breast cancer screenings, Papanicolaou (Pap) tests, or contraceptive care<br>• Women's health nurse practitioners may also provide adolescent healthcare, pregnancy testing, fertility evaluation, family planning services, prenatal visits, after-pregnancy care, breastfeeding counseling, and menopausal care<br>• Can assist in delivering babies, but may not independently deliver babies<br>• Can assist in surgeries, but may not independently perform surgery |

| Legal Status and Prescriptive Authority | Education | Payment/Insurance Coverage in NY |
|---|---|---|
| • Authorized to practice with collaboration agreement/supervision by a MD, DO, dentist or podiatrist in 24 states, including New York<br>• Authorized to independently practice in 26 other states with certain state-based limitations<br>• May not prescribe medications, but can only administer them, in 14 states, including New York<br>• Can prescribe medications on a limited basis or with physician supervision in 20 other states and can independently prescribe medications in another 16 states and D.C. | • Must complete education of a registered nurse<br>• A minimum of one year of full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting<br>• Master's or Doctorate Degree from a nurse anesthesia educational program | **Medicaid**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |
| • Authorized to practice with supervision by a MD, DO, dentist or podiatrist in 15 states, including New York<br>• Authorized to practice independently in 35 other states and D.C.<br>• Can independently prescribe medications in 22 states, including D.C.<br>• Can prescribe medication under supervision or may not prescribe, only administer, in 28 other states, including New York | • Must complete education of a registered nurse<br>• Master's or Doctorate Degree in Nursing with an Adult/Gerontology, Pediatrics, or Neonatal major | **Medicaid**<br>**Medicare**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |
| • Authorized to practice and prescribe medications independently in 27 states, including New York, and D.C.<br>• Authorized for reduced or restricted practice under supervision and can prescribe medications with physician oversight in 23 other states | • Must complete education of a registered nurse<br>• Master's Degree in Nursing or Doctorate Degree in Nursing | |

| Category | Title | Scope of Practice and Services |
|---|---|---|
| **Registered Nurse** | | • Can manage and coordinate various aspects of a patient's care, including assessing patients, requesting medical tests, making diagnoses, and administering treatments as part of a medical professional team<br>• A labor and delivery (L&D) nurse specializes in supporting patients during and after birth under the supervision of a nurse midwife or physician and can provide care for infants immediately after delivery.<br>• A neonatal nurse specializes in working with newborn babies, including those born with issues such as premature birth, birth defects, infections, or cardiac issues.<br>• Can assist in delivering babies, but cannot independently deliver babies<br>• Can assist in surgeries, but cannot independently perform surgery |
| **Physician Assistant** | | • Practices allopathic medicine under physician supervision, including providing medical histories and performing physical examinations, ordering and interpreting lab tests, diagnosing and treating illnesses, and counseling patients<br>• Can assist in delivering babies, but cannot independently deliver babies<br>• Can assist in surgeries, but cannot independently perform surgery |
| **Childbirth Educator** | | • Works in a nonclinical capacity to prepare families for pregnancy<br>• Offers non-biased perinatal information, support, encouragement, guidance, and education to families, provides information on birth options and resources, and helps families understand their rights according to current healthcare policy and legal statutes<br>• May not diagnose medical conditions or give medical advice, perform any type of clinical task or conduct any type of physical or behavioral assessment or exam, or provide or interfere with medical treatment |
| **Lactation Consultants/ Counselors** | **International Board-Certified Lactation Consultant** | • Provides comprehensive, skilled care and evidence-based information for breastfeeding and human lactation, from preconception to weaning, for breastfeeding families<br>• Develops an individualized feeding plan in consultation with the client and provides evidence-based information regarding use during breastfeeding and human lactation, of medications, alcohol, tobacco and addictive drugs, and herbs or supplements, and their potential impact on milk production and child safety<br>• May not deliver babies or perform surgery |

| Legal Status and Prescriptive Authority | Education | Payment/Insurance Coverage in NY |
|---|---|---|
| • Is authorized to practice in all 50 states, D.C., and all U.S. territories<br>• May not prescribe medications, but can administer medications as prescribed by a health professional with prescriptive authority<br>• Authorized to dispense some medications, including contraceptives and drugs for STI care in some outpatient settings in 16 states, not including New York | • Associate's Degree in Nursing or a Bachelor's Degree in Nursing | **Medicaid**<br>**Medicare**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |
| • Is authorized to practice in 37 states, including New York, and D.C.<br>• May not prescribe medications | • Bachelor's Degree<br>• Master's Degree from a physician assistant program | |
| • No formal authorization is required to provide services<br>• May not prescribe medications | • No mandated educational path<br>• Usually, completes an accredited certification program | |
| • No formal authorization is required to provide services<br>• May not prescribe medications | • A health sciences background (various educational routes accepted) in which 14 IBCLC-approved health science courses are completed<br>• A minimum of 95 hours lactation specific education (including 5 hours of communications skills) | **Medicaid**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |

| Category | Title | Scope of Practice and Services |
|---|---|---|
| Lactation Consultants/ Counselors | Certified Lactation Counselor | • Provides clinical breastfeeding counseling and management support to families who are thinking about breastfeeding or who have questions or problems during the course of breastfeeding/lactation<br>• May not deliver babies or perform surgery |
| | Certified Breast-feeding Educator | |
| | Certified Lactation Educator | • Teaches families about preparing for their infant, how lactation works physiologically, common challenges to expect, and other general lactation support<br>• May not deliver babies or perform surgery |

| Legal Status and Prescriptive Authority | Education | Payment/Insurance Coverage in NY |
|---|---|---|
| • No formal authorization is required to provide services<br>• May not prescribe medications | • A Bachelor's degree or higher, or a Commission on Accreditation of Allied Health Education Programs (CAAHEP) approved, post secondary, lactation consultant program<br>• Training based on the WHO/UNICEF Breastfeeding Counseling Training Course | **Medicaid**<br>**TRICARE**<br>**Private Insurance**<br>**Out-of-Pocket** |
| | Training based on the WHO/UNICEF Breastfeeding Training Course<br>**Total Years of Education: 1-6 months**<br>**Total Clinical Training: 45-52 hours** | |
| | • Accredited certification course | |

# BRONX MATERNAL HEALTH

The Bronx compares poorly with the other boroughs in maternal and infant health. This section examines the social determinants of health contributing to the poor maternal and infant health outcomes in The Bronx. These factors are discussed in their relation to health outcomes: proximate factors that directly affect health, mid-level factors that implicate access and education, and ultimate factors that reflect societal causes.

## Proximate Factors: Disease, Health Behaviors, and Domestic Violence

The Bronx suffers from several proximate factors that contribute to poor maternal health, such as diabetes, hypertension, and obesity, all of which are found in higher rates in comparison to the city as a whole.[17] These conditions are known to cause negative effects on maternal and infant health, in some cases leading to complications during pregnancy and a higher risk of injury or death to both infant and mother.[18]

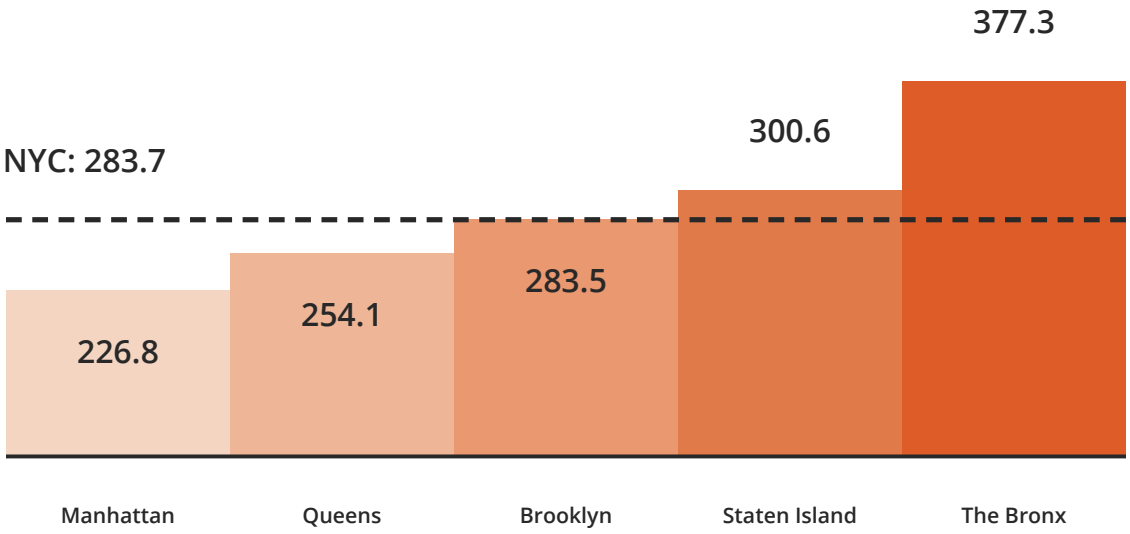
Additionally, alcohol and tobacco consumption, even in small amounts is known to contribute to pregnancy related complications that harm the life and wellbeing of both mother and infant.[19] In The Bronx, 17% of adults reported binge drinking, defined as having five or more drinks for men and four or more for women, within the last 30 days, the second-highest rate of all the boroughs.[20] Bronxites are also more likely to smoke tobacco than residents of the city as a whole, with 13.7% of Bronxites smoking regularly compared with 10.9% of city residents overall.[21] Domestic and intimate partner violence is another factor that has been linked to poor pregnancy outcomes. In 2020, the rate of domestic violence incidents nearly doubled for all Bronx precincts, and eight of the fifteen community districts with the highest number of intimate partner homicides were in The Bronx.[22] More than half of The Bronx population identifies as Black or of Hispanic origin, and 52.7% are women.[23] Unfortunately, Black and Hispanic women of childbearing age are at a disproportionately higher risk of domestic violence incidents and homicide than their White counterparts, placing them at greater risk for pregnancy related complications.[24] Women who are abused during their pregnancy are less likely to receive prenatal care or delay care until later than recommended.[25] Domestic violence significantly increases the risk of low birth weight and preterm birth and women who experience abuse during their pregnancy are more likely to report symptoms of depression after giving birth.[26]

## Maternal and Infant Health in The Bronx

Across numerous maternal and infant health indicators, health outcomes and access to care are by far the worst in The Bronx compared to all other boroughs. Collected by the NYC DOHMH, the data provides a comprehensive but alarming narrative of the state of health in The Bronx.


Figure 1

**The Bronx Severe Maternal Morbidity (SMM) Rate of 377.3 was the highest among all the NYC boroughs.**

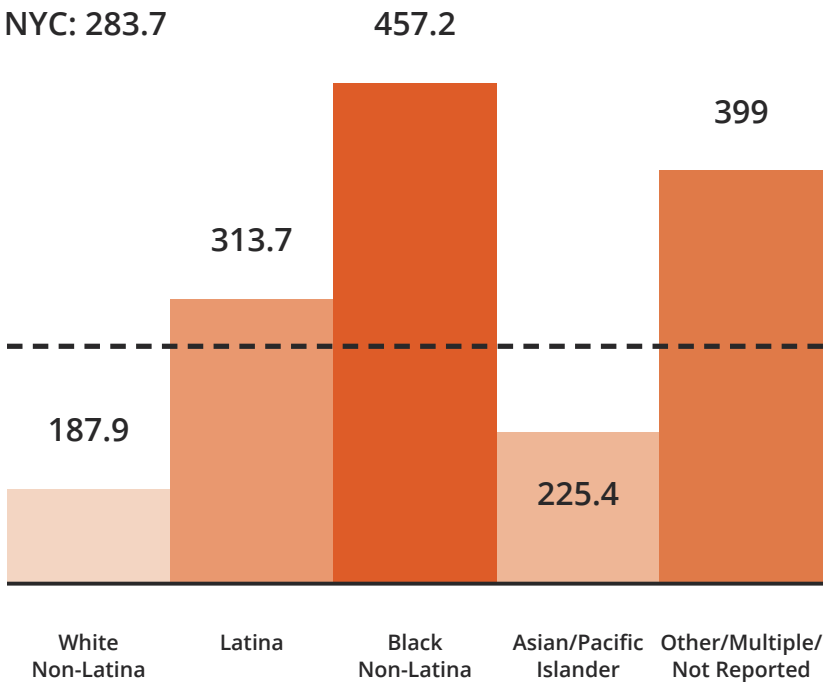



The SMM rate is a calculation of life-threatening complications during pregnancy and childbirth.

**Source:** New York City Department of Health and Mental Hygiene, Maternal Mortality and Severe Maternal Morbidity in New York City Report, April 2021

Figure 2

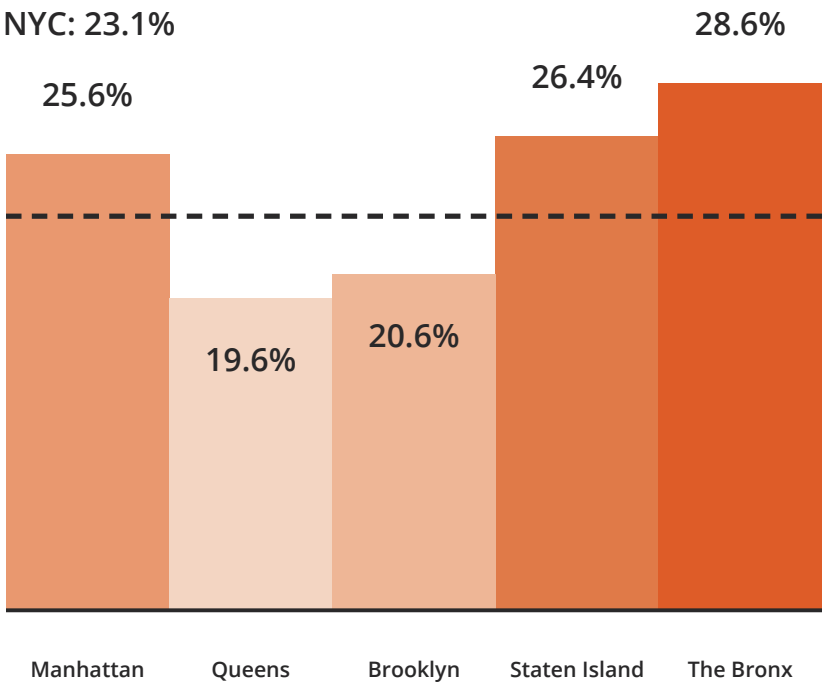
## Black women in NYC have a maternal morbidity rate more than twice that of White women.




**Source:** New York City Department of Health and Mental Hygiene, Maternal Mortality and Severe Maternal Morbidity in New York City Report, April 2021.

Figure 3

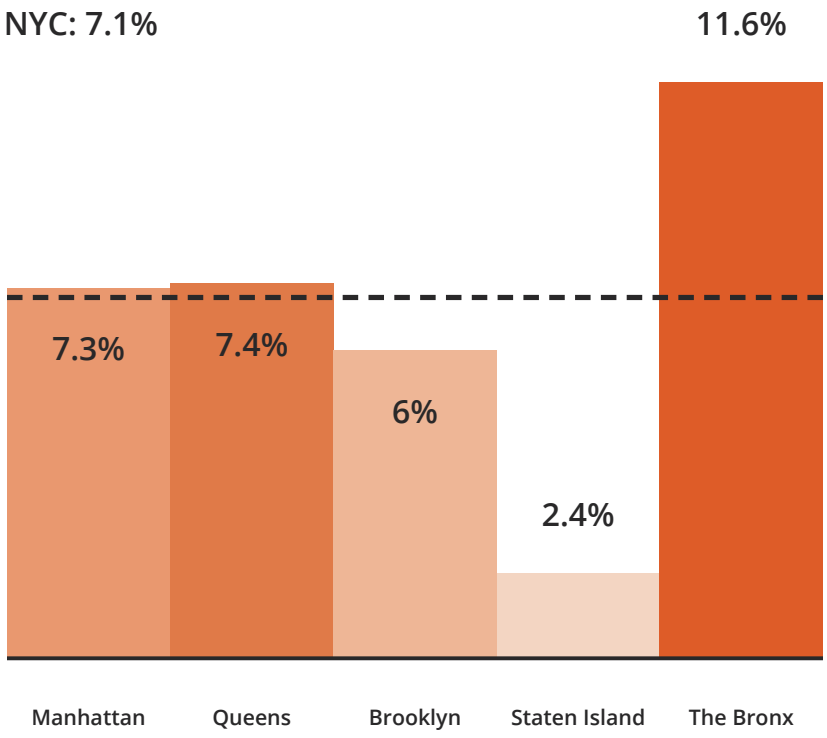
## The Bronx has the highest percentage of pregnant women in WIC who were obese before pregnancy.




**Source:** New York City Department of Health Community Health Indicator Reports Data

Figure 4

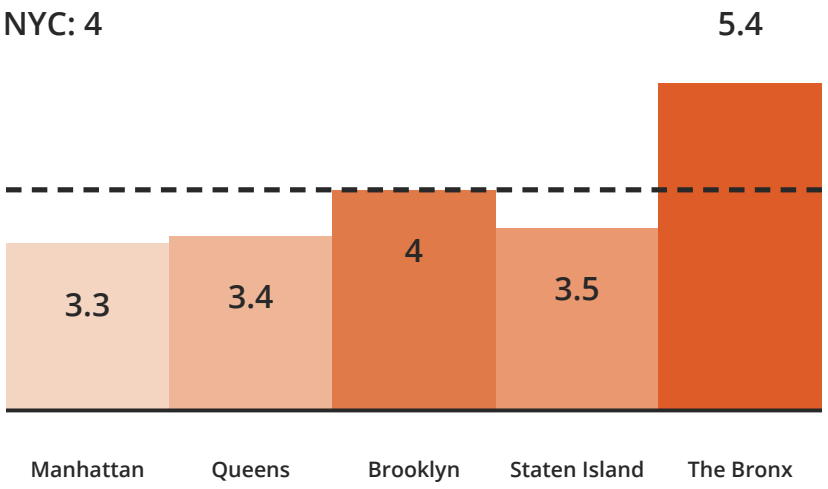
## The Bronx has the highest percentage of live births in which the mother had late or no prenatal care.




**Source:** New York City Department of Health and Mental Hygiene, Maternal Summary of Vital Statistics 2021

Figure 5

## The Infant Death Rate (IDR) is the number of deaths under one year of age per 1,000 live births.

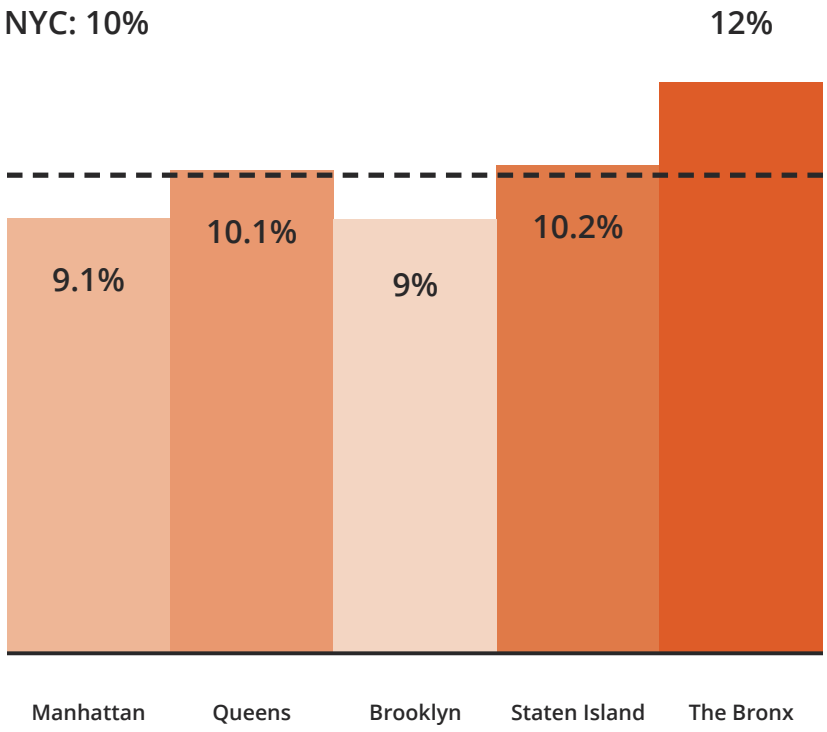



The Bronx has the highest IDR of any borough in the city.

**Source:** New York City Department of Health and Mental Hygiene, Maternal Summary of Vital Statistics 2019, Table 45: Infant Deaths, Neonatal Deaths, Post Neonatal Deaths and Perinatal Mortality by Resident County

Figure 6

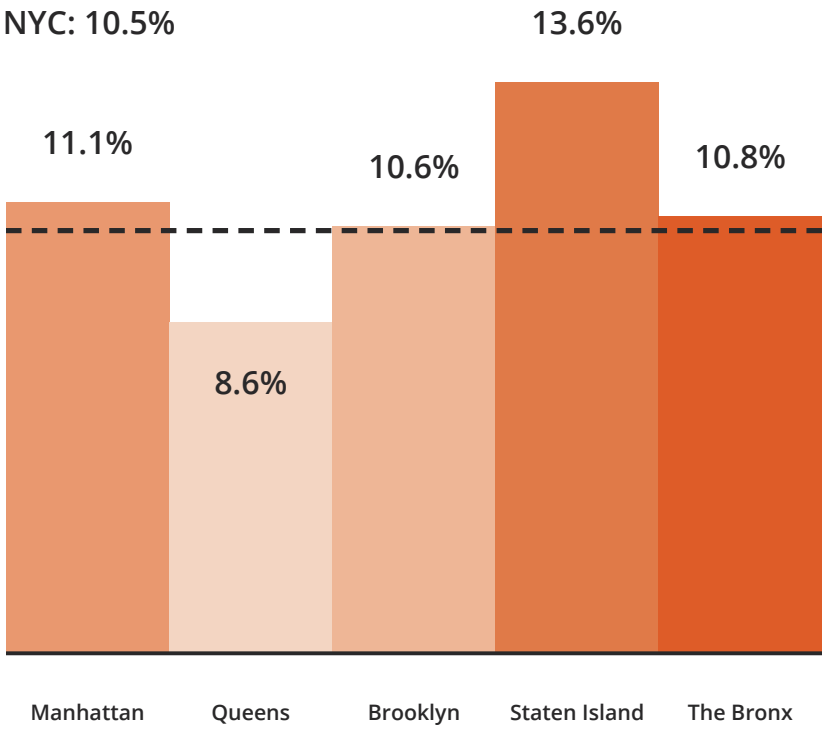
## The Bronx has the highest percentage of preterm births of any of the five boroughs.




**Source:** New York City Department of Health and Mental Hygiene, Maternal Summary of Vital Statistics 2021

Figure 7

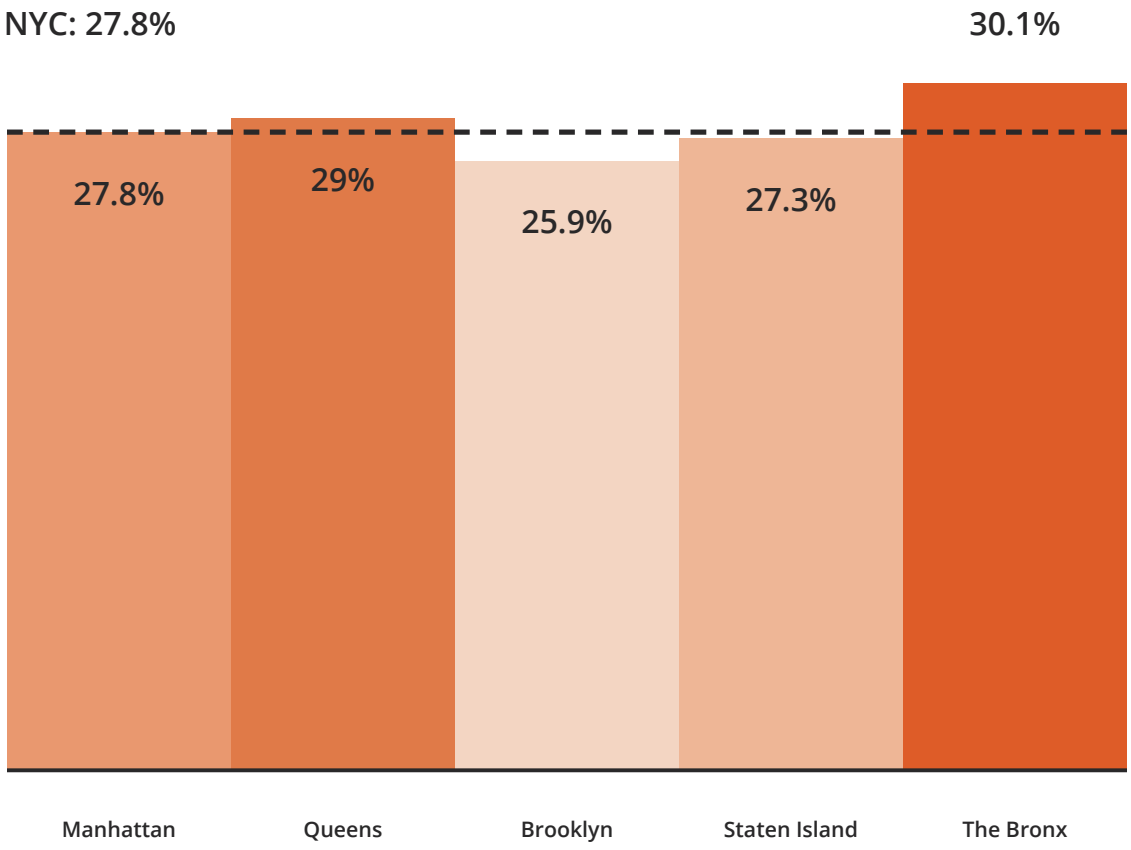
## The Bronx has a percentage of babies born with low birth weight that is higher than the city average.




**Source:** New York City Department of Health and Mental Hygiene, Maternal Summary of Vital Statistics 2021

Figure 8

## The Bronx has the highest percentage of low-risk pregnancies that ended in a C-section.




**Source:** New York City Department of Health Community Health Indicator Reports Data

## Mid-Level Factors: Access to Care and Health Education

There are several mid-level factors that affect maternal and infant health. One of these is access to prenatal care, which is associated with healthier outcomes for both mother and infant.[27] Babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who access timely and adequate care.[28] Pregnant Bronxites receive prenatal care at a significantly lower rate than those in other boroughs. The percentage of Bronx women who received late or no prenatal care is 11.6%, compared to the citywide average of 7.1%, and more than four times that of Staten Island, 2.4%. Thousands of Bronx women are not getting the prenatal care that they need. Only 61.4% of pregnant women in The Bronx received adequate prenatal care, a much lower percentage of mothers than the New York City average of 72.7%.

Another factor is that the healthcare system often incentivizes spending as little time as possible with patients, which can lead to less robust care. The reimbursement rates that healthcare providers are provided for giving services to those enrolled in Medicaid are relatively low, which makes patient care especially challenging for Bronx hospitals that primarily serve Medicaid patients.[29] Qualitative studies by The Commonwealth Fund in 2018 and 2019 found that, "Physicians often have difficulty getting prior approval from Medicaid for procedures or prescriptions. This was particularly salient for low-income patients who could not afford the service if it were not covered. PCPs felt they lost valuable time dealing with managed care companies to get tests and medications approved — time they could otherwise be spending with patients."[30]

Reimbursement rates also incentivize the quantity of patients over the quality of care. Nonprocedural care, like most primary care services, is reimbursed at lower rates than procedural care. This adds to the pressure to see more patients and spend less time with each one, despite the exponential growth of primary care guidelines to include numerous screenings and preventative services.[31] Women of child-bearing age, women of color, and low-income women especially need more support than the time typically allotted for patient-centered care, further signifying the need for a birthing center that can provide the foundation for a strong provider-patient connection and access to continuous care and education into the postnatal period. Mothers on Medicaid deserve access to the same quality of care and patient engagement as mothers with private insurance.

Health literacy is also an important factor to consider. The U.S. Department of Health and Human Services (HHS) defines health literacy as the extent

to which individuals can receive, process, and understand basic health information in order to make suitable health decisions. While there is no available data on health literacy in The Bronx, educational attainment can be used as a proxy variable, as the level of educational attainment within a population has been shown to track closely with said population's levels of health literacy.[32] The Bronx consistently scores poorly on metrics of educational attainment when compared with other boroughs, with lower average test scores, lower rates of graduation, and higher rates of student absenteeism.[33] However, it can be difficult to parse out the effect of health literacy alone, as upstream factors such as educational attainment, health literacy, poverty, and institutional neglect all affect health outcomes and tend to correlate with each other.[34]

## Ultimate Factors: A Legacy of Discrimination and Disinvestment

Bronx residents are particularly vulnerable to the correlated issues of poverty, lack of nutrition, and lack of education.[35] In 2022, young Black (18.5%), Hispanic (23.3%), and Asian (23.3%) adults in The Bronx saw unemployment rates greater than their White (16.2%) counterparts.[36] Furthermore, The Bronx has some of the highest rates of food insecurity in the country, and more than 50% of South Bronx families rely on Supplemental Nutrition Assistance Program (SNAP) benefits to access food. Still, only 4% meet the U.S. dietary guidelines of consuming five or more servings of fruits and vegetables daily.[37]

These factors are upstream of many of the mid and downstream health issues experienced by pregnant women in The Bronx. Lack of prenatal care and high rates of chronic illness are most often seen in communities with high poverty and low access to primary and preventative care. Addressing the root causes of these inequities requires a wide-ranging effort to build stronger public institutions that provide more equitable access to healthcare.[38]

However, the disparity in maternal health cannot be attributed to these issues alone; for decades, structural racism has been the root cause of sidelining the health and quality of life of people of color. Maternal and infant health outcomes are worse among women of color, reflecting historical and generational disinvestment and discrimination. According to the New York City Department of Health and Mental Hygiene (DOHMH), from 2001 to 2019, Black women had a pregnancy-related mortality ratio nearly 9.2 times that of White women.[39]

The New York State Department of Health (DOH) released a report on maternal mortality in April 2022, a culmination of research by the department's Maternal Mortality Review Board (MMRB) and Maternal Mortality and Morbidity Advisory Council (MMMAC). Then-New York State Health Commissioner Dr. Mary T. Bassett said that, **"Examining maternal health outcomes from a racial equity perspective is critical to unearthing institutional issues so they can be addressed."**[40]

The DOH report found that Black women die at higher rates from pregnancy-related causes than their peers. Moreover, Black women are five times more likely to die from pregnancy-related complications than White, non-Hispanic women. The leading causes of these pregnancy-related deaths were embolism (**20%**), hemorrhage (**20%**), and mental health conditions, which include depression, anxiety, and substance use disorder (**15%**). A case-by-case analysis of each pregnancy-related death in 2018 revealed that **78%** of those deaths were preventable. Furthermore, **100%** of the deaths caused by mental health conditions, hemorrhage, and cardiomyopathy were preventable. In **46%** of the deaths, discrimination was identified as a probable circumstance surrounding the death.[41] This data is a stark reminder that, even in the twenty-first century, more must be done to recognize our racial biases and their impact on families, communities, and health outcomes.

Additionally, the Black Maternal Mortality Task Force Report published by The Bronx Borough President's Black Maternal Mortality Task Force in 2021 compiled data from many governmental agencies. This data showed that Black women were more likely to experience unsafe childbirth across a variety of indicators,

even after controlling for socio-economic factors, and were more likely to give birth in lower-quality hospitals.

Also, Black women disproportionately live in areas with greater air pollution and where outbreaks of waterborne diseases have happened in recent years. The report presented data on poor maternal health outcomes for Black women as a clear sign of racism within the health system. Black women, even those with high levels of education, are more likely to face communication issues and lack of acknowledgment with their healthcare providers, contributing to a weak patient-provider relationship and feelings of problems or symptoms being discredited.[42]

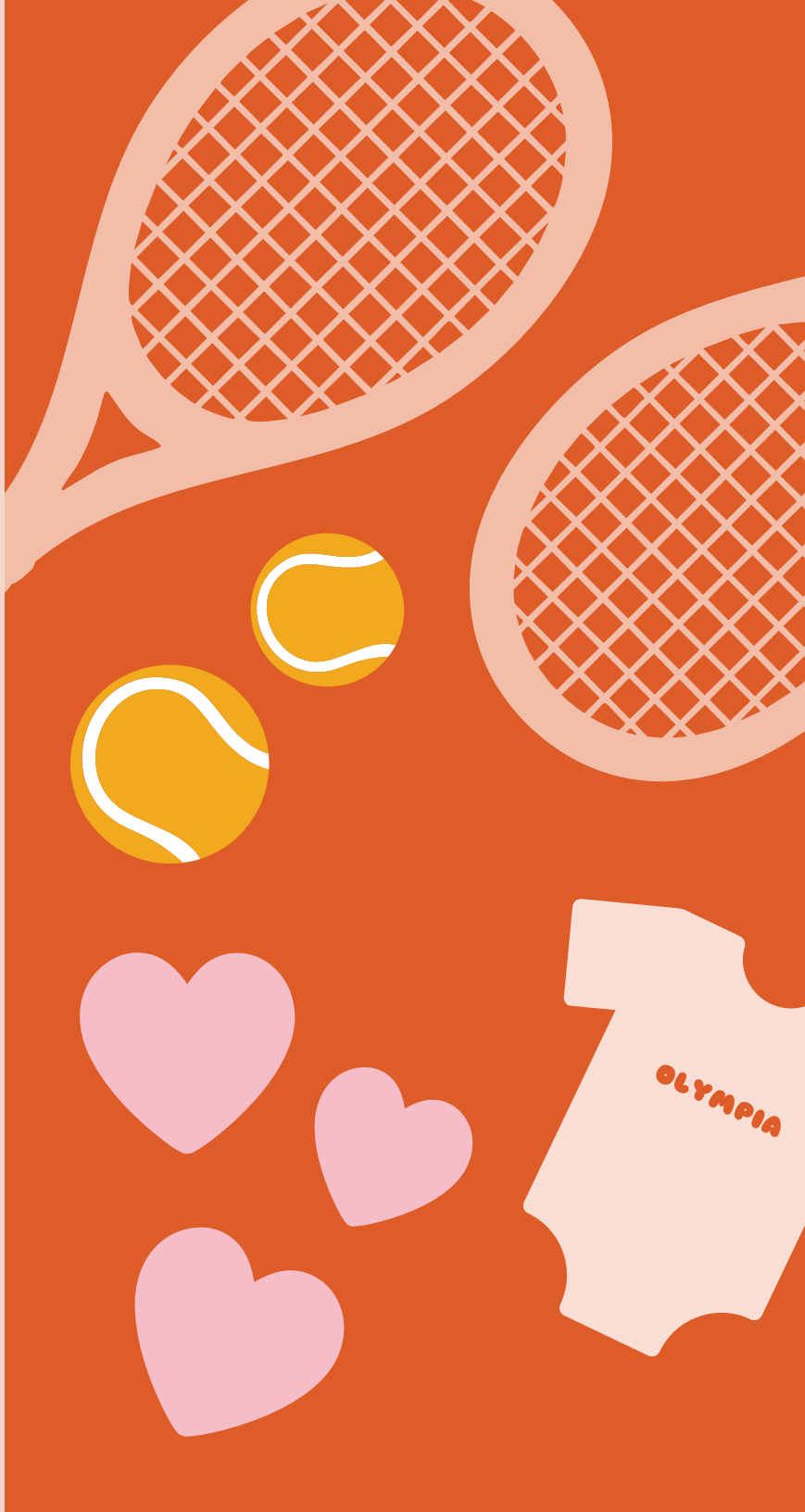
Black and Latina women reported significantly higher rates of discrimination during hospital stays than White women. Such racial bias and discrimination within the healthcare system is a significant cause of the disparities in health outcomes. Many medical professionals who study the intersection of the Black experience and the healthcare system have written that a legacy of discrimination against Black women is still affecting healthcare treatment in the United States.[43]

Maternal and infant mortality statistics are not just numbers, they are lives who were not given an equal opportunity to thrive. The 2022 documentary *Aftershock* chronicles tragic true events that show the lives behind maternal mortality statistics. The documentary recounts the stories of Shamony Gibson and Amber Rose Isaac, two young women who died after birth-related complications. The journey of their partners, Omari Maynard and Bruce McIntyre, is documented as they process life after loss and become activists for maternal health. *Aftershock* explores the systematic issues that cause women, particularly women of color and women from marginalized backgrounds, to disproportionately become the victims of maternal mortality and morbidity. *Aftershock* premiered at the Sundance Film Festival and was awarded the Special Jury Award: Impact for Change.

Black women can be subject to medical racism regardless of their socioeconomic status. The case of professional tennis player and household name, Serena Williams was captured by national media, when she nearly lost her life after giving birth. The persistent dismissal of her symptoms and concerns almost led Williams to becoming another statistic. Shalon MauRene Irving, an epidemiologist with the Centers for Disease Control and Prevention (CDC) who led significant research on systemic factors that affect racial and ethnic minorities, is another example of how race is often a determining factor in health and life outcomes for women of color. Shortly after giving birth to her daughter, Dr.Irving succumbed to pregnancy-related complications that went unnoticed during preventative care.

## SERENA WILLIAMS SPEAKING OUT ABOUT HER CHILDBIRTH EXPERIENCE

A professional tennis player, the winner of 23 Grand Slam titles, and a relentless advocate for racial and gender equality, Serena Williams is a trailblazer on and off the court. In an essay in Elle magazine in 2018, Williams revealed her alarming experience of giving birth to her daughter Olympia.[44]



Williams learned in 2010 that she had blood clots in her lungs, and that she was always at a high risk of their return. After giving birth by cesarean section in 2017, Williams kept asking a nurse when she would be given heparin, a blood thinner used to prevent or dissipate blood clots. Williams described, "I asked a nurse, 'When do I start my heparin drip? Shouldn't I be on that now?' The response was, 'Well, we don't really know if that's what you need to be on right now.' No one was really listening to what I was saying. Still, I felt it was important and kept pressing." Williams developed a hacking cough, which caused her C-section stitches to burst, and she was taken for surgery to be restitched. She underwent a total of four surgeries in the following days.

Williams explained what happened between those surgeries: "I spoke to the nurse. I told her: 'I need to have a CAT scan of my lungs bilaterally, and then I need to be on my heparin drip.' She said, 'I think all this medicine is making you talk crazy.' I said, 'No, I'm telling you what I need: I need the scan immediately. And I need it to be done with dye.' I guess I said the name of the dye wrong, and she told me I just needed to rest. But I persisted: 'I'm telling you, this is what I need.' Finally, the nurse called my doctor, and she listened to me and insisted we check. I fought hard, and I ended up getting the CAT scan. I'm so grateful to her. Lo and behold, I had a blood clot in my lungs, and they needed to insert a filter into my veins to break up the clot before it reached my heart...My personal OBGYN was amazing. She never made me feel dismissed. Another doctor was supposed to be checking in but I didn't see him very much. In fact, I saw him only once."

The physicians ultimately discovered that Williams had an embolism in one of her arteries, a hematoma in her abdomen, and more blood clots that could travel to her lungs if not treated. These clots contributed to her cough and could have led to much more serious consequences if not managed. Williams was treated for a total of seven days before being able to leave the hospital with her newborn daughter.

**"Being heard and appropriately treated was the difference between life or death for me,"**

Williams reflected as she highlighted the disproportionately high maternal mortality rates among Black mothers compared to their White counterparts. "I know those statistics would be different if the medical establishment listened to every Black woman's experience."

## SHALON IRVING

The 2017 death of Shalon Irving illustrates the implicit biases in the healthcare system.[45] Shalon MauRene Irving, PhD, MPH, MS, CHES, was an epidemiologist with the Centers for Disease Control and Prevention (CDC) and a lieutenant commander in the US Public Health Service Commissioned Corps. She made significant contributions in the field of public health, particularly her research on how systemic factors affect racial and ethnic minorities, including how they can increase maternal mortality rates among Black mothers.

After giving birth to a daughter in January 2017, Irving began to feel unwell.[46] She began experiencing chronic pain, headaches, and swelling in her legs. After receiving a test for postpartum pre-eclampsia, she was sent home without treatment. After returning to her doctor again, she was sent home with a prescription to treat hypertension. That night she collapsed and was rushed to a hospital, where she passed away a week later, only three weeks after having given birth.

The cause of death was determined to have been from complications of high blood pressure. Irving's death could have been avoided with proper screening and preventative care. Her tragic passing serves as a reminder that systemic racism can affect all Black mothers, no matter their level of education or socioeconomic status.


# FACTORS LEADING TO MATERNAL AND INFANT MORTALITY & MORBIDITY

# THE CURRENT STATE OF HEALTHCARE IN NEW YORK

## Hospital Birth Services in The Bronx

In The Bronx, there are three public hospitals and three private hospitals that provide maternal and birthing services. The following figures present basic indicators of birthing care at each hospital, based on 2019 New York State Department of Health data, as well as a brief summary of each hospital's model of birthing care.

### Jacobi Medical Center

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 1569 | 57.24 | 62.29 | 37.71 | 16.46 |

### North Central Bronx Hospital

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 969 | 65.13 | 69.74 | 30.26 | 15.31 |

North Central Bronx's (NCB) Midwifery Unit was reopened in May of 2019 after closure in August of 2013 for a $2 million renovation. The New York City Council contributed $600,000 to the project. Prior to its closure, the labor unit at NCB delivered about 1,400 babies per year, many through the well-regarded midwife program. The new, larger Midwifery Unit is now co-located on the same floor as the Women's Health Services Unit to improve patient experience and expand access to the hospital's unique midwifery maternal services. The new, relocated unit is placed such that pregnant individuals can easily access prenatal services, and physicians, nurses, midwives, and other clinicians can move seamlessly between services to care for patients in a larger, more modern space. The unit is staffed by **12 doctors**, **53 registered nurses**, **16 midwives**, and **10 physician assistants**, which is over 30% more staff than before the closing. It is estimated that the renovated unit can handle up to **2,000 deliveries per year**, in addition to expanding outpatient care and offering new surgical and fertility services.

### Lincoln Medical Center

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 1417 | 0 | 67.56 | 32.44 | 16.28 |

Lincoln Medical Center provides comprehensive women's health services and OB/GYN care through its Women's Health Center and its labor and delivery suite. Expectant mothers going into labor and delivery are assigned their own physicians and are cared for by a team that includes nurses and counselors. Lincoln's Labor and Delivery Suite offers private and family-friendly rooms equipped with lounge chairs, private bathrooms, and telephones. The postpartum floor has rooming in, single and double rooms with amenities such as a soaking tub and showers. Patients can also receive prenatal services from OB/GYN physicians. Expectant mothers with high-risk pregnancies are provided care in the recently established Maternal Fetal Testing Unit. Lincoln also offers childbirth and breastfeeding classes to mothers and their partners, family members, or friends. Lincoln has been designated as a "Baby-Friendly" hospital as part of the international Baby-Friendly Initiative to encourage hospitals and birthing centers to offer an optimal level of care for breastfeeding mothers and their babies.

## BronxCare Hospital Center

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 1738 | 6.13 | 59.55 | 40.45 | 3.18 |

Bronxcare offers full gynecologic and maternity health services to expectant mothers. Women can receive prenatal care, gynecologic care, family planning, and preventive care. OB/GYN outpatient visits are also provided at BronxCare's Women's Health Center and the BronxCare Health & Wellness Center. The Women's Health Center High Risk Obstetrics program provides specialized services for high-risk pregnancies. BronxCare also has a Birthing Spa, which offers the option of whirlpool delivery baths to expectant mothers. Midwives are also employed at BronxCare and primarily work in the Prenatal Care Program. It involves a total of 10 sessions throughout the pregnancy, each led by a BronxCare midwife.

## Montefiore Medical Center – Wakefield and Jack D. Weiler Hospitals

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 4935 | 0 | 67.14 | 32.86 | 28.35 |

Montefiore has 11 obstetric practices staffed by physicians, midwives, nurse practitioners, nutritionists, and social workers. These practices collectively provide prenatal care, detailed ultrasounds, preconception counseling, Maternal Fetal Medicine (high-risk pregnancy) care, Reproductive Genetics, Family Planning, and ready referral to a host of other subspecialty services as needed. Montefiore is designated as a Level 4 Regional Perinatal Care Center accepting transfers from throughout the region when specialty care is needed. Montefiore Medical Center has two birthing facilities – Weiler and Wakefield. Both hospitals are designated as Baby Friendly.

**Montefiore's Comprehensive Family Care Center has provided midwifery care for a little over 22 years. Midwifery services have recently been added to the Wakefield Campus where they provide labor and delivery services with the support of physicians. Doulas are welcome on both campuses.**

## St. Barnabas Hospital Health System

| Total 2020 Births | % Attended by a Licensed Midwife | % Vaginal Births | % Cesarian Births | % Augmented Labor |
|---|---|---|---|---|
| 751 | 21.51 | 66.67 | 33.33 | 18.44 |

SBH Health System offers full gynecologic and maternity health services to expectant mothers and has been recognized as a national center of excellence in women's health. Care is provided by physicians, nurses, nurse midwives, and social workers. SBH's labor and delivery unit was recently renovated and provides services through physician and midwifery care models. The new birthing suites also offer Jacuzzis for labor and equipment to support high-risk pregnancies. SBH also provides prenatal care, postpartum care, free online childbirth classes, perinatal education resources, and hosts a "Meet the SBH Maternity Care Team" event for expectant mothers and their partners.

**Midwives at St. Barnabas Hospital provide maternity care at all stages of pregnancy, including pre-pregnancy counseling, prenatal care, childbirth planning, labor support and delivery, postpartum care, breastfeeding support, and circumcisions. Since introducing midwifery services, SBH has seen a decrease in the rates of episiotomies. Low-risk pregnancies can be attended by a midwife. Should a pregnancy be high-risk, a physician is involved, but the midwife is still able to assist in care. SBH midwives also provide well-women care.**

## Midwife Services in The Bronx

Midwifery services are offered in both hospitals and private practices in The Bronx. Jacobi Medical Center, North-Central Bronx Hospital, Lincoln Medical Center, BronxCare Health System, Montefiore Medical Center, and St. Barnabas Health System all offer midwifery services at varying levels, from teaching prenatal education classes to providing labor and delivery services. There are also a few private practices that offer prenatal, labor and delivery, and postpartum services in The Bronx.

## Doulas in Bronx Hospitals

Unlike midwives, doulas are rarely integrated into hospital settings. A 2014 report by the non-profit organization Choices in Childbirth found that there was insufficient access to doula care in New York City.[47] Cost was highlighted as one of the main barriers to access, with many doulas in New York City reporting that they often have to turn away clients who cannot afford their services. The report states that a private doula can make up to **$2,800** per birth, with an average of **$1,550** per birth.[48] The Choices in Childbirth report also found that there were not enough doulas to serve the population of New York City, and that women in marginalized communities lacked access to these services.

The landscape for doula services is changing rapidly in New York State. Both Governor Hochul and Mayor Adams have made efforts to make doula services more accessible for pregnant women, through pilot programs and coverage through Medicaid. In 2023, the Governor increased doula reimbursement rates and coverage through Medicaid. In her 2024 State of the State, she also proposed further expansions to doula access through changes in New York State Department of Health regulations. Additionally, data from DOHMH shows that pregnant women in The Bronx are less likely to have access to doulas than women in the other boroughs. Only **1%** of Bronx women had a doula available to them during labor and delivery, compared to over 4% citywide.[49]

## Time is Money

Though hospitals have a large range of services available, the model of managed care has severely limited the time providers are able to spend with each expectant mother. The large number of patients that doctors must interact with, as well as payment structures incentivizing quantity of patients seen over quality of care provided, mean that doctors generally find themselves needing to depersonalize and "*streamline*" care at the expense of the patient.[50]

## What Efforts are Being Made State, City, and Borough-wide to Increase Access to Maternal Healthcare?

Listed below are several initiatives at the borough, city, and state levels to increase access to maternal healthcare.

### New York State Medicaid Efforts

In 2019, New York State began a Medicaid Pilot Program to provide Medicaid coverage for doula services. The program was piloted in Erie County.[51] The program provided doula services for up to four prenatal visits, support during labor and delivery, and up to four postpartum visits. Doulas were required to register as providers with New York State Medicaid and provide verification of successful completion of training requirements. Upon fulfilling the prerequisites, doulas were eligible to enroll in one of the several plans participating in the pilot.[52] More information about the pilot can be found in the appendix.

Initially, there were delays in implementation; the State struggled to find willing doulas to participate due to low compensation. The program reimbursed only $30 for a home visit, and $360 for a labor delivery, well below market rates. Critics feared that this low rate of reimbursement would only attract inexperienced doulas. The New York State Department of Health (DOH) website claims that 1,108 birthing individuals have taken part in the program.[53] 82% of claims have been for prenatal visits, 6% for births, and 12% for postpartum visits. 95% of participants indicated that the program helped with their childbirth, and 93% rated their doula highly.[54]

In 2023, Governor Kathy Hochul signed legislation that would allow doula care to be covered by Medicaid. Under this legislation, Medicaid will cover $1500 in

the city of New York for doula services, as well as $1,325 in the Upstate region. This coverage went into effect on January 1, 2024. The legislation also required the New York State Department of Health to create and maintain an online database of qualified doulas so that New York residents can easily access their services.[55] Further, as of June 10, 2024, the New York State Commissioner of Health issued a standing order expanding access to doula services for all birthing persons in New York. Under this order, doulas may provide physical, educational, emotional, and non-medical support for birthing persons before, during, and up to twelve months after childbirth.[56]

New York State has been making strides to better support birthing persons. Notably, New York has become the first state to expand paid family leave to cover prenatal appointments, allowing workers to take time off without financial strain. Under the updated guidelines, starting on January 1, 2025, eligible pregnant employees are entitled to 20 hours of paid leave in a 52-week calendar period to attend appointments for prenatal care. This includes physical examinations, monitoring, testing, and consultation.

**The Citywide Doula Initiative**

This initiative's initial goal was to train **50 doulas** and reach **500 families** by the end of June 2022.[57] Families who enrolled in the program will receive doula support both at home and in the clinical setting, with three prenatal home visits, support during labor and delivery, and four postpartum visits. Clients who give birth at home will receive the same number of visits. The program will include screening and referrals for family needs and stressors, such as food insecurity.

Seven vendors were chosen to partner in this work, including the Northern Manhattan Perinatal Partnership, which will provide services in the southwest Bronx, as well as Ancient Song Doula Services, Caribbean Women's Health Association, and the Mama Glow Foundation, which will provide services to the rest of The Bronx.

The Citywide Doula Initiative had three main goals:

1. *Provide equitable care:* Doulas would be provided to eligible residents of the **33 neighborhoods** identified by the Taskforce on Racial Inclusion and Equity (TRIE). Priority would be given to people who are income-eligible for Medicaid or are giving birth for the first time (or the first time in over 10 years), as well as those who have had a previous traumatic birth experience, have no other labor support, live in a shelter, are in foster care, or have a high-risk medical condition.

2. *Expand the doula workforce:* DOHMH aimed to train **50** community members as doulas by June 30, 2022 and to provide additional opportunities for professional development. DOHMH also aimed to help uncertified doulas become certified.

3. *Create partnerships with hospitals:* DOHMH aimed to create doula-friendly hospital policies and practices and increase provider referrals to doula services.

According to a December 2023 DOHMH report, as of March 2023, the Citywide Doula Initiative has enrolled nearly 800 women in doula services and trained 62 community members as doulas.[58] Although this citywide effort promises to address inequities and expand community-based doula support, it should be noted that none of the providers in this program are Bronx-based. Not only does this present a huge accessibility challenge for low-income families and communities of color, but also raises concern for the lack of priority toward historically underserved neighborhoods in The Bronx.

**The New York Coalition for Doula Access (NYCDA)**

The NYCDA is a private nonprofit formed in 2011.[59] The NYCDA expands access to perinatal and doula support, with a particular focus on communities that are at greatest risk for poor outcomes. In collaboration with DOHMH, the NYCDA helped develop the Principles of Doula Support in the Hospital, which defines a doula, the scope of their services, and seven characteristics of a doula-friendly hospital. The NYCDA continues to work to ensure that doulas have a voice in addressing birth equity in New York State.

**The Midwifery Initiative**

In March 2022, Mayor Eric Adams announced The Midwifery Initiative.[60] This initiative is multifaceted and consists of creating a steering committee of midwives and birthing stakeholders to review data and formulate plans regarding birthing care, the implementation of assessment tools in hospitals to monitor indicators of maternal health, and the facilitation of cross-training among birthing professionals. The results of the initiative are yet to be quantified.

**The Maternity Hospital Quality Improvement Network (MHQIN)**

The MHQIN is a city-based community initiative to prevent and reduce disparities in maternal mortality and severe maternal morbidity.[61] The MHQIN's aims are threefold. First, it aims to enhance clinical practice through severe maternal mortality case reviews and to promote surveillance of maternal mortality and severe maternal morbidity in New York City. Second, the MHQIN strives to support anti-racist hospital systems, with a focus on addressing implicit bias and structural racism and the integration of doulas into the birthing team. Third, the MHQIN aims to promote patient advocacy and empowerment by increasing access to health promotion programs through the Neighborhood Birth Justice hubs and connecting expectant mothers with community-based doulas and services.

**New York City Neighborhood Birth Justice Hubs**

The Neighborhood Birth Justice Hubs provide sexual and reproductive health education and advocate for sexual and reproductive health equity and justice for all city neighborhoods.[62] With one to two Hubs located in each borough, these Hubs provide community members and expectant mothers with evidence-based reproductive health education, connect birthing individuals to healthcare providers and birthing professionals, and teach expectant families how to advocate for respectful care throughout pregnancy and early motherhood. In The Bronx, the Neighborhood Birth Justice Hub is The Bronx Health Link, located at 851 Grand Concourse, Suite 914.[63]

**The Bronx Health Link**

The Bronx Health Link (TBHL) was founded in 1998 through a collaborative effort involving The Bronx Borough President's Office, Montefiore Medical Center, Bronx-Lebanon Hospital Center, Our Lady of Mercy Center, and St. Barnabas Hospital.[64] TBHL conducts an annual community needs assessment of residents' health situations as determined by a survey and a series of focus groups and community forums. The assessment engages thousands of residents, healthcare providers, schools, researchers, community-based organizations, government agencies, and policymakers in pursuit of better health outcomes for residents of The Bronx. Since 2001, TBHL has received numerous grants from the City Council's Infant Mortality Reduction Initiative and New York State's Comprehensive Perinatal and Prenatal Services Network to coordinate health and human service providers who engage in activities that promote maternal and infant health. Additionally, TBHL provides educational workshops on healthy pregnancy, postpartum depression, safe sleep, and breastfeeding classes.

TBHL is also The Bronx Hub for the City Birth Justice Defender Initiative, which helps empower residents to advocate for respectful maternity care. This initiative is a collaboration with DOHMH. In 2021 then-Councilmember Vanessa L. Gibson allocated **$324,000** of her discretionary funding to TBHL for the expansion of their perinatal education and free doula services.

### The Bronx Maternal Health Consortium

In October 2022, Bronx Borough President Vanessa L. Gibson launched the Bronx Maternal Health Consortium (BMHC). Born out of The Bronx Borough President's Black Maternal Mortality Taskforce in 2020-21, the BMHC is committed to addressing maternal mortality and improving maternal health of all communities in The Bronx through policy, advocacy, and diversifying birthing care in the borough.[65]

The BMHC's main objective is to bring together a borough-wide body of public and private entities that provide maternal health services across The Bronx to share resources and increase access to such services. The BMHC consists of representatives from community-based organizations, government agencies and offices, and all Bronx public and private hospitals. In establishing this community of stakeholders, the BMHC is poised to spearhead a network of equitable health services and to advocate for the rights and needs of Bronx mothers at clinical, community, and policy levels. The BMHC is especially committed to dismantling the severe health disparities that cause disproportionately poor health outcomes among mothers in communities of color. The Co-Chairs of the BMHC are Dr. Chinyere Anyaogu MD, MPH, FACOG, Deputy Chief Medical Officer of New York City Health + Hospitals/Jacobi and North Central Bronx, and Dr. Deborah Campbell, MD, FAAP, Chief of the Division of Neonatology at the Children's Hospital at Montefiore.

### WOMB Bus

Founded by Myla Flores as an innovative response to New York's challenging regulations for Birth Center licensure, Womb Bus is a creative alternative to transcend systemic health inequalities impacting families in The Bronx by centering community care. The Womb Bus is run by a team of BIPOC doulas and birthing professionals serving families and their needs throughout their reproductive lifespan, while actively taking steps to create a safe, serene, and deeply supportive birth center, a valuable and necessary option for more New Yorkers. The Womb Bus receives financial and operational support from the Save-A-Rose Foundation, the Monarch Foundation, The Bronx Health Link, Black Women's Blueprint, and community donations. The Womb Bus has worked with over 800 families since its inception in 2022.[66]

*WOMB Bus outreach at a community baby shower*

**Maryam Clinic**

Maryam is a reproductive health and wellness clinic being incubated with support from The Birthing Place Foundation, which also supports Womb Bus. Maryam will serve Norwood and surrounding neighborhoods with person-centered and culturally responsive reproductive healthcare, professional services, special programs and workshops all provided by a diverse team of doctors, midwives, doulas, and other providers.

**Bronx Doula Access Project**

The Bronx Doula Access Project aims to increase access to doula services across The Bronx.[67] In partnership with TBHL, The Birthing Place, Womb Bus, Ashe Birthing Services, and Conscious Birth Collective, the Bronx Doula Access Project offers free childbirth education and doula services for expectant families in The Bronx. The Project is sponsored by The Bronx Delegation of the New York City Council, the Council's Women's Caucus, and Bronx Councilmember Althea Stevens.

## What is the Current Landscape of Birthing Centers in New York?

A birthing center provides health services before, during, and after birth through a midwifery and wellness model. Birthing individuals can determine their preferences for delivering their baby and can receive patient-centered guidance from multidisciplinary birthing professionals to create an individualized birthing plan. Birthing centers provide pregnant women with an environment that centers them in their birthing process, in a less medicalized and more holistic manner.

There are three birthing centers in New York State, two of which are in New York City:

**The Brooklyn Birthing Center (BBC)** is a freestanding birthing center in Brooklyn. The BBC was opened in 1999 by Dr. Norma Veridiano, the center's current medical director, and Dr. James Ducey. The center offers women's health services, prenatal care, labor and delivery services, lactation classes, and other maternal health services. Clients are transferred to Maimonides Hospital or Mount Sinai West for other levels of care and in emergencies. The cesarean section rate is 14%.

**The Birthing Center of New York (BCNY)** is a freestanding birthing center in Brooklyn. BCNY was founded in 2017 by Dr. Lisa Eng. Antepartum services are provided by New Life Medical Esthetics, Wellness and OB/GYN. BCNY also offers classes by lactation consultants and childbirth specialists. Clients are transferred to Maimonides Hospital or Brooklyn Hospital Center in cases of emergencies. The Birthing Center of New York has a cesarean section rate of 0%.[68]

**The Birth Center of Buffalo (BCB)** is a freestanding birthing center providing reproductive care in Buffalo, NY. The Center opened in 2014 and is currently directed by Dr. Katharine Morrison. The Center has a transfer agreement with Oshei Children's Hospital and its physician director has admitting privileges at all the Kaleida Hospitals.[69] The physician director has made contracts with Independent Health and Blue Cross Blue Shield, so that the Birthing Center of Buffalo is in network with those insurers.[70] The Center also has contracts with Managed Care Medicaid for both of those private insurers. The Birth Center of Buffalo has a cesarean rate of 14%.

New York has several other private midwifery practices across the state, including in Monsey, Waverly, Buffalo, Brooklyn, Burdett, Monroe, Spring Valley, and Ithaca. These practices are generally also staffed by licensed midwives, nurses, lactation consultants, and childbirth educators. Other than the 3 licensed freestanding birth centers in New York described earlier, all other private midwifery-run birth centers in New York have not yet received New York State licensure and thus will only charge fees for staff services, not a facility fee.

*Birthing room at The Brooklyn Birthing Center*

## Lessons from History

Over the past three years, staff from the Office of The Bronx Borough President have spoken with midwives and other birthing professionals who have worked at birthing centers throughout New York, including those previously employed at birthing centers that have closed, as well as those who work at New York State's remaining birthing centers. These professionals, who spanned a variety of positions and backgrounds, shared their experiences with birthing centers, both the successes that demonstrate the value and necessity of birthing centers as well as the challenges. These individuals include those who worked or received services at the now-closed Childbearing Center of Morris Heights, the Brooklyn Birthing Center, the Birthing Center of New York, and the Birth Center of Buffalo, as well as those who are trying to open new licensed birthing centers in New York.

While there are currently no birthing centers in The Bronx, the borough has a storied history with this model of care. From its 1988 opening to its 2012 closure, the Childbearing Center of Morris Heights was the first licensed out-of-hospital, midwifery-run childbearing center in a low-income community in the country.[71] From its location in the West Bronx, expectant mothers who were identified as having a low-risk pregnancy were able to receive all their prenatal care from midwives with an OB-GYN available for emergencies or consultations. During the center's years of operation, the Director of Midwifery was Dr. Jennifer Dohrn, a certified nurse-midwife. The midwives provided prenatal care, performed deliveries, and neonatal physical exams, and saw their patients back within three days after delivery. Visiting nurses were on staff to make daily home visits to the mothers and infants in the days leading up to the first follow-up visit. There was an established connection to BronxCare Health System (formerly Bronx Lebanon Hospital) for any complications or emergencies, including cesarean sections.

Furthermore, during interviews, birthing center staff spoke about how a birthing center can be a culturally competent and affordable alternative to hospitals and provide healthcare access to communities with ingrained medical mistrust, especially for expectant mothers of color. Those from diverse religious and cultural backgrounds also gravitate towards these centers because birthing centers offer options to incorporate specific cultural practices requested by members of these communities into their maternal care plan. This, combined with the lower costs and lower rates of caesarian sections, show that these birthing centers bring real value to those who use them. Birthing centers become a part of the local community. Workers at both existing and now-closed birthing centers

*Waiting area at the Maryam Clinic*

all shared anecdotes about how they became integrated with the community that they served. One recalled how they put up teddy bears in the lobby, and each teddy bear had a small sign with the name of a child who had been born there. Others described how parents who had given birth at their center and lived in the neighborhood would walk by with their children and check in from time to time. These stories demonstrate the value of a dedicated birthing center in emotionally connecting with local residents.

Rosie Hernandez is a perinatal educator and certified lactation counselor at The Bronx Health Link. A mother herself, she has given birth in a hospital setting and in a birthing center. In an interview with staff from the Office of The Bronx Borough President, she recalled how birthing in the hospital felt rushed and overmedicalized and made her feel helpless.

"I became a patient, as opposed to an individual who was giving birth for the first time. Many of my requests were not honored and I didn't know what to advocate for, I just knew that I could do it by myself if they believed in me, but I didn't get that," she said. "Hospital policy would not let my husband be with me during the epidural procedure."

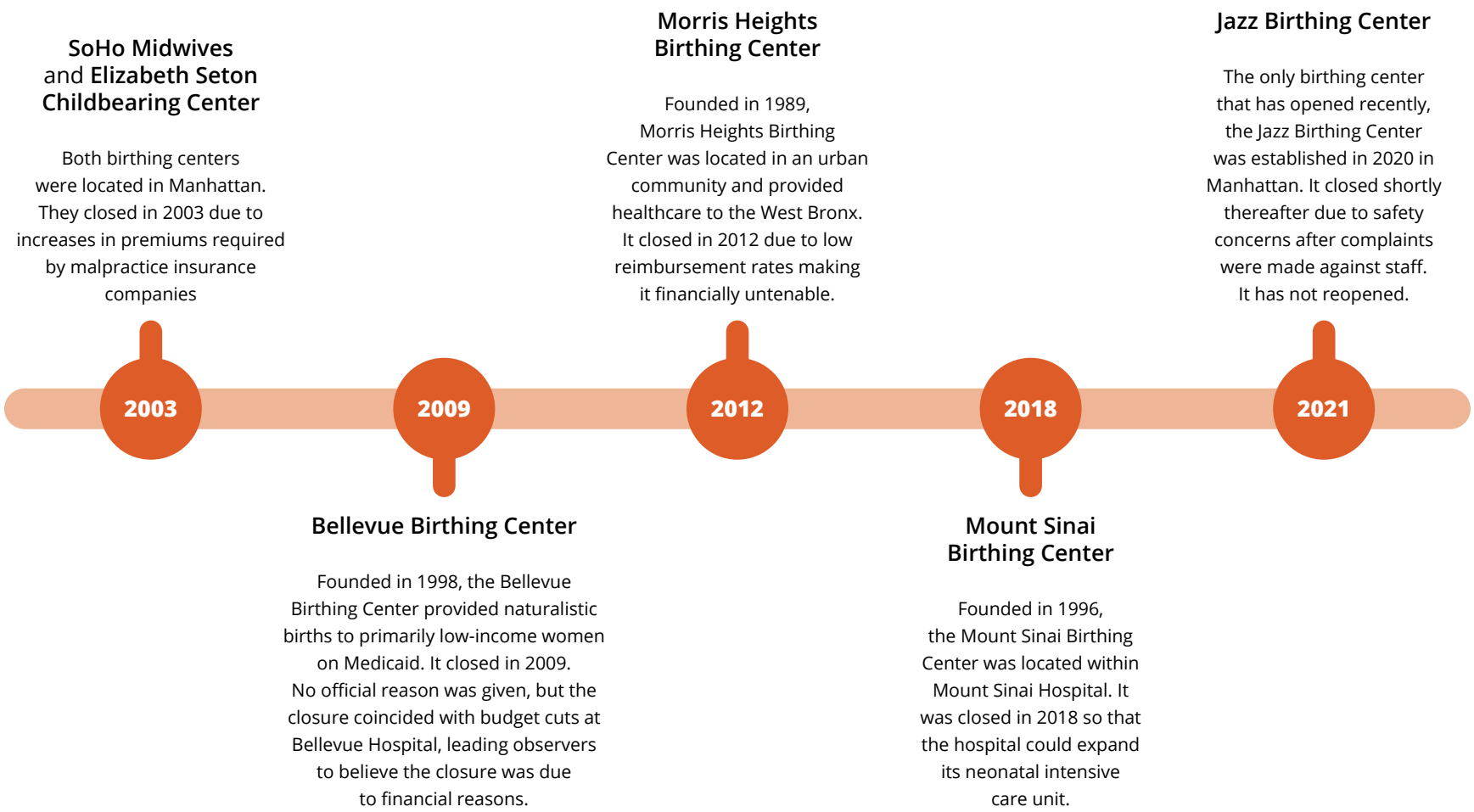
Contrasting that with the care she received at the Childbearing Center of Morris Heights, Hernandez explained, "The model of midwifery care is so different. The doctors aren't in the driver's seat, the mother's body is in the driver's seat. I was able to move; I listened to my body. I labored in my grandmother's nightgown; I wouldn't have been able to do that in a hospital. There were no restrictions. Families should have options; they have a voice and should be listened to."

The Baldwin-Carrion family had such a supportive and stellar experience at Morris Heights Childbearing Center; they delivered all three of their children at this facility. This perspective reflects global attitudes toward pregnancy in most nations outside of the U.S. Linda Baldwin recounted that what differentiated the birthing center was the warm and serene space for mothers, which reduced stress and anxiety and cultivated a calm and focused frame of mind for the delivery. The clinic environment offered patients physical, social, and emotional comforts through their labor and allowed the delivery to follow a natural progression without time constraints. Most important was the fact that family members were welcomed and allowed to participate in this arduous but joyous journey.

Additionally, this midwifery model rests on the development of a close longitudinal relationship with the provider from the prenatal screenings and wellness checks to the critical post-partum visits that monitor how the family deals with mental and physical adjustments to becoming a new parent and ensuring that mother and baby are thriving. In retrospect, their motivation to choose this type of birth was captured by the former first lady of The Bronx: "People go to the hospital when they are sick, and pregnancy is not an illness!"

## THE DISAPPEARANCE OF BIRTHING CENTERS

**While the nation has seen growth in the number of birthing centers in recent years, New York City has seen the number decrease. In most cases, the cause of the closure was due to financial problems.[72]**



## The Case for a Birthing Center

There is no single solution to the maternal mortality crisis; however, what this analysis shows is that there is a critical need for investment in The Bronx to address the maternal health crisis. The various city and statewide initiatives previously described will certainly have a positive impact on maternal health in the state and city. However, these individual investments work as separate entities, and it may be difficult for expectant mothers to navigate and access all of them without a high level of health and financial literacy. There is a significant unmet need for a single accessible location in The Bronx where expectant mothers can access all maternal health services and social support.

A birthing center is not only a place for delivering babies but is also a hub for education and community outreach. Maternal health literacy and health literacy in general significantly affect health outcomes for mother and baby. As seen in Figure 4, the data shows that many young women, especially in The Bronx, do not have sufficient access to prenatal care to provide them with the information they need to prepare for childbirth. Bronx mothers should be given a fair opportunity to access individually catered support, outreach, and educational services. They deserve the same respect and treatment as any other woman.

A birthing center offers residents of communities that have been disproportionately impacted by decades of medical neglect a voice in their pregnancy journey, the chance to have someone who understands them, and the possibility to have family involvement as part of a social support network at the birthing center. Such a center could act as a central hub providing modern care with a personal touch, to prevent pregnancy complications, to coordinate education and outreach efforts, and to offer expectant mothers with low-risk pregnancies a culturally sensitive and low-stress place to give birth. It is essential to provide a diversity of options for care, so that each expectant mother has the ability to choose the best option for herself and her family.

Furthermore, a birthing center located in The Bronx, particularly one that is catered to populations that suffer from high rates of poverty, would be a step towards a more equitable distribution of healthcare in the city. More women are opting for the holistic care model offered by birthing centers as evidenced by their growth in the United States in recent years. Bringing a birthing center to The Bronx would give marginalized populations access to the same amenities that more affluent groups benefit from and would improve birthing healthcare in New York City.


**The creation of a birthing center alone would not solve the maternal mortality crisis, but it would be an important step toward getting women the care, knowledge, and advocacy that they are currently unable to attain.**

Leaders in healthcare and policy must pursue holistic strategies that will tackle the underlying causes of maternal deaths, while also engaging with new patient-centered solutions. The following section of this report will expand upon the laws and regulations related to creating a birthing center and the challenges of maintaining a birthing center in New York State.


The Bronx
Needs MIDWIVES!
Deserves
Wants

# THE REGULATORY ENVIRONMENT

A large part of community value comes from the dedication of the workers. However, doctors, midwives, and other staff all admit that there were serious challenges to keeping their operations running. The regulations placed on birthing centers reduce profit margins and increase barriers to staying open. This is one of the reasons that the number of birthing centers in New York has not kept up with national trends. This section will examine the regulatory requirements placed upon birthing centers in New York City and how existing birthing centers adapt to them.

## Current New York State Laws for Birthing Center Operation

In order for a birthing center to legally operate in New York, it must follow Section 2803 of the Public Health Law and be regulated by the State Hospital Code found in Sub-Chapter C of Title 10 Department of Health, Chapter V Medical Facilities of the New York Codes, Rules and Regulations.[73] The laws identify two categories of birthing centers: birth centers, which are directed by physicians, and midwifery birth centers, which are directed by midwives. This report focuses on the establishment of a midwifery birth center, which is regulated by Article 10, Part 795 of the State Hospital Code.[74] **The main provisions of the law are:**

1. Only patients at low risk are admitted and cared for at the midwifery birth center. Written policies, procedures, and standard risk assessment criteria for determining low-risk pregnancies based upon generally accepted standards of practice must be developed and implemented.

2. Services are provided by a licensed midwife to patients at low risk, during pregnancy, labor, delivery, and who require less than 24 hours of supervision after birth.

3. Birthing centers must be open 24 hours per day.

4. Midwifery birth centers shall have written plans and procedures for the transfer of patients to the obstetrical or pediatric services of the receiving hospital(s) when complications arise.

5. Surgical procedures are limited to those which may be performed during and after an uncomplicated childbirth, such as episiotomy and repair.

6. The birthing center operator must ensure that at a minimum emergency

equipment and supplies approved by the midwifery birth center director are available for use for resuscitation of both adult and neonate patients.

7. The operator of the birthing center must appoint a director who is a licensed midwife or physician. The director may appoint a consultant physician who is available for consultation and referral. The director also ensures that the midwifery birth center has collaborative relationships with one or more licensed physicians and pediatricians and has transfer agreements with perinatal centers.

8. Trained and qualified staff must be available to educate and assist patients to initiate breastfeeding.

9. Certain services, including laboratory, radiology, and family planning, must be available either on-site or by referral.

Those opening a birthing center must submit a Full Review Establishment with Construction Certificate of Need (CON) application through the New York State Electronic Certificate of Need (NYSE-CON) system for review and approval by the state Department of Health (DOH).[75]

Once a CON is submitted, DOH must evaluate it and present its recommendation to the Establishment and Project Review Committee of Public Health and Health Planning Council (PHHPC), which will provide approval. DOH must issue final approval before the facility's operating certificate is awarded.

The CON application process places strict regulations on birthing centers, creating high standards for entry. Such regulation is understandable, as it prevents low-quality health centers of any kind from proliferating. However, the current regulations may be making establishment of birthing centers almost impossible for aspiring entrepreneurs.

*Labor and Delivery Nurse demonstrating water birth facility at The Birthing Center of New York*

One example of the difficulty the CON process places on potential birthing center operators is the experience of Trinisha Williams. Williams is a trained and experienced midwife who has been trying to open a birthing center in Brooklyn, but she has been unable to complete the CON application process.

In an interview with staff from the Office of The Bronx Borough President, she detailed how the process requires that she have a year's worth of capital upfront. Moreover, Williams explained how under working capital guidelines, a birthing center must estimate its third-year expenses and show that it has two months of that budget on hand before it opens its doors to clients and only half of that capital can be borrowed. It is unlikely that birthing care providers attempting to establish birthing centers will be able to meet these sorts of financial demands.

Finding an adequate space in which to operate proves difficult from a financial perspective as well. The birthing center must meet several architectural requirements including being accessible to disabled individuals, having a kitchen space, meeting minimum space requirements, and more.[76] This space also must be able to transport a patient to a hospital within 20 minutes, per state regulations. This means that those hoping to open a birthing center must find a pre-existing affordable space that already meets all the building requirements or be faced with high costs of remodeling. Williams pointed out that some existing birthing centers do not even meet these requirements but received their CONs years ago when regulations were not as stringent.

Even with an identified space that meets the requirements, a potential birthing center founder must have that property reserved when starting the application process but cannot begin operation until after the CON has been obtained.[77] This means a prospective birthing center entrepreneur would have to pay rent for their space for months with no source of income and no guarantee that they will even be approved.

"I'm a midwife; I can deliver babies. I just can't do it at a facility until it's regulated by the city," Williams explained. "If I have an address and I told the state I want to deliver babies there, I need to pay rent or own the building until [the certificate of need] comes through. That's where the challenge starts, it's one of the biggest barriers. I am a midwife. I can't afford $9,000 worth of rent a month to not offer a service. I just can't."

Williams is not alone in this struggle. Doula and birthing healthcare activist Myla Flores shared in her interview with staff from the Office of The Bronx Borough President that she conducted an informal "Freestanding Birth Centers in New York State" survey of 14 midwives, doulas, and childbirth educators in New York who want to open a birthing center. Twelve professionals completed the survey, all of whom work in in-home settings, private midwifery practices, or hospitals. Of those who completed the survey, ten professionals said that state regulations, the CON process, or upfront costs are primary barriers to opening a birth center.

In these interviews, the birthing professionals expressed that the application process itself is opaque and difficult for those without the training to navigate it. Moreover, despite the vast responsibilities that the PHHPC has in approving CONs for all healthcare facilities, including for birthing centers, there are no midwives on the Council. This suggests a significant gap in the representation of diverse professionals working in birthing care and ultimately allows the CON process to favor larger health facilities. Hospitals and other institutions with large amounts of funding overcome the CON's challenges by hiring specialists to undertake the rigorous application process.

The regulations and requirements placed on birthing centers to get a CON are based on the underlying assumption that they are like large health centers and hospitals. The application process assumes access to resources and capital at a scale that is beyond the scope of nascent birthing centers. Given freestanding birthing centers' thin margins and low levels of capital during their early years, the challenging CON requirements are fatal to the prospects of opening new birthing centers in New York.

However, not all of those who were interviewed for this report agreed that the CON application process is burdensome or a significant factor for the dearth of birthing centers in New York. Dr. Katharine Morrison of the Buffalo Birthing Center emphasized that it is insurance reimbursements, and not the CON process, that prevents birthing centers from opening and staying open.

"New York State was very reasonable. They only are interested in safety. They were extremely accommodating." Dr. Morrison said of her own CON application process.

Dr. Morrison expressed concerns that relaxation of CON standards could lead to unsafe birthing centers. She argued that money, not the CON process, is the reason for the failure of birthing centers. Until insurance companies pay reasonable rates for the work done at birthing centers, those centers will continue to struggle, regardless of the CON requirements.

Regulation is necessary to keep women who use birthing center services safe and healthy. Lax regulations that lead to low-quality birthing centers would not serve the community. However, regulations that effectively bar the creation of new birthing centers are equally inefficient. There must be a streamlined and supportive process that equitably allows for birthing centers to enter the market at a price point relative to their expected revenues.

"I am not against regulation," Williams said, "but the standard of regulation is so high that midwives cannot move forward."

## Malpractice Insurance

Malpractice insurance is another costly barrier to entry. Birthing centers, like all healthcare providers, must have insurance against malpractice lawsuits. Hospitals and other more well-funded health centers can purchase malpractice insurance at discounted rates due to their size. The size of hospitals also allows insurance costs to be relatively small compared to the amount of money moving through the system. By contrast, birthing centers are smaller and operate on much thinner margins, causing the cost of malpractice insurance to be relatively large when compared to potential revenues. A 2009 study by the American Association of Birth Centers identified high malpractice insurance rates as a principal obstacle to birth center sustainability.[78]

Nearly all birthing care professionals who contributed their experience to this report highlighted malpractice insurance as a major source of financial strain. One reported that malpractice insurance costs roughly **$58,000** per year while another said their annual cost was **$124,000**.

## Recent State Efforts to Amend Birthing Center Regulations

In January 2022, Governor Kathy Hochul signed a bill to streamline the process of applying to open a birthing center.[79] The initial bill the Legislature passed the previous May largely stripped away New York's onerous requirements and allowed any birthing center applicant with accreditation from the Commission for the Accreditation of Birth Centers

(CABC) to be approved, aligning with national standards for birthing centers. The goal was to ensure that an entrepreneur would be able to fast track their application so long as their center met the standards of the CABC, sidestepping the most burdensome regulations.


Governor Hochul sparked controversy when she added last-minute chapter amendments to the bill.[80] These amendments allowed the DOH to overlay additional criteria on top of national accreditation, including evidence of the capability to fund renovations and construction costs, as well as life, safety, and building standards. The amendments also stated explicitly that some of the standard requirements for an Article 28 license, like an assessment of an owner's "character and competence," will apply.

Activists argue that this may lead to an application process that is just as obtuse as the previous one. Since the signing of the bill, no new birthing centers have been opened.

Speaking about the law, Williams said "[In January 2022] they passed the law that said, 'We'll change the Certificate of Need [process]. We'll make some compromises so that all these stringent rules don't apply to birthing centers.' They said, 'Give us ninety days and we'll get back to you.'" Advocates continue to urge the state to streamline regulatory processes for establishing new birth centers and support legislative efforts that enhance birth center access.

In the summer of 2023, DOH announced proposed changes to their regulations overseeing perinatal services, perinatal regionalization, birthing centers, and maternity birthing centers.[81] These changes were made based on the recommendations of 49 experts, as well as several subcommittees that met to discuss the state of birthing care in New York State. The proposed changes had the stated goal of ensuring a safe environment for patients through the implementation of safe practices and training in cultural competency, all while having a negligible effect on the cost of providing birthing care.

Despite these goals, the American Association of Birthing Centers released a letter criticizing the proposed regulation changes.[82] The letter argues that the proposed changes are not in line with the best practices suggested by birthing center accreditation agencies and groups.

In her 2024 State of the State Address, Governor Hochul again raised the issue of the CON process as a burdensome hurdle for owners of small healthcare businesses. Governor Hochul called on the New York State Department of Health to update its CON process to account for this. The proposed changes would create a less cumbersome CON application process for those projects that fall below a certain financial threshold.

Although CONs were initially implemented to control healthcare costs and prevent unnecessary healthcare facilities from being created, states with CON processes have higher average healthcare costs than those without them.[83] CON processes in many cases act as impediments to new healthcare facilities being opened, which is why states with such processes have fewer hospitals than those without as well as higher levels of mortality by some estimates after controlling for other factors.[84]

For this reason, in the last 40 years, 15 states have repealed their CON requirements.[85] West Virginia, facing its own lack of robust maternal healthcare, passed a law in March 2023 repealing the need for birthing centers to obtain a CON in order to open.[86] In their letter critiquing the proposed 2023 regulation changes, the American Association of Birthing Centers advocated exempting birthing centers entirely from the CON requirement in New York State, citing the dearth of new birthing centers as evidence that the current system is not serving the needs of New Yorkers.

## Making "Impossible Math" Work

In a 2019 article "Impossible Math: Financing a Freestanding Birth Center and Supporting Health Equity," Dr. Katy B. Kozhimannil detailed how birthing centers are struggling to stay open for a variety of reasons.[87] The main challenge is financial: insurance reimbursement rates are far too low for any birthing center to make financial sense.

Nationwide, half of births to low-income women are covered by Medicaid, which reimburses health services at half the rate of private insurers. This is exacerbated by the fact that hospitals charge more for the same services in cases of uncomplicated births. In 2010, freestanding birthing centers charged only an average of **$2,227 per birth** while hospitals charged **$10,166**. Beyond this, birthing centers often offer birth-related services that are not billable, such as facility fees for the infant. This point was supported by Trinisha Williams,

who described how much of her job involved being on call with her clients answering clinical questions, providing health education, and offering emotional support, none of which is billable.

Additionally, reimbursement payments go to the facility where the child is born. If a freestanding birthing center must, for medical reasons, transfer the pregnant mother to a hospital, where she then gives birth, then the hospital collects the reimbursement from insurance companies instead of the birthing center. Dr. Katharine Morrison, the owner and sole provider at The Birthing Center of Buffalo, spoke about the frustration of spending months with an expectant mother only for the bulk of the payment to go to the hospital. "I have had to turn many people away because their insurance will not pay and been 'stiffed' in many other cases. For example—for 9 months of care, 10 classes of 2 hours in length, many hours of attendance in labor, 3 home visits, 6 weeks of postpartum care—Medicaid BCBS pays $5,500. That's fine. [However,] if the patient transfers to the hospital for epidural or medical issues that make out-of-hospital birthing inappropriate, and I go to the hospital with her, I receive $1,750. I've already paid the birth assistant $500 for the hours at the Birth Center, not to mention the classes, etc. The insurers' rationale is that they are paying the hospital the facility fee, so they only owe me the professional fee. I do not break even on that patient."

Cost challenges were echoed by other birthing care professionals across the state who are trying to start licensed birthing centers or are running private midwifery practices. Eight of the 12 midwives, doulas, and childbirth educators who completed the "Freestanding Birth Centers in New York State" survey created by Bronx doula Myla Flores identified low insurance reimbursement rates and rising costs of medical malpractice insurance as major challenges to starting and maintaining a birthing center.

*Water birth tub at The Brooklyn Birthing Center*

The experiences of New York's birthing professionals are indicative of a system in which the per-birth reimbursement is woefully inadequate compared to the costs of running a birthing center. The current framework favors a higher volume of births (with less attention paid to each individual person) or towards raising fees on expectant mothers to the point that only the very wealthy can afford birthing center services.

As a result of this, new licensed birthing centers are not opening, and hospitals are closing their birthing centers. Mount Sinai closed its birthing center in 2019 to create more space for private-pay postpartum rooms. While this may have been a sensible financial decision for the hospital, this decision leaves New Yorkers with fewer options for childbirth with low chances of medical intervention. The remaining birthing centers are not affiliated with any hospitals and their managers have control over their fates.

Dr. Norma Veridiano, an obstetrician-gynecologist (OB-GYN) and the president of the Brooklyn Birthing Center, expressed difficulties finding and retaining workers, since trained midwives working at the Brooklyn Birthing Center are required to put in long hours. Many find that they can find better-compensated or less-taxing work elsewhere and leave.

The Brooklyn Birthing Center would be able to retain workers by paying them more or hiring more workers to lessen the workload for each individual person. However, they are financially constrained by the amount of reimbursement they receive from health insurance companies.

Trinisha Williams, who had previously worked for the Brooklyn Birthing Center, explained how the aspects of a birthing center that differentiate it from a hospital experience, such as the one-on-one relationship and the personal care,

are the very things that cannot be billed to an insurance company. "When [the patient calls] and I'm on the phone for 40 minutes talking about her diet, her exercise, I'm not going to get reimbursed for that. I can talk to her about what she should be eating, treat her, give her the medication, and that's 40 minutes that you can't see a patient in the office," Williams explained.

Birthing centers in The Bronx closed for very similar reasons, according to Dr. Jennifer Dohrn, a certified nurse-midwife and nurse practitioner serving as a Professor at Columbia University School of Nursing. In addition to being a nurse-midwife and nurse practitioner, Dr. Dohrn has a doctorate in nursing and was the Director of Midwifery at the now-closed Childbearing Center of Morris Heights.[88] During her years at Morris Heights, Dr. Dohrn explained that the Center had an impressive record of health indicators. The cesarean section rate for women who were transferred to hospitals was 9%. She compared this with the overall rate of 35% for New York City, although she stressed that some of this was a result of the Center only treating low-risk pregnancies. There were no maternal deaths during her time there, and fewer than five babies died after the transfer of a mother to a hospital. Of the babies born at the center, there were no deaths.

Despite the center's positive outcomes, Dr. Dohrn recalled a struggle to bring in enough money from the reimbursement for each birth. "We fiscally became a burden to the health center because the birthing center was not able to sustain itself economically. [...] After 24 years, they said the births weren't bringing in enough money to cover the costs and be fiscally solvent and we were closed."

*Tree of Births at The Birthing Center of New York* ►

## IMAGINING A BIRTHING CENTER

The current operation model for birthing centers is not financially sustainable for most private operators. A new incentive structure would encourage more private actors to enter the space. Another possible solution is to create a public birthing center through the public hospital system.

This public birthing center would be built on the property of or adjacent to an existing public hospital. Having a public birthing center connected to the hospital is crucial because, in emergencies, patients could be transferred to the hospital quickly and with ease. However, the birthing center would not be a wing or a floor within the hospital; it would have a clear, delineated separation from the hospital, with a public-facing entrance so that patients could enter without going through the hospital lobby. This is important because many of the interviewees stressed that the value of birthing centers comes from ways in which they are seen as separate from hospitals and as a part of the community. One former birthing center employee spoke about the way in which members of the community would drop in unannounced for a quick chat. This type of community engagement is crucial to the success of a new birthing center, which may not be possible if it is located inside a hospital.

The physical distinction between the birthing center and the hospital would also make clear the division in healthcare models. As opposed to the hierarchical model associated with hospitals, the birthing center would embrace a collaborative care model. The patient would be in communication with a team of maternal healthcare professionals, each with their own focus but all working in collaboration with each other.

This public birthing center would be a central hub for pregnancy-related education and community outreach. It would provide labor and delivery services for low-risk pregnancies, diverting low-risk cases out of maternity wards, allowing those facilities to dedicate more time and financial resources to treating high-risk pregnancies. Beyond this, the birthing center could offer a host of prenatal, postpartum, and educational services to expectant mothers and families, individualized to pregnancies of any risk level. According to interviews, diversifying services beyond labor and delivery would increase the revenue stream for the birthing center, improving its financial status. With these comprehensive services, the birthing center would help create a more robust maternal healthcare outreach and support network and would become an important part of the birthing healthcare ecosystem in The Bronx.

*Family **(top)** and birthing room **(bottom)** at The Birthing Center of New York.*

This birthing center would have amenities similar to other birthing centers in New York City. There will be rooms in which to give birth, some of which will be equipped with birthing tubs. It is important that the rooms have a comfortable, home-like aesthetic, a distinguishing feature of birthing centers.

The staff would include midwives and nurses, with at least one OB-GYN physician on-call at all times. Doulas may accompany expectant mothers to all birthing center visits and the delivery, and the birthing center would be prepared to refer expectant mothers to doula services if requested. Other professionals, such as lactation consultants, childbirth educators, physician assistants, and nurse practitioners, may also work for or be affiliated with the birthing center. Many people who work at birthing centers are qualified to fill multiple roles, such as a nurse who is also a lactation consultant. See the appendix for definitions of various birthing care professionals and their scopes of practice.

While it is important for this birthing center to be built adjacent to and have a relationship with a hospital, its services, operations, and finances must be managed separately. Almost all birthing centers run by hospitals were eventually closed. The birthing centers which are still open are all run by physicians who are invested in the mission of the birthing center, not the returns. As such, a birthing center in The Bronx must be run by a physician or midwife committed to the mission of providing birthing services.

*Babies born at The Child Bearing Center of Morris Heights*

# A PATH FORWARD: POLICY RECOMMENDATIONS

New York City must take steps to address the shortfall in affordable birthing services for all. All New Yorkers have the right to a safe and equitable birthing process in which their experiences and needs are centered and respected. There must be steps taken to allow for the creation of a public birthing center and for private entrepreneurs to join the market and provide their services, including:

## Improve Birthing Center Funding

One of the major issues facing birthing centers is their inability to maintain themselves through their current revenue streams. The birthing center providers interviewed for this report all cited issues with insurance reimbursements, malpractice insurance, and staffing costs. Tackling each of these issues is essential to achieve stability of birthing center operations.

The State should make birthing center services mandatory for coverage in health insurance policies in New York. This would eliminate a strong barrier to entry for birthing centers that have trouble working with insurers. This insurance mandate should include both services provided as well as a facility fee. The birthing center should be reimbursed regardless of whether a patient has been transferred to the hospital. It unduly burdens birthing centers when they provide healthcare to a pregnant woman for months just to lose out on a large part of their reimbursement if complications arise and a hospital transfer is required.

The State should provide subsidies to reduce the cost of malpractice insurance for small providers such as birthing centers. While malpractice insurance is necessary for all medical providers, the cost cannot be so prohibitive as to prevent their operation entirely. The cost of malpractice insurance should be relative to an establishment's revenue.


Birthing centers are less expensive on average and result in fewer costly cesarean sections. Ensuring pregnant individuals receive prenatal, perinatal, and postnatal care at birthing centers will result in less unnecessary spending on healthcare, which in turn will save the city and state money. Given this calculus, it is in the financial interest of the government to have more birthing centers available. Subsidizing the malpractice insurance of small birthing centers will provide a greater return for the public.

The major issue with staffing for birthing centers is the low salary levels that they can offer as small providers with thin profit margins. The providers interviewed for this report spoke about how they would hire new midwives and train them, only to see them leave for better paying positions in hospitals or as home-birth midwives. To tackle the staffing issues, the State should increase funding for midwife training programs, expanding them to train more nurse-midwives each year. The State should also consider subsidizing midwives who work primarily with low-income or high-risk patients.

## Streamline CON Process

There must be a more streamlined process for applying for a CON to open a birthing center. The current process is too complex to navigate for those without access to expensive lawyers or consultants. The DOH should amend the process so that a qualified practitioner can navigate the process without aid. Furthermore, the DOH should speed up approvals of CONs for birthing center applicants. Based on increased desire for out-of-hospital births nationally, the stated desire for advocates and providers to open birthing centers yet being unable to, and the rise in maternal mortality and morbidity rates both locally and nationally, there is a clear need for more birthing centers in our communities. While the CON helps provide safeguards ensuring that providers are operating safe and effective facilities, the CON process cannot be so onerous as to prevent their opening entirely. The process should act as a protection for patients not a complete roadblock for them getting the care they desire. It is entirely possible for the state to establish a process that protects patients while enabling providers to more easily open these facilities.

*Mari G. Millet, President & CEO, Morris Heights Health Center*

## Establish an Equitable CON Process for All Applicants

The CON process must be faster because small-scale entrepreneurs are unable to hold a vacant property while waiting for months or years to receive their certificate to begin practice. This may mean the creation of two tiers of certificates of need, one for large institutions such as hospitals and another for smaller institutions. Governor Hochul supported such an approach in her 2024 State of the State, and enacting these proposals will be crucial for opening more birthing centers.

The CON process is not universal among all states. Several states have abolished their CON processes altogether for opening healthcare facilities. Other states have taken steps towards narrowing the need for a CON, including West Virginia, for example, which has taken steps towards eliminating the need for a CON to open a birthing center. Like New York, West Virginia has a dearth of birthing centers, and they are pursuing the elimination of the CON requirement as a way to spur opening more. While eliminating the CON process might not be right for New York, the state should look to what other states are doing to better inform their regulatory requirements.

## Expand and Increase Medicaid Reimbursements

The State should increase Medicaid reimbursements for births and birthing-related services. This will allow more money to flow to existing birthing centers, which will allow them to offer higher wages and prevent staff turnover. This will also incentivize more private actors to enter the market. Over one million Bronx residents are enrolled in Medicaid, accounting for over 70 percent of the borough's population.[89]


Because of this high enrollment rate, Medicaid reimbursements are of particular import for The Bronx. Additionally, low-income and Black New Yorkers are more likely to be on Medicaid and also face the greatest risk of maternal mortality and morbidity. By making it more feasible for them to access birthing center services, their potential harms can be significantly reduced.

## Expand and Increase NYC Care Reimbursements

NYC Care, the City's healthcare access program that guarantees low-cost and no-cost services offered by Health + Hospitals to New Yorkers who do not qualify for or cannot afford health insurance based on federal guidelines, should also include an H+H birthing center in its network and cover services provided by its staff. H+H facilities often see the lowest-income New Yorkers, and The Bronx is the proud home of three H+H hospitals and four clinics. H+H also offers the most robust midwifery care that currently exists in the borough. Expanding that further can only benefit Bronx mothers.

## Provide Reduced-Interest or Interest-Free Loans

The State should provide low-interest or interest-free loans to individuals who are looking to create a birthing center to help them meet the up-front costs of opening a birthing center.

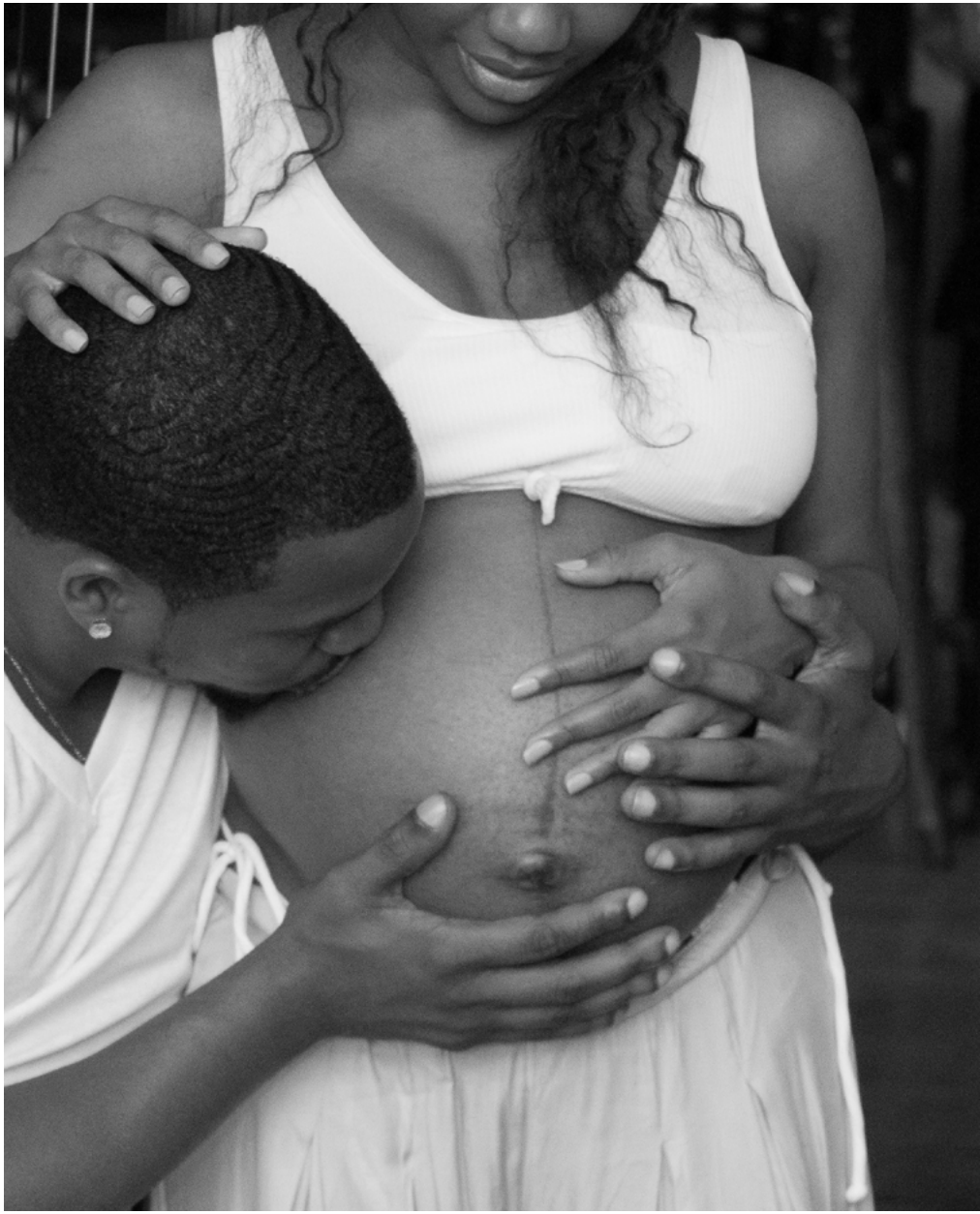
New York City and New York State both have programs that provide loans to causes that are deemed as socially beneficial through programs such as the New York Returnable Grant Fund at the city level or New York Forward Loans at the state level. Given that birthing centers provide an important service that is currently missing throughout our state, and especially in The Bronx, groups that currently provide small business and non-profit funding should provide loan packages to maternal healthcare entrepreneurs. Providing potential birthing center providers with this assistance would go a long way to helping them open up and begin seeing patients.

There is no single, simple solution, but a two-pronged approach – the creation of a public sector birthing center and the implementation of reforms to allow the private sector to meet demand – will ensure that more families in The Bronx and throughout New York City have access to the lifesaving healthcare services they want and need.

# CONCLUSION

Boroughwide, citywide, and even nationwide research and data analysis reveal that there is a history of racist policy and biased practices in healthcare which have fueled the gap between the healthcare system and Black and Brown communities. The Bronx faces numerous health challenges such as chronic illnesses, food insecurity, and health illiteracy. We must meet our residents where the need is. New York City is not a victim of bad circumstances. The tools needed to build a thriving maternal healthcare system are attainable.

For far too long, New York has paid insufficient attention to the existing health disparities and disproportionately negative maternal health outcomes for Black and Brown women. New York lacks a conducive organizational structure for the flourishing of birthing centers. Between high malpractice insurance fees, low reimbursement rates, high rent, and high staff salaries, the current system places financial constraints on birthing centers. New entrants into the marketplace, who might otherwise innovate or find ways to be profitable, are prohibited by regulations that were made to regulate much larger institutions. The current system is not conducive to the success of birthing centers. Prevention is better than treatment, and a birthing center in the heart of The Bronx would be a milestone preventative measure for improved health outcomes among expecting women in The Bronx.



New York has the power to change. Policy and Medicaid changes need to happen, and they should begin in The Bronx because we are the epicenter of many health inequities and disinvestment. A birthing center is a step towards greater equity because the Black and Brown women who have been neglected for far too long deserve the same healthcare options that women in other states and affluent women in New York have access to. In addition to providing services that meet the maternal health needs of Bronxites, this birthing center would act as a model for other boroughs to emulate, a safe community for women of all ages before, during, and after their pregnancy journey.

Changes to public and private insurance reimbursement for birthing services and an overhaul of the Certificate of Need application process will help birthing centers meet the high demand for comprehensive birthing care. Birthing centers on their own will not be enough to reverse increasing maternal and infant mortality, as this systematic problem will require holistic solutions across many levels of society. However, at a time when mothers and children are suffering, it is incumbent on The Bronx, New York City, and New York State to provide them with places where they can have access to the same birthing care that many of the wealthiest members of our city are opting for.

A Bronx-based birthing center would not stop the maternal mortality crisis on its own, but it would be a critical step toward addressing healthcare inequities. It would give more autonomy to birthing individuals. Access to patient-centered care would help ensure all birthing individuals have the fundamental right to a healthy and safe experience throughout the course of their pregnancy. We must seek to ensure that The Bronx is prioritized in birth equity initiatives because all pregnant people, regardless of their background, deserve a space where they can be cared for, where they can be heard, and where they can feel safe.

# APPENDIX & REFERENCES

# APPENDIX

This appendix will define relevant birthing care professionals, including descriptions of each professional's scope of services and practice, education, training, certification, licensure, and insurance coverage options for services.

## Doula

### Scope of Services

A doula, also known as a birth companion, birth coach, or post-birth supporter, is a trained non-medical professional who provides continuous physical, emotional, and informational support to pregnant women and their families before, during, and shortly after childbirth.[90] This support can help families handle the physical, emotional, and practical issues that surround childbirth. For example, a doula can offer attention to physical comfort through techniques such as touch and massage and assistance with breathing; emotional reassurance, comfort and encouragement; information about what's happening during labor and the postpartum period, including explanations of procedures; help with facilitating communication between the patient and the hospital staff; guidance and support for loved ones; and assistance with breastfeeding.[91] A doula may not diagnose medical conditions or give medical advice, perform any type of clinical task, conduct any type of physical or behavioral assessment or exam, administer medications, or provide or interfere with medical treatment, including delivering babies or performing surgery. Doulas may not prescribe medications. There are numerous types of doulas that provide support for different populations throughout the perinatal period. This report focuses on two types of doulas primarily involved in the prenatal period, labor and delivery, and the postpartum period.

#### Birth Doula

A birth doula meets with clients before, during, and after childbirth to help prepare for birth, breastfeeding, and parenting.[92] During labor and birth, birth doulas can help the individual stay comfortable by providing comforting touch and guidance on breathing, relaxation, movement, and positioning. Immediately after birth, they can show their clients how to maintain skin-to-skin contact and breastfeed the baby. Birth doulas can also help clients navigate hospital policies and costs and encourage

#### Postpartum Doula

A postpartum doula begins working with pregnant women and their families in the first few days after childbirth.[93] They can provide evidence-based information on physical recovery from birth, emotional well-being, infant feeding, and parent-infant bonding. They can also help with cooking and other household duties. This support gives families the time they need to rest and focus on the baby. A postpartum doula can also help clients understand what to expect from the baby and can provide infant-soothing and coping skills.

Both categories include community-based doulas. These doulas work with clients who identify as part of communities that have historically faced worse birth and maternal health outcomes.[94] These clients include individuals who are teenagers, are socioeconomically disadvantaged, or identify as a person of color.[95] Community-based doulas meet with their clients several months before birth, attend the birth, and meet in the weeks to months following the birth.[96] During their visits, these doulas discuss topics ranging from birth and breastfeeding to bonding with the baby. They also tend to collaborate with other community programs to provide greater support for their clients and are trained to address all the needs of their clients, including but not limited to referrals to food pantries and housing programs.

### Education, Training, Certification, and Licensure

There is no mandated education or training for a doula in New York City.[97] However, most doulas complete a course or certification program, ranging from a few days to a few months in length. Prominent global certification organizations include DONA International, International Childbirth Education Association, and the Childbirth and Postpartum Professional Association. In New York City, the following organizations provide doula certifications and training and are recommended by the DOHMH: Citywide Doula Initiative (through Ancient Song Doula Services), Healthy Women, Healthy Futures, Bikur Cholim, Birth Day Presence, Carriage House Birth, and Mama Glow. Generally, most doula certification programs take less than a year.[98] Once certified, doulas do not need to recertify. Active licensure is not mandated.

### Paying for a Doula and Insurance Coverage Options

Most people pay for doula services out of pocket.[99] Some private insurance

plans cover doula services to varied extents. In terms of public insurance, six states (Oregon, Minnesota, New Jersey, Florida, Maryland, and Virginia) currently reimburse for doula services through Medicaid as of June 2022.[100] Five other states (California, Illinois, Indiana, Nevada, and Rhode Island) and the District of Columbia plan to obtain Centers for Medicare & Medicaid Services (CMS) approval to implement doula coverage through Medicaid in 2022 and 2023.[101] Five more states (Arizona, Connecticut, Georgia, Louisiana, and Washington) are considering a Medicaid doula program through Medicaid.[102]

DOH announced the launch of a pilot expansion of the State's Medicaid program to cover doula services for Medicaid fee-for-service and Medicaid Managed Care enrollees.[103] Phase 1 of the pilot launched in Erie County on March 1, 2019. Only doulas serving Medicaid-eligible clients residing in Erie County and all ZIP codes in Brooklyn except 11207, 11212, and 11233 were able to apply for enrollment in the Medicaid Doula Pilot Program. Once enrolled as a Medicaid provider, doulas were able to bill Medicaid for up to four prenatal visits, support during labor and delivery, and up to four postpartum visits provided to Medicaid-eligible clients residing in the above-mentioned areas.[104] To become a doula provider for Medicaid Managed Care clients, a doula had to first enroll with the Medicaid Program. Once enrolled as a Medicaid provider, a doula could then reach out to the Managed Care Organizations (MCO) that are participating in the Doula Pilot Program to apply to join the MCO's doula provider network. Depending on the payer, there are two different ways for doulas to be reimbursed: fee-for-service, in which doulas will bill the Medicaid program directly through fee-for-service (FFS) via the eMedNY system, or managed care, in which doulas will submit a claim to the Managed Care Plan, which will then reimburse the doula. In order to follow federal Medicaid requirements applicable to covered services, doula services must be reimbursed on an FFS schedule.[105] The plans participating in the Pilot Program in Erie County were Fidelis Care New York, Inc., HealthNow New York, Inc., Independent Health's MediSource, United Healthcare Community Plan, WellCare of New York, and YourCare Health Plan. The plans participating in the Pilot Program in Brooklyn will be Affinity Health Plan, Empire BlueCross BlueShield Health Plus, Fidelis Care New York, Inc., HIP (Emblem Health), Healthfirst PHSP, Inc., MetroPlus, United Healthcare Community Plan, and WellCare of New York.[106] In 2023, the pilot program was extended to all New Yorkers who are covered by Medicaid.

In New York City, Mayor Eric Adams launched the Citywide Doula Initiative in early 2022.[107] The Citywide Doula Initiative provides professional, no-cost doula services to residents of neighborhoods that have been particularly hard-hit by COVID-19.[108] The program prioritizes people who: live in a shelter, are in foster care, have no other labor support, are giving birth for the first time or for the first time in at least 10 years, had a previous traumatic birth experience, or have a high-risk medical condition. To access these doula services, clients must live in a designated neighborhood and be income-eligible for Medicaid. In The Bronx, Ancient Song Doula Services is designated to provide these low-cost or no-cost doulas to eligible clients and serves the following designated ZIP codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10463, 10466, 10467, 10468, 10472, 10473, and 10474. This includes Mott Haven, Melrose, Hunts Point, Longwood, Morrisania, Crotona, Highbridge, Concourse, Fordham, University Heights, Belmont, East Tremont, Kingsbridge, Parkchester, Soundview, Williamsbridge, Baychester, and Edenwald. These neighborhoods were identified as those most affected by COVID-19 or those that have a high percentage of other health and socioeconomic disparities, according to the New York City Taskforce on Racial Inclusion and Equity. At the time the Taskforce was established, these communities accounted for over 50% of New York City's COVID-19 cases. To learn more visit the DOHMH's Doula Care webpage.

For U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component, who are covered by TRICARE, the TRICARE Childbirth and Breastfeeding Support Demonstration (CBSD) covers the services of certified non-medical labor doulas.[109] TRICARE will cover up to six visits by a certified labor doula. These visits can be before you give birth or after you give birth. Beneficiaries also get one visit during birth. The CBSD will cover certified network doulas at no additional cost. Non-network doulas must meet the CBSD qualifications. The CBSD is only for TRICARE Prime or TRICARE Select enrollees.[110] The CBSD doesn't cover TRICARE For Life, US Family Health Plan, or the Continued Health Care Benefit Program.[111]

The CBSD will run from January 1, 2022 to December 31, 2026. The CBSD will expand overseas on January 1, 2025. To learn more, visit the TRICARE CBSD webpage.

## Midwife

A midwife provides independent care and counseling during pregnancy, childbirth, and the postpartum period. Midwives are trained to assess, diagnose, and treat women in the areas of sexual and reproductive health, gynecological health, and family planning, and can provide services in these areas, including pre-pregnancy care.[112] Midwives can also provide primary care for individuals from adolescence throughout the lifespan as well as care for healthy newborns during the first four weeks of life. While midwives are well-known for attending births, 76% of certified nurse-midwives and certified midwives identify reproductive care and 49% identify primary care as responsibilities in their full-time positions. These responsibilities include but are not limited to annual exams, basic nutrition counseling, parenting education, patient education, and reproductive health visits. Depending on certification level by the American College of Nurse-Midwives, midwives may: prescribe medications; conduct physical examinations; treat substance use disorder; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order medical devices, durable medical equipment, and home health services.[113] Midwifery care includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling.[114] There are several types of midwives, each recognized for their different educational and professional experiences.

### Certified Nurse Midwife (CNM)

**Scope of Practice and Services**

CNMs are individuals trained and licensed in nursing and midwifery. CNMs can independently provide care related to pregnancy, childbirth, the postpartum period, sexual and reproductive health, gynecological health, and family planning services including preconception care.[115] Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. CNMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment, conduct physical examinations, admit, manage, and discharge patients, order and interpret laboratory and diagnostic tests, and order medical devices, durable medical equipment, and home health services. CNMs' services include health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. CNMs can deliver babies, manage emergency situations during labor, repair lacerations, and may provide surgical assistance to physicians during cesarean births.[116] Nurse midwives may act as primary maternity care providers for women.[117] They also provide wellness care, educating their patients on how to lead healthy lives by discussing topics such as nutrition and disease prevention. Nurse midwives also provide care to their patients' partners for sexual or reproductive health issues. While CNMs can deliver babies, they must refer to a physician in the case of high-risk pregnancies or complications during delivery. CNMs also may not perform surgery. CNMs are authorized to practice in all 50 states, the District of Columbia (D.C.), and most U.S. territories. CNMs can prescribe medications in all 50 states, D.C. and most territories.[118]

**Education, Training, Certification, and Licensure**

CNMs must complete a Bachelor of Science degree in Nursing (BSN) from an accredited institution and a Master's or Doctoral degree in Midwifery. Given that a CNM is both a nurse and a midwife, CNMs must complete the education pathways of both professions and maintain active certification and licensure for both roles. Hence, CNMs must pass the American Midwifery Certification Board Licensing Exam and become certified by the American Midwifery Certification Board.[119] They must also pass the National Council Licensure Examination-Registered Nurse (NCLEX-RN) exam and obtain state licensure.[120] To maintain the designation of CNM, midwives must be recertified every five years through AMCB and must meet specific continuing education requirements. CNMs must also maintain active licensure with the licensure agency for their U.S. state (Boards of Nursing, Boards of Medicine, Boards of Midwifery/Nurse-Midwifery, or Departments of Health). In New York, CNM licensing for both midwifery and nursing occurs through the New York State Education Department Office of the Professions.[121]

**Paying for a CNM and Insurance Coverage Options**

As of January 1, 2011, Medicare payment for certified nurse-midwives services is increased to 100% of the Physician Fee Schedule (PFS).[122]

Most private insurance plans cover midwifery services as a maternity benefit, but individuals should check with their insurance provider about coverage of gynecological services provided by midwives.[123]

### Certified Midwife (CM)

**Scope of Practice and Services**

CMs provide the same midwifery services as CNMs. CMs are authorized to practice in 9 states, including New York, and D.C. CMs can prescribe medications in 5 states, including New York, and D.C.[124]

**Education, Training, Certification, and Licensure**

CMs must complete a bachelor's degree in a field of choice and a master's degree in midwifery. CMs also must pass the American Midwifery Certification Board Licensing Exam and become certified by the American Midwifery Certification Board.[125] To maintain the designation of CM, midwives must be recertified every five years through AMCB and must meet specific continuing education requirements.[126] CMs must also maintain active licensure with the licensure agency for their state.[127] In New York, CM licensing for both midwifery and nursing occurs through the New York State Education Department Office of the Professions.

**Paying for a CM and Insurance Coverage Options**

As of 2022, Medicaid in Maine, Maryland, New York, Rhode Island, and D.C. covers CNM services.[128] Medicare and TRICARE do not cover CM services.[129] Most private insurance plans cover midwifery services as a maternity benefit, but individuals should check with their insurance provider about coverage of gynecological services provided by midwives.[130]

### Certified Professional Midwife (CPM)

**Scope of Practice and Services**

CPMs offer care, education, counseling, and support to women and their families throughout the caregiving partnership, including pregnancy, birth, and the postpartum period.[131] CPMs provide ongoing care throughout pregnancy and continuous, hands-on care during labor, birth, and the immediate postpartum period, as well as maternal and infant care through the six-to-eight-week postpartum period. CPMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment and are trained to recognize abnormal or dangerous conditions requiring consultation with or referral to other healthcare professionals. They conduct physical examinations, administer medications, and use devices as allowed by state law, and order and interpret laboratory and diagnostic tests. CPMs can deliver babies but cannot treat high-risk pregnancies or complications during delivery. CPMs cannot perform surgery. CPMs are authorized to practice in 37 states, including New York, and D.C.[132] CPMs may not prescribe medications; however, they may obtain and administer certain medications in select states.[133]

**Education, Training, Certification, and Licensure**

A CPM must have a high school diploma or equivalent. Following this, CPMs must achieve one of the following: complete a midwifery education program accredited by the Midwifery Education Accreditation Council (MEAC), complete the North American Registry of Midwives' Portfolio Evaluation Process, be an AMCB-Certified CNM/CM with at least ten community-based birth experiences, or complete an equivalent state licensure program.[134] Upon completing one of these pathways, a CPM must pass a certification exam and become certified with the North American Registry of Midwives. To maintain certification, CPMs must recertify every three years. CPMs must also maintain active licensure with the licensure agency for their state.

**Paying for a CPM and Insurance Coverage Options**

Fourteen states include CPM services in state Medicaid plans, but New York does not cover them.[135] Medicare and TRICARE also do not cover CPM services in any U.S. state. Six states mandate private insurance cover CPM services.[136] Individuals should check with their insurance provider about coverage of CPM services.

## Physician

### Obstetrician-Gynecologist (OB-GYN)

**Scope of Practice and Services**

An obstetrician-gynecologist, or OB-GYN, is a physician that specializes in female reproductive health. Obstetrics involves working with pregnant women, including delivering babies, while gynecology involves the female reproductive system, treating a wide range of conditions, including sexually transmitted infections (STIs) and chronic pain. OB-GYNs are trained surgeons who can perform a wide range of procedures, including

cesarean sections, instrumental deliveries during childbirth, hysterectomy, removing growths such as ovarian cysts and uterine fibroids, and surgery to repair pelvic organ injuries. OB-GYNs can also perform a wide range of routine and in-office procedures, including pap smears to test for cervical cancer, STI tests, fertility treatments (egg retrievals for IVF or egg-freezing), pelvic ultrasounds to check the pelvic organs and monitor pregnancy, infertility treatments and counseling, management of urinary issues such as urinary tract infections and urinary incontinence, and breast exams and breast health management, including mammograms and other breast cancer screenings.[137] OB-GYNs can practice in all U.S. states and territories and can prescribe medications.

**Education, Training, Certification, and Licensure**

Allopathic OB-GYNs must complete a bachelor's degree, a Doctor of Medicine degree (MD), and an OB-GYN residency program. They must pass the United States Medical Licensing Exam. They may also complete an additional fellowship in a subspecialty of choice, such as complex family planning, female pelvic medicine and reconstructive surgery, gynecologic oncology, maternal-fetal medicine, and reproductive endocrinology and infertility.[138]

Osteopathic medicine is practiced by a Doctor of Osteopathic Medicine (DO), who brings a holistic approach to care by focusing on looking beyond symptoms to understand how lifestyle and environmental factors impact well-being.[139] Osteopathic OB-GYNs must complete a bachelor's degree, a DO degree, and an OB-GYN residency program in order to practice in the United States.[140] They must pass the Comprehensive Osteopathic Medical Licensing Examination and can maintain board certification with the American Osteopathic Association. They may also complete an additional three-year fellowship in a subspecialty of choice, such as Maternal-Fetal Medicine, Reproductive Endocrinology/Infertility, Gynecologic Oncology, or Female Pelvic Medicine Reconstructive Surgery.[141]

Allopathic and osteopathic OB-GYNs must maintain active licensure in their state of practice.

**Paying for an OB-GYN and Insurance Coverage Options**

Obstetrics and gynecological services are primarily paid for through insurance coverage. All Medicaid plans cover pregnancy and childbirth services provided by a physician.[142] Medicare covers a range of gynecological wellness visits and screenings, including but not limited to clinical breast exams, pap smear tests, human papillomavirus tests, and pelvic exams.[143] TRICARE covers most pregnancy, prenatal, postpartum, and women's health services, slightly varying by individual plan.[144] Almost all private insurance plans cover OB-GYN services, the extent slightly varying depending on the plan. In some states, eligible pregnant people can receive healthcare benefits through the Children's Health Insurance Program (CHIP).[145] All obstetric and gynecological services provided by OB-GYNs are cataloged in the List of Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes (the Code List).[146] The Code List is maintained and updated by the CPT Editorial Panel, the American Medical Association, and The Centers for Medicare & Medicaid Services.[147] These billable codes allow OB-GYNs to receive out-of-pocket payments or insurance reimbursement for all services.

### Family Physician

**Scope of Practice and Services**

Family practice doctors provide care to people of all ages, including expectant mothers and infants.[148] These generalists treat chronic conditions, evaluate symptoms, offer primary care, and make referrals to specialists. All family physicians are trained in obstetrics, and some offer a full scope of maternity care services, encompassing pre-and-post-natal care as well as deliveries including caesarean sections.[149] Family physicians can practice in all U.S. states and territories and have prescriptive authority.

**Education, Training, Certification, and Licensure**

Allopathic family physicians must complete a bachelor's degree, an MD, and a family medicine residency program. They must pass the United States Medical Licensing Exam and obtain state licensure.

Osteopathic family physicians must complete a bachelor's degree, a DO degree, and a family medicine residency program in order to practice in the United States.[150] They must pass the Comprehensive Osteopathic Medical Licensing Examination and obtain state licensure. They can become board-certified with the American Osteopathic Association.[151]

**Paying for a Family Physician and Insurance Coverage Options**
See "Paying for an OB-GYN and Insurance Coverage Options" in the OB-GYN section of the appendix. Physicians of all specialties are paid in a similar manner with minor nuances.

## Advanced Practice Registered Nurse

Advanced Practice Registered Nurses (APRNs) are RNs who have completed a Master's of Science in Nursing (MSN) or higher in one of the four APRN specialty roles: the Certified Nurse-Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), or Nurse Practitioner (NP).[152] APRNs are high-level nurses who have much more responsibility and autonomy wit in their roles. All APRNs must be certified by relevant organizations and must register with their state's Board of Nursing.[153]

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, created by the National Council of State Boards of Nursing, recognizes that APRN practice must be regulated in one of these four roles and in at least one of six population foci: (1) family/patient across the life span (2) adult-gerontology, (3) pediatrics, (4) neonatal, (5) women's health/gender-related, or (6) psychiatric/mental health.cxx The recommendations of the Consensus Model influence the licensure, accreditation, certification, and educational preparation of all future APRNs.

It is important to note that New York State law restricts the use of the title "nurse" to persons who are licensed by the New York State Education Department as an RN, LPN, CNS, or NP. Graduates of certain RN or LPN education programs may also use the title of "graduate nurse" or graduate practical nurse" if they have applied for a New York State RN or LPN license and a limited permit. Other nurse professions discussedare not formally recognized by New York, but may still provide health services with certain restrictions.

### Certified Nurse Midwife (CNM)

See CNM description in the Midwife section of the appendix.

### Certified Registered Nurse Anesthetist (CRNA)

**Scope of Practice and Services**

A certified registered nurse anesthetist (CRNA) is certified in anesthesia.[154] In many states, CRNAs can practice without physician supervision.[155] They administer anesthesia and provide care before, during, and after surgical, therapeutic, diagnostic, and obstetrical procedures.[156] They also provide pain management and some emergency services. Before a procedure begins, nurse anesthetists discuss with a patient any medications the patient is taking as well as any allergies or illnesses the patient may have, so that anesthesia can be safely administered. Nurse anesthetists then give a patient general anesthesia to put the patient to sleep so they feel no pain during surgery or administer a regional or local anesthesia to numb an area of the body. During the procedure, they monitor the patient's vital signs and adjust the anesthesia as necessary. CRNAs can assist in delivering babies, but cannot independently deliver babies; similarly, CRNAs can assist in surgeries, but cannot independently perform surgery.

CRNAs are authorized to practice with collaboration agreements/ supervision by a MD, DO, DDS, or podiatrist in 24 states, including New York, and are authorized to independently practice and prescribe in 26 other states with certain state-based limitations. New York does not formally recognize CRNAs as an APRN, but CRNAs may practice under physician supervision.[157] In 2001, the Centers for Medicare & Medicaid Services (CMS) changed the federal supervision rule to allow states to opt-out of this supervision requirement (which applies to hospitals and ambulatory surgical centers) by meeting three criteria: consult the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state, determine that opting out is consistent with state law, and determine that opting out is in the best interests of the state's citizens.[158] As of October 2022, 22 states and Guam have opted out of the federal physician supervision requirement. Additional states do not have supervision requirements in state law and are eligible to opt-out.

CRNAs may not prescribe medications, but can only administer them, in 14 states, including New York. In 20 other states, CRNAs can prescribe medications on a limited basis or with physician supervision. CRNAs can only independently prescribe medications in the last 16 states and D.C.[159]

**Education, Training, Certification, and Licensure**

CRNAs must complete a bachelor's or master's degree in nursing or another appropriate major. They must pass the NCLEX-RN exam and obtain state licensure. Following this, they must pursue a minimum of one year of full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting within the United States, its territories, or a U.S. military hospital outside of the United States.[160] The average experience of RNs entering nurse anesthesia educational programs is 4.5 years, according to the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). RNs may then apply and pursue an accredited nurse anesthesia educational program, which usually lasts between 24 and 51 months, depending on university requirements. Following completion of this program, CRNAs must pass the National Certification Examination and become certified by the NBCRNA.[161] CRNAs can pursue a fellowship in a specialized area of anesthesiology such as chronic pain management following the attainment of their degree in nurse anesthesia. CRNAs must recertify every four years.

**Paying for a CRNA and Insurance Coverage Options**

Legislation passed by Congress in 1986 made CRNAs the first nursing specialty to be accorded direct reimbursement rights under the Medicare program and CRNAs have billed Medicare directly for 100% of the physician fee schedule amount for services.[162] Thus, Medicare covers CRNA services. In some states, Medicaid programs do reimburse hospitals for anesthesia services provided by a CRNA, but regulations vary by state.[163] TRICARE covers medically necessary services during labor and delivery including anesthesia.[164] In terms of private insurance, individuals should check with their insurance provider about coverage of CRNA services.

### Certified Nurse Specialist (CNS)

**Scope of Practice and Services**

CNSs have advanced clinical expertise in a specialized area of nursing practice. The work of the CNS includes, but is not limited to, diagnosis and treatment of acute or chronic illness in an identified population with emphasis on specialist care for at-risk patients and populations. CNS practice extends from wellness to illness and from acute to primary care.[165] CNSs can assist in delivering babies, but may not independently deliver babies; similarly, CNSs can assist in surgeries, but may not independently perform surgery. CNSs are authorized to practice with supervision by a MD, DO, DDS, or podiatrist in 15 states, including New York. In 35 other states and D.C., CNSs are authorized to practice independently. They can also independently prescribe medications in 22 states, including D.C. In 28 other states, including New York, CNSs can prescribe medication under supervision or can only administer medications, not prescribe.[166]

**Education, Training, Certification, and Licensure**

CNSs must complete a bachelor's or master's degree in nursing or another appropriate major. They must pass the NCLEX-RN exam and obtain state licensure. Then, they must complete a Masters or Doctorate Degree in Nursing with a major in the clinical nursing specialty to which the nurse is assigned and obtain certification.[167] The APRN Consensus Model states that clinical nurse specialists who practice in the majority of states must obtain certification based on a population area: Adult/Gerontology, Pediatrics, or Neonatal.[168] Within these population specialties, CNSs can further specialize in a subspecialty of choice. There are several organizations that offer CNS certification, including the American Nurses Credentialing Center (certification in Adult-Gerontology) and the American Association of Critical Care Nurses (certifications in Acute Care-Adult-Gerontology, Acute Care-Pediatric, and Acute Care-Neonatal).[169] In New York, CNSs can be certified to practice in Adult Health, Pediatrics, Psychiatric/Mental Health, and Oncology. Recertification occurs every five years.[170]

**Paying for a CNS and Insurance Coverage Options**

Medicare, Medicaid, and TRICARE cover most services provided by a CNS if they have the legal authority under state law to perform the service to be billed and medical direction and appropriate supervision is provided as required by the law of the state in which the services are furnished.[171] In 1997, Medicare expanded reimbursement to all geographical and clinical settings allowing direct Medicare reimbursement to the APRN, but at 85% of the physician rate. In terms of private insurance, individuals should check with their insurance provider about coverage of CNS services.

### Nurse Practitioner (NP)

**Scope of Practice and Services**

Nurse Practitioners (NPs) provide comprehensive care to patients. NPs serve as primary and specialty care providers, delivering advanced nursing services to patients and their families.[172] They assess patients, determine how to improve or manage a patient's health, and discuss ways to integrate health promotion strategies into a patient's life. A women's health nurse practitioner (WHNP) can provide preventive care such as well gynecological exams, breast cancer screenings, Papanicolaou (Pap) tests, or contraceptive care.[173] WHNPs may also provide adolescent healthcare, pregnancy testing, fertility evaluation, family planning services, prenatal visits, after-pregnancy care, breastfeeding counseling, and menopausal care.

NPs are licensed in all states and D.C., and they practice under the rules and regulations of the state in which they are licensed. States vary in regulatory rules. In 27 states, including New York, and D.C., NPs are permitted to undertake "full practice," meaning NPs in these states can prescribe, diagnose, and treat patients without physician oversight.[174] 23 other states require physician oversight to prescribe medications or to diagnose and treat patients. NPs cannot perform surgeries or deliver babies themselves, though they can assist other health professionals for these procedures.[175]

**Education, Training, Certification, and Licensure**

NPs must complete a bachelor's or master's degree in nursing or another appropriate major. They must pass the NCLEX-RN exam and obtain state licensure. They must then complete a nationally accredited NP graduate degree program.[176] To receive certification, NPs must pass a certification exam, and can become certified by any of several organizations: the American Academy of Nurse Practitioners Certification Board (certifies in Family care, Adult-Gerontology Primary Care, and Emergency care), the American Nurses Credentialing Center Certification Program (certifies in Adult care, Adult-Gerontology Acute Care, Adult-Gerontology Primary Care, Advanced Diabetes Management Emergency care, Family care, Gerontological care, Pediatric Primary Care, Psychiatric-Mental, and School care), the American Association of Critical-Care Nurses Certification Corporation (certifies in Acute Care Adult-Gerontology and Acute Care), the Pediatric Nursing Certification Board (certifies in Primary Care Pediatrics and Acute Care Pediatrics), and the National Certification Corporation (certifies in Neonatal care and Women's Health Care).[177] NPs must recertify every five years.[178] They must also maintain active state licensure.

**Paying for an NP and Insurance Coverage Options**

Medicare, Medicaid, and TRICARE cover most services provided by an NP if they have the legal authority under state law to perform the service to be billed.[179] Most private insurance plans also cover NP services, but coverage may vary depending on insurance company and plan.

## Registered Nurse

**Scope of Practice and Services**

Registered nurses (RNs) provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their families.[180] Registered nurses typically assess patients' conditions, record patients' medical histories and symptoms, observe patients and record their observations, administer medicines and treatments, set up plans for patient care or contribute information to existing plans, consult and collaborate with doctors and other healthcare professionals, operate and monitor medical equipment, help perform diagnostic tests and analyze the results, teach patients and their families how to manage illnesses or injuries, and explain what to do at home after treatment. RNs cannot perform surgeries or deliver babies themselves, though they can assist other health professionals for these procedures.

A labor and delivery RN (L&D RN) cares for mothers during labor and birth and provides the infant's initial postpartum care under the supervision of a nurse midwife or physician.[181] During delivery, an L&D RN can assist and encourage the mother, monitor labor progress, and call-in specialists when needed. After birth, L&D RNs can monitor vital signs of the mother and baby and educate the family on infant care. In a birthing center, L&D RNs can assist during labor and postpartum, monitor progress and vital signs, refer to hospital care if needed, and can provide basic care for the newborn and mother during the initial postpartum period. The L&D RN can also carry out a nurse midwife's or physician's orders, such as inducing labor.

RNs are authorized to practice in all 50 states, D.C., and U.S. territories. RNs have no prescriptive authority but can administer medications as prescribed by a health professional with prescriptive authority.

They are authorized to dispense some medications, including contraceptives and drugs for STI care in some outpatient settings in 16 states, not including New York.[182]

**Education, Training, Certification, and Licensure**

An RN must complete an associate's degree in nursing (ADN), a bachelor of science in nursing degree (BSN), or a diploma or certificate from an approved nursing program.[183] They must also pass the National Council Licensure Examination (NCLEX-RN). Nurses may become certified through professional associations in specific areas, such as but not limited to neonatal care, perinatal care, maternity care, or obstetrics, but further certification is not required to work in maternity care and childbirth.[184] Following this, RNs must obtain and maintain active state licensure.

**Paying for a RN and Insurance Coverage Options**

Currently, Medicare cannot make direct payments to registered nurses under Part B. Medicare will pay physicians, hospitals, skilled nursing facilities, home health agencies, and others for the services of nurses that are either directly employed or under contract through benefit categoriesthat allow each of these institutional or practitioner types to be paid by Medicare.[185] Medicare pays for therapeutic services provided by registered nurses in physician offices and hospital outpatient departments under the "incident to" a physician's service benefit category. "Incident to" a physician service means that the patient has or will be seeing the physician or other certified practitioner and the related service being provided by the nurse or other staff is "incident to" the physician service. A similar model is used for Medicaid, TRICARE, and private insurance plans.

## Physician Assistant

**Scope of Practice and Services**

A physician assistant (PA) is a licensed clinician who can diagnose and treat patients in all medical specialties and settings. They take medical histories, conduct physical exams, diagnose and treat illness, order and interpret tests, develop treatment plans, prescribe medication, counsel on preventive care, perform procedures, assist in surgery, and make rounds in hospitals and nursing homes.[186] PAs differ from NPs in that PAs are educated and practice in all aspects of medicine, while NPs must specialize. PAs must practice medicine under the direction and supervision of a licensed physician.[187] PAs cannot perform surgeries or deliver babies themselves, though they can assist other health professionals with these procedures.

In the OB-GYN field, PAs can evaluate and manage common gynecological conditions as well as provide patient education and counseling on various relevant health conditions. PAs can work in both outpatient and inpatient OB-GYN settings. In outpatient settings, PAs can perform annual pap/pelvic and breast exams, address gynecological complaints, address menopause management issues, provide family planning services, and provide prenatal and postnatal care.[188] PAs can provide counseling on contraception, breast self-examination, prenatal care, childbirth, postnatal care, and lactation. In inpatient settings, physician assistants may perform a number of procedures including but not limited to amniotomies, internal monitor placement, fetal monitor strip interpretation, ultrasounds, colposcopies, intrauterine device insertion and removal, vulvar and endometrial biopsies, and loop excision electrocoagulation procedures. PAs are trained to assist in deliveries and surgeries, such as cesarean sections, hysterectomies, and post-partum tubal ligation, but most hospitals do not allow PAs to perform such procedures independently. PAs can monitor the recovery process, order lab work, and provide pre-and-post-operative counseling.[189] PAs are authorized to practice in all 50 states, D.C., and U.S. territories, and have dependent prescriptive authority in all 50 states, D.C., and some territories, with physician supervision.

**Education, Training, Certification, and Licensure**

A PA is required to have a bachelor's degree and a master's degree from an accredited program.[190] PAs must also pass a certification exam and be certified by the National Commission on Certification of Physician Assistants in order to practice.[191] Recertification occurs every 10 years.[192] PAs must also obtain and maintain active state licensure. Currently, most state laws require PAs to have an agreement with a specific physician in order to practice. In New York, a PA works under the supervision of a licensed physician who is responsible for the PA's performance as well as the overall care of the patient. The PA may have more than one supervising physician; however, there must be one clearly designated supervising physician who is available at any one time.[193]

**Paying for a PA and Insurance Coverage Options**

All 50 states and D.C. cover medical services provided by PAs under Medicaid with the same or lower reimbursement rate as that of a physician.[194] Medicare covers services that PAs provide in all practice settings at 85% of the physician fee. Almost all services that would be covered by Medicaid if provided by a physician are also covered when provided by a PA, with minor variations by state law. Medicare does not require the physician to see or treat a patient or to be physically on-site when a PA treats a patient except for a designated small number of services that can be performed only by physicians.

TRICARE covers all medically necessary services provided by a PA as long as the physician supervisor of the PA is a TRICARE-authorized provider. Almost all private insurance plans cover PA services as well, with slight variations in individuals plans.

## Childbirth Educator

**Scope of Services**

Childbirth educators provide information and training to expectant parents in preparation for labor, birth, and the postpartum period.[195] Childbirth educators are non-clinical professionals and do not offer medical advice, prescribe medications, diagnose medical conditions, or perform clinical procedures or treatments of any kind.[196]

**Education, Training, Certification, and Licensure**

While there is no mandated certification to be a childbirth educator, it is highly recommended and beneficial to be certified.[197] There are numerous courses and private certifications, ranging from a few days to a few months in length.

**Paying for a Childbirth Educator and Insurance Coverage Options**

Fifteen states provide coverage for childbirth education classes through their Medicaid program, and 14 cover infant care and parenting education classes.[198] Ten states – Arizona, Colorado, Delaware, Hawaii, Illinois, Indiana, Michigan, Oregon, Pennsylvania, and Wisconsin – and D.C. cover both services. New York only covers childbirth education classes and reimburses them as an office visit component. Some TRICARE plans may cover childbirth educator services. Medicare does not cover childbirth classes.[199] Most private insurance also covers childbirth educator services as part of prenatal care services, but coverage may vary depending on insurance company and plan.

## Lactation or Breastfeeding Consultant/Counselor

There are a variety of professional counselors and consultants related to breastfeeding and lactation.[200] Lactation consultants are authorized to work in all 50 states, D.C., and U.S. territories. Lactation consultants cannot deliver babies or perform any medical tasks or procedures.

### International Board-Certified Lactation Consultant (IBCLC)

**Scope of Practice and Services**

International Board-Certified Lactation Consultants (IBCLCs) are medical care professionals who undertake the clinical management of breastfeeding.[201] IBCLCs are experts and skilled in breastfeeding and serve as supporting hands for the parents who are struggling with complex and common problems surrounding breastfeeding.

**Education, Training, Certification, and Licensure**

IBCLCs require a health sciences background (various educational routes accepted) in which 14 IBCLC-approved health science courses are completed. This includes a minimum of 95 hours of lactation-specific education (including five hours of communications skills) and usually 300 to 1000 hours of clinical practice. IBCLCs also must maintain board certification with the International Board or Lactation Consultant Examiners in order to practice.[202] Only an IBCLC can be a Registered Lactation Consultant (RLC). All IBCLCs need to be obtain and maintain state licensure.[203]

### Certified Lactation Counselor (CLC)

**Scope of Practice and Services**

A CLC, also known as a lactation or breastfeeding counselor or educator, teaches about breastfeeding and helps mothers with basic breastfeeding challenges and questions.

**Education, Training, Certification, and Licensure**

The CLC certification requires a minimum of a 45-hour course with a 2.5-hour test administered by the Academy of Lactation Policy and Practice (ALPP). These counselors and educators have special breastfeeding training, usually a weeklong course.[204]

### Certified Breastfeeding Educator (CBE)

**Scope of Practice and Services**

A CBE, also known as a lactation or breastfeeding counselor or educator, teaches about breastfeeding and helps mothers with basic breastfeeding challenges and questions.

**Education, Training, Certification, and Licensure**

CBEs must complete 45 hours of training through a program. CBE programs are provided by various private companies with variable standards. The CBE certification is conferred by the Lactation Consultation Services, and recertification occurs every five years.

### Certified Lactation Educator (CLE)

**Scope of Practice and Services**

CLEs are qualified to teach families about preparing for their infant, how lactation works physiologically, common challenges to expect, and other general lactation support.[205]

**Education, Training, Certification, and Licensure**

CLEs must complete 45 hours of training through a program. CLE programs are provided by various private companies with variable standards.[206] CLEs do not need to receive certification to provide services. Other types of lactation consultants include Lactation Educator Counselors (LEC) and Certified Breastfeeding Counselors (CBC). These professionals have varying levels of education and do not require certification to provide services. Peer educators who can also provide guidance around breastfeeding include Women, Infants, and Children Peer Counselors (WIC Peer Counselors) and La Leche League Leaders (LLL).

**Paying for a Lactation Consultant/Counselor and Insurance Coverage Options**

The Affordable Care Act defines breastfeeding support, supplies, and counseling for the duration of breastfeeding as women's preventative care and requires almost all insurance plans, including Medicaid, U.S. Marketplace plans, and other private insurance plans, to cover these services.[207] All new health plans must cover breastfeeding equipment and supplies without any co-payment, co-insurance, or deductible for these benefits.[208] State Medicaid expansion across the U.S. varies, and thus breastfeeding consultation coverage varies as well. In 34 states, including New York, and D.C. breastfeeding classes are covered through Medicaid.[209] In 30 states, including New York, and D.C., inpatient lactation consultation is covered through Medicaid. In 27 states, including New York, and D.C. outpatient lactation consultation is covered through Medicaid. In 20 states, including New York, and D.C., lactation consultation home visits are covered through Medicaid. Medicare does not cover breastfeeding services. Most private insurance also cover breastfeeding consultant services, but coverage may vary depending on insurance company and plan. The TRICARE Childbirth and Breastfeeding Support Demonstration (CBSD) covers services by certified lactation consultants and counselors.[210] To qualify, mothers must be enrolled in TRICARE Prime or TRICARE Select, be at least 27 weeks pregnant, and qualify for TRICARE 's breastfeeding support benefit. There are no cost-shares, copayments, or deductibles for covered breastfeeding counseling services. Additional charges may apply for out-of-network services. Coverage may vary based on which type of consultant provides the services around breastfeeding support.

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