What is a Freestanding Birth Center?

A birth center is an outpatient facility existing within the health care system designed to follow the midwifery model of care. Birth centers provide family centered care for healthy people before, during, and after normal pregnancy, labor, and birth.[1] Routine gynecological care as well as classes and support groups are often offered in birth centers. A birth center is typically a retrofitted house containing a kitchen, a waiting room, an exam room, bathrooms, and 2-3 birthing rooms. Birth centers function more like a physician's office than like a healthcare facility.[2] The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine state that licensed birth centers are appropriate for "Peripartum care of low-risk women with uncomplicated singleton term pregnancies with a vertex presentation who are expected to have an uncomplicated birth."[3]

As of 2017, there are 345 birth centers in 37 states plus DC, which represents a growth of 76% since 2010[4]. Freestanding birth centers are recognized by statute, legislation, or medicaid in 41 states.[5]

How are Birth Centers Staffed?

Freestanding birth centers are most often owned and staffed by a mixture of Certified Nurse Midwives (CNMs) and Certified Professional Midwives (CPMs), with the slight majority owned by CNMs. Medical and Naturopathic doctors also occasionally own or staff birth centers.

CNMs are graduate level nurse-practitioners (APRNs) with education and experience in both hospital and out of hospital settings. They can prescribe medications and provide primary care and they are licensed to practice in all states.[6] CPMs go through an education process that can include a mixture of apprenticeship and formal classes that prepares them to provide out of hospital obstetric care. They are licensed to practice in 31 states, including Vermont.

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1 https://www.birthcenters.org/page/bce_what_is_a_bc

2 https://www.birthcenters.org/page/bc_experience

3 https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Levels-of-Maternal-Care

4 https://cdn.ymaws.com/www.birthcenters.org/resource/collection/028792A7-808D-4BC7-9A0F-FB038B434B91/Birth_Center_in_the_United_States.pdf

5 https://www.birthcenters.org/page/bc_experience

6 http://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf

Birth centers also employ auxiliary staff including registered nurses, nursing assistants, doulas, midwife assistants, and administrators.

Are Birth Centers Safe?

Numerous studies and meta-analyses have shown that having a baby in a birth center is at least as safe as having a baby in a hospital for low risk women. A 2018 review of 17 birth center studies found identical neonatal mortality rates between birth center births and low-risk populations in hospital.[7] Starting labor with a midwife in a birth center confers a radically lower risk of interventions such as epidurals, vacuum extraction, having perineal trauma requiring suturing and most drastically, cesarean section.[8]

Every major birth center study in the last decade has shown a birth center c-section rate of between 4% and 6% with infant outcomes the same as low-risk populations delivering in hospital.[9] The national C/S rate is 32%, Vermont's is 27%, and the national low risk rate is 26%. This means that the c/s rate for women choosing birth centers is at minimum 4 times lower than if those same women choose hospital birth, with the same level of safety. This has been shown to be true of medicaid beneficiaries as well as people with private insurance.[10]

As one 2013 study wrote in their conclusion: “If the 15,574 women who planned to give birth in birth centers had instead chosen hospital births, it is estimated that they would have experienced 3,000 additional—and unnecessary— Cesareans. Instead, these C-sections were safely and effectively prevented, along with a potential cost-savings of at least $4.5 million.”[11]

Additionally, care by midwives reduces the risk of preterm birth, which is a leading cause of neonatal mortality.[12] Women receiving care from midwives report higher patient satisfaction and have higher rates of breastfeeding. Higher rates of breastfeeding lead to healthier infants which decreases the cost of pediatric care in the first year of life.

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[7] https://onlinelibrary.wiley.com/doi/full/10.1111/jmwh.12701

[8] https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

[9] https://www.ncbi.nlm.nih.gov/pubmed/27926797 , https://www.ncbi.nlm.nih.gov/pubmed/26773853, https://www.birthcenters.org/page/bce_bc_results/Birth-Center-Results.htm, as well as all other studies referenced in this section

[10] https://innovation.cms.gov/Files/reports/strongstart-prenatal-fg-finalevalrpt.pdf

[11] https://www.ncbi.nlm.nih.gov/pubmed/23363029

[12] https://www.ncbi.nlm.nih.gov/pubmed/27121907

At a time when the C-section rate in America is more than double what the WHO recommends and the USA has the worst rate of maternal mortality in the developed world, birth centers should be enthusiastically encouraged.

Are Birth Centers Cost effective?

Care by midwives in birth centers is exceptionally affordable to the healthcare system. In the 2013 study I referenced earlier, the researchers estimated that more than $30 million was saved over 3 years because of the 15,574 women in their study who chose to give birth in birth centers.

The Centers for Medicare and Medicaid Services (CMS) published results of their Strong Start for Mothers and Newborns study in 2018 comparing birth centers to maternity care homes. They concluded "Women who received prenatal care in Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start. In particular, rates of preterm birth, low birthweight, and cesarean section were lower among Birth Center participants, and costs were more than $2,000 lower per mother-infant pair during birth and the following year. These promising Birth Center results may be useful to state Medicaid programs seeking to improve the health outcomes of their covered populations." [13]

Do Vermont Families Want Birth Centers?

Between 2004-2010, out of hospital births increased by more than 40% in the United States.[14] A sample of 2400 mothers in 2013 found two-thirds of mothers planning more children would consider a birth center separate from a hospital. [15] A 2013 study of 15,574 women who planned to give birth in a freestanding birth center reported that 98.8 percent of these women would recommend birth centers to friends and/or return to the center for a subsequent birth. [16] Every person has the right to make an informed choice about their reproductive healthcare and the place of birth that best fits their needs, and clearly birth centers are in demand.

Comments on a community assessment survey sent out in the Brattleboro VT community in the Fall of 2018 include:

“Fantastic! Would love one in Northern Vermont! So sad that Vermont (of all places) does not have a free standing Birth center!”

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[13] https://innovation.cms.gov/initiatives/strong-start/, https://innovation.cms.gov/Files/reports/strongstart-prenatal-fg-finalevalrpt.pdf
[14] https://europepmc.org/abstract/med/24594003
[15] http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf
[16] https://www.birthcenters.org/page/bce_bc_results/Birth-Center-Results.htm

"I think it's an excellent idea. I used midwives with both my birth experiences (one in VT, one out of state) and loved the kind and attentive care I received with them."

"It would be the best thing to happen to pregnant and birthing women in this state"

"Yes! I would have loved having that option here in southern Vermont and would definitely have chosen to birth in a birth center had there been one close to me!"

"As a birth worker for 20 years here in VT, and as a woman who had 2 hospitals births and one home birth, I strongly feel a free standing birth center would be a huge asset to our growing Vermont families!!"

Why is licensure of birth centers important?

Licensure of birth centers provides for patient safety and is expected by patients, collaborating medical providers, and insurers. Only licensed facilities are eligible for payment by Medicaid and most private health plans. Healthcare providers must work in licensed facilities to be eligible for professional liability insurance. Thus, licensure is highly desirable for freestanding birth centers.

VT Medicaid and other insurers

Vermont Medicaid will need to amend medicaid regulations to officially recognize birth centers as facilities that can bill a facility fee. The facility fee is the primary income for a birth center and birth centers are not financially viable without it. Washington state medicaid is a good model for this as they have recently revised their regulations in regards to birth centers.

It should be stated in legislative statute that private insurance companies that operate in Vermont are required to cover services in Vermont licensed birth centers. Florida has such a statute (Title XXXVII chapter 627.6406**)** that states:

- "Any policy of health insurance which provides coverage for maternity care must also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.332.
- "Any policy of health insurance that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant."

Certificate of Need (CON)

Vermont birth centers should be excluded from Certificate of Need review under 18 V.S.A. § 9435 (a) which excludes "the offices of physicians, dentists, or other practitioners of the healing arts . . . in which such providers perform a range of diagnostic and treatment services usually performed by such providers on an outpatient basis".

The majority of states that license birth centers do not require a CON and instead have a separate classification for freestanding birth centers or classify them as ambulatory care centers, community health clinics, diagnostic and treatment centers, or outpatient clinics.

Birth centers are limited to low risk maternity care and do not provide the same services as a hospital bed in the same community. There is no capability for surgical birth or anesthesia in a freestanding birth center, instead there is intensive support for physiologic birth and postpartum care that includes home visits.

In states that do require that birth centers go through the CON process, most or all prospective birth centers are rejected due to strong hospital opposition. In the state of Kentucky in 2015, The Franklin Circuit Court ruled that the services provided in a freestanding birth center were unique from hospital births, even when those hospitals employ midwives, and that hospitals could not be involved in a birth center CON. State CON is also typically prohibitively expensive for birth centers.

It is important to note that historically the Green Mountain Care Board seems to have a personal bias against birth centers.

What should licensure look like?

The American Association of Birth Centers (AABC) publishes national standards for birth centers that states can use as a template for licensure. These standards, revised in 2017, can be found here: https://c.ymcdn.com/sites/www.birthcenters.org/resource/resmgr/AABC-STANDARDS-RV2017.pdf

The AABC recommends including the following guidelines and avoiding the associated pitfalls:

> **Guidelines for Transfer and Collaboration**
>
> Regulations should require written practice guidelines and policies that include plans to transfer to an acute care hospital with maternity and newborn services should circumstances warrant as well as a plan for consultation with a board certified OB/GYN. Guidelines for transfers should include plans for emergent and non-emergent situations for both mothers and newborns, antepartum, during labor, and postpartum. These guidelines should also include indications for transfer, and plans for communication with the receiving hospital both during and after transfer has been achieved. It is important to keep in mind that fewer than 2% of transfers from birth centers are urgent.[17]

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[17] https://cdn.ymaws.com/www.birthcenters.org/resource/collection/DCBDA72A-41EA-4AFE-A8D1-112542F4A0BC/The_National_Birth_Center_Study_II_-_Fact_Sheet.pdf

These guidelines do not need to be in the form of a contract or written agreement with a hospital or physician. In states where written contracts or agreements are required, hospitals and/or physicians charge large fees or simply refuse to sign the agreements to keep the birth center from operating.

Physical Layout

Regulations for the physical layout of birth centers should be based on business occupancy requirements and should not require enhancements that increase cost but do not improve safety. Because care provided in freestanding birth centers is limited to low risk maternity and newborn care, business occupancy construction standards are the acceptable level. **There is no need for facility construction to be at the level of hospitals or ambulatory surgery centers to safely meet the needs of the low risk women and infants served in birth centers.**

The center may be an adaptation of a house and should include birthing rooms, toilet facilities for staff, patients, and families; bath facilities; storage facilities; examination areas; laundry facilities; sterilizing area; areas for laboratory and emergency equipment. Hand washing facilities should be immediately available to all examining and birth rooms. Residential, professional, or commercial zoning regulations, rather than hospital regulations, should apply to the birth center.

If using FGI guidelines, Vermont's regulations should specify that we use the most updated version of the guidelines and that waivers for certain requirements may be possible.

Facility Specific

Regulations for birth centers need to be specific to the facility and not include regulations regarding provider's scope of practice. For scope of practice issues, it is best for providers to be regulated under those practitioners' individual licensing boards and not in birth center regulations. For example, like most states Vermont does not require physician oversight for CNMs. Consequently it would not make sense to require physician oversight for CNM-run birth centers.

Clinical Director

Birth centers should have a clinical director who is a Vermont licensed CNM, CPM, or OB/GYN who is responsible for overseeing the quality of medical care and services at the birthing center.

Equipment

Birth centers should be equipped with items needed to provide low-risk maternity care and the equipment and readiness to initiate emergency procedures in life threatening events. This includes but is not limited to a heat source for the newborn, portable lighting, Sterilizer or demonstration of sterilizing capability, Blood pressure equipment, thermometers, fetoscope, or doptone, Oxygen,Neonatal resuscitation bag, and Intravenous equipment.

Patients

Only clients who meet the eligibility criteria shall be admitted to the birthing center for intrapartum care. In order to be eligible, the client's licensed or certified practitioner shall determine that the client was medically, psychologically, surgically, and obstetrically uncomplicated during her prenatal care. A client shall not present any of the following contraindications to intrapartum birth center care: a. Placenta previa; b. Multiple fetuses; c. Insulin dependent diabetes; d. Rh factor sensitivity with positive antibody titre e. Labor before the 37th week of pregnancy f. Active primary herpes at term g. Fetal death h. Suspected intrauterine growth retardation i. Fetal distress as indicated by persistent bradycardia or tachycardia

Care Provided

Preconception counseling, health and nutrition counseling, prenatal care, lactation assistance, family planning, childbirth education, postpartum care, newborn transition care, early recognition and prevention of potential health problems, detection of any abnormal conditions in the mother, fetus, and newborn. Additional services as allowed in provider scope of practice including annual exams, Pap screening, miscarriage management, IUD and contraceptive implant placement and removal, STD and vaginal infection treatment, medication abortion, and other gynecologic services.

Prenatal care shall include, but is not limited to, a health examination including pelvic and speculum exam, as applicable, a social, family, medical, reproductive, nutritional, and behavioral history, assessing vital signs, arranging for routine prenatal blood tests, nutritional assessment and counseling, Pap smear if indicated, chlamydia and gonorrhea screening tests as applicable, establishment of gestational age, and advising of available prenatal testing. Each prenatal visit shall include but is not limited to blood pressure monitoring, urine dip for protein and glucose, which may be performed by the client, assessment of general health, monitoring of uterine measurements, fetal

heart rate, and fetal activity, and arranging for birthing center tests or procedures as indicated.

Intrapartum care shall include, but is not limited to monitoring the condition of mother and fetus, providing emotional and physical support, assisting with the delivery, repairing minor tears or episiotomies as necessary, examination and assessment of the newborn, Inspection of the placenta, membranes, and cord vessels and management of any maternal or neonatal complications.

Postpartum care shall include, but is not limited to: (1) Remaining with the client and newborn for a minimum of 2 hours after birth or until: a. The infant: 1. Is alert; 2. Has good color; 3. Has a good sucking reflex; 4. Is breathing normally; and 5. Has a stable temperature within the range of 97 to 100 degrees F; and b. The mother: 1. Has a firm fundus; 2. Does not have excessive vaginal bleeding; 3. Is afebrile; 4. Has voided; and 5. Has established successful breastfeeding, if applicable; (2) Obtaining or arranging for a blood sample from the newborn for metabolic disorders (3) Providing the client with information on routine postpartum and newborn care, including follow up care with a pediatrician or family practitioner for the newborn

Hospital Privileges

Ideally, birth center CNMs shall maintain privileges at the local hospital so that they may transfer with patients who risk out of birth center care but not out of the CNM scope of practice. This includes but is not limited to patients who would like an epidural, who need induction or augmentation of labor, who have meconium in the amniotic fluid, who need continuous electronic monitoring, or who need blood pressure lowering medications in labor. Hospitals should cooperate with birth center CNMs to make these privileges possible for the safety and satisfaction of patients.