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Testimony to the Vermont Senate Health and Welfare committee

My name is Kathleen McGraw MD, FHM, CPE, and Chief Medical Officer at Brattleboro Memorial Hospital. I am a practicing Hospitalist, a member of the VAHHS Board and the Chair of the Chief Medical Officer Committee of VAHHS.

Thank you for inviting me to testify about the licensing of Free Standing Birthing Centers and I would like to comment specifically on the question of if they should be regulated by the CERTIFICATE OF NEED process.

I'd like to start by describing the state of the OB right now in VT and then look at what having or not having a CERTIFICATE OF NEED process would do to that reality.

Nationally births are trending down. We see this dramatically in VT which, per CDC statistics, has the lowest birthrate in the nation. Nationally less than half of all rural counties no longer have OB services because of the expense of providing such services. In VT providing OB is a labor of love, poorly compensated and high risk. Most of the births are Medicaid funded, and hospitals provide birthing services at a loss. Brattleboro Memorial Hospital (or BMH) alone loses $4M a year on its birthing services, roughly half from the OB offices and half on the hospital side. Between 2012 and 2021 the total number of births at BMH dropped 31%. Springfield hospital also had a declining number of births, and an insurmountable loss of money associated with it. In 2019 they elected to close their birthing services. BMH stepped in to assist that community by providing prenatal services on site in Springfield and deliveries at BMH. Our total decline in births INCLUDES the addition of these patients. Currently OB services in VT are very at risk. The finances do not support them. The communities want and need them. Most of the services are Medicaid. Yet the risk of not having services within a community can be large. Maternal and fetal mortality is not a theoretical risk. Advanced practices and technology have helped reduce the risk, but it is with the careful attention of highly skilled personnel and attendant surgical services that this risk is aptly managed. The skill level of these personnel cannot be overlooked. In fact, during COVID, as we had to redeploy various staff to other areas to provide care and plug holes in staffing, we did not deploy other staff into our birthing center. Why? Because as difficult as it is to take a nurse from one setting and move them to another to help cover needed absences, that is not possible in OB. The skillset is specific and learned over time. Anything that jeopardizes that nursing workforce also jeopardizes the safety of our deliveries.

So what does it take to run a birthing center? It is one of those services that has to be ready 24/7 to deliver babies. That means having staff on site even when there are no laboring moms. That means having an anesthesia team at the ready at all times. It also is a service that needs volume to be able to remain skilled. This is part of why we picked up the Springfield services. Low birth numbers are a problem in VT. Everyone has to work hard to keep up their skills since we don't have large volume. Volume is key to seeing not only the normal presentations, but also successfully learning and practicing the less frequent presentations, and being able to readily identify the potentially dangerous situations. And make no mistake, those are not uncommon in births, and endanger not one, but 2 patients, both mother and baby. Right now our community hospitals manage the routine deliveries, the known low risk deliveries, and the

unknown high risk deliveries. We also take care of the emergency birth situations that arise from home births that encounter problems. Our doctors have to pick up the pieces of home births gone awry. These patients arrive in the midst of delivery, without provider relationships, a patient who has intentionally not chosen a hospital for birth and a situation almost always involving risk and surgery. These are the patients for whom the true commitment of the doctor to the wellbeing of the patient no matter the situation is most evident. A free standing birthing center would depend on a nearby hospital to provide c-section services for patients. Nationally the number of patients needing c-sections from a Free Standing Birthing Centers stands at around 6%. A low number, but a real one nevertheless. These are patients who for whom delivery can be in-process on transfer, with dramatic consequences if surgery is not readily available. The need for speed is why we have an operating room actually in our birthing center. We have learned that the time that it takes to get a patient into elevators and into an OR elsewhere in the hospital can be minutes wasted and make the difference between the safe delivery of a healthy child, and a much more heartbreaking complicated outcome. A Free Standing Birthing Center depends on the ready availability of a hospital to provide this. Any Free Standing Birthing Center needs the presence of a skilled hospital based program as a partner for patient safety.

So what would happen if we had Free Standing Birthing Centers in a community for which there was not a true assessment of need? To start with, the volume of deliveries for the hospital would obviously go down. This would jeopardize the skill set of the staff at the hospital for delivering babies, but I would also posit that it would jeopardize the skill set of those in the Free Standing Birthing Centers, since low numbers split into two parts become very low numbers for both entities. This means that hospitals and physicians would need to evaluate their ability to continue their safe skillset for this service. A natural outcome would be the closure of hospital based birthing centers. This means more OB deserts. It also means far more risk for patients and their babies having to travel such distances.

Further, a Free Standing Birthing Center without evident need for its presence would put hospitals in a more fragile financial situation. The reality is that right now hospitals are already very fragile. I am sure you have aware of this from numerous angles, including the beleaguered workforce, the missing workforce, and the fragile state of hospital finances, initially caused by COVID, but now existing as a new normal. A Free Standing Birthing Center will obviously not be taking all comers. They cannot keep their doors open working at a substantial loss the way that hospitals do for this service. That means they would be shifting the payer mix, taking the private insurance and private pay patients, leaving the Medicaid patients for the hospitals. Furthermore, routine hospital births subsidize complex births. This equation creates insufficient numbers on both sides, and a much worse financial burden for the hospitals, risking hospital sustainability. In addition, it risks creating situations where a patient giving birth in an outpatient setting has nowhere to transfer to for emergency birth care.

Make no mistake, a Free Standing Birthing Center could provide an amazingly beautiful safe birthing experience for some patients. But the key is the importance to have the need for the Free Standing Birthing Center in a community evaluated. That is the only way to ensure the safety of the result for all the patients. At a minimum, ensuring there is actually a need is the first step in providing any care. That is the whole purpose of a CERTIFICATE OF NEED. It is intended to ensure there are no duplicative services, to provide some cost containment, and provide for

equity of access. A lack of a CERTIFICATE OF NEED process endangers the safety of our patients as well as the financial stability of the hospitals, and in the event of resulting OB closure, creates longer drive times for routine hospital births, and an untenable distance for emergency interventions.

Please, please consider this full perspective as you consider the request to exempt Free Standing Birthing Centers from the CERTIFICATE OF NEED process.

Thank you.

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