Freestanding Birth Centers: An Evidence-Based Option for Birth

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ABSTRACT
Every childbearing person has the right to learn about all options for perinatal care provider and birth setting. To ensure an informed decision about their preferred birth plan, information should be provided either preconceptionally or in early pregnancy. Personal preferences and risk status should be considered in decision-making. Numbers of births in birth centers have doubled over past decade to almost 20,000 births per year. The evidence shows that childbearing people who participate in birth center care, even if they have only birth center prenatal care, experience better outcomes including lower rates of preterm birth, low birth weight births, and cesarean birth, and higher rates of breastfeeding when compared to people with similar risk profiles who receive typical perinatal care.

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All childbearing people have the right to learn about their various options for perinatal care provider and birth setting, including the freestanding birth center. The freestanding birth center setting is sometimes misunderstood by consumers, in part because many hospitals have co-opted the term “Birth Center” as a part of the name of their labor and delivery unit. Information should be available to inform those planning a pregnancy and pregnant people about their birth setting options, so they can make an informed decision about their preferred birth plan. We will provide an overview of the history, accreditation, the model of care, and the evidence of birth center outcomes.

The freestanding birth center is an option for lower risk clients to choose for their perinatal care and birth. The number of births in birth centers has doubled over past decade to 20,000 births per year, which represents only 0.5% of all births in the United States (Martin et al., 2021). An additional number of people participate in birth center prenatal care and postpartum care, but don’t give birth in birth centers, with some transferring to hospital care due to antepartum transfers, intrapartum transfers, and others choosing to have hospital birth by preference, even though they are risk appropriate for birth center birth (Alliman et al., 2019; Jolles et al., 2017).

The freestanding birth center is defined as a facility where birth is planned to take place away from the hospital and away from the person's residence, where care is provided in the midwifery and wellness model, with birth center care integrated into the healthcare system (American Association of Birth Centers [AABC], 2017). This model of care is documented going back to 1946 with La Casita in Santa Fe, founded in a small house, and run by Catholic Maternity Institute medical mission Sisters and nurse-midwives, Theophane Shoemaker and Helen Herb (Cole & Avery, 2017). Beginning in 1949 in Southern Georgia, Beatrice Borders, a state licensed Grand midwife, operated a freestanding birth center named after her mother, also a midwife (Mastrovita, 2021). This facility served over 6,000 Black women in the Jim Crow south who had no access to hospital care. These early versions of the birth center model were called a "maternity home" and "nursing home," respectively, and were born out of the necessity to care for underserved populations (Cole & Avery, 2017; Digital Library, 2021).

Modern freestanding birth centers began in the mid-1970's during the time of increasing consumer awareness and concern about unnecessary medical interventions routinely taking place in the hospital setting (Cole & Avery, 2017; Lothian, 2001). Childbearing people sought access to birth centers as part of the movement to have more control over setting and care processes in labor and birth (Cole & Avery, 2017). Over the past 40 years, the number of birth centers in the United States has grown to more than 400 as of 2021 (AABC, 2021). The number of births in birth centers has doubled over the past 10 years and was almost 20,000 in 2019 (AABC, 2021; Martin et al., 2010; Martin et al., 2021) yet this represents only .5% of annual births in the United States (Martin et al., 2021).

In 1985, the American Association of Birth Centers established the Standards for Birth Centers, a document outlining evidence-based care and best practices for birth center operation (American Association of Birth Centers [AABC], 2017). Since that time, the standards have been revised and updated as needed with the input of multiple experts and stakeholders. The Commission for the Accreditation of Birth Centers (CABC) is a separate organization that accredits birth centers in the United States, using the AABC Standards as a guide (Bauer & Stapleton, 2021). Birth centers are licensed in 41 states and the District of Columbia and have deemed licensure in 2 additional states. Five states that do not license or regulate birth centers allow them to operate, but in these states without licensure or other regulation, birth centers are not eligible for Medicaid reimbursement (Figure 1). The AABC has created model regulations that states may use when they wish to add birth center licensure (AABC, 2021). Accreditation and a care model following the AABC Standards are considered the "gold standard" for birth center practice.

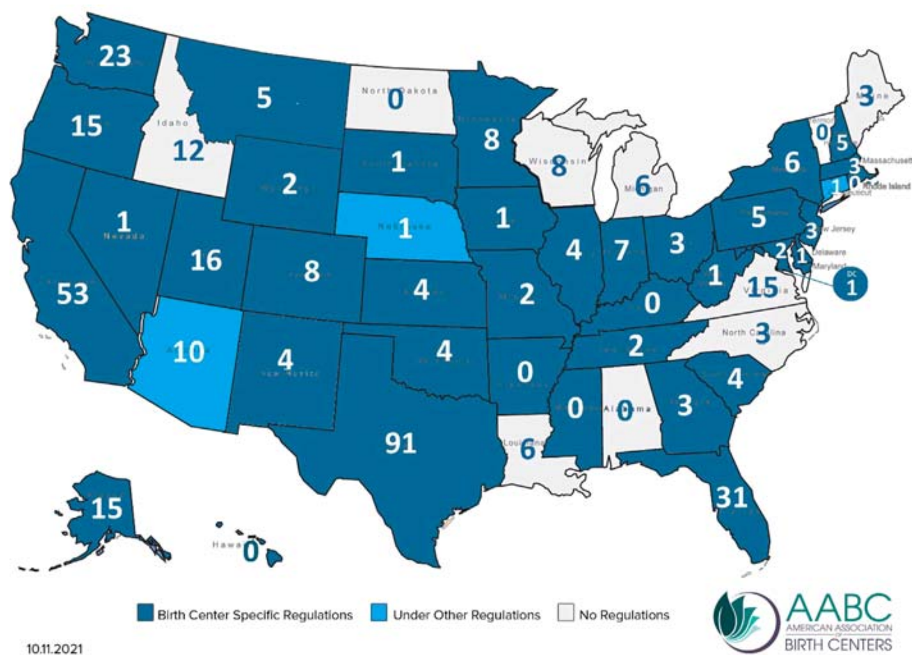

Figure 1. Map of licensure and birth center numbers in the United States, 2021.

BIRTH CENTER MODEL OF CARE

What makes birth center care different from typical care in a hospital and what do childbearing families need to know to choose the best perinatal care setting to meet their preferences and needs?

Childbearing people should understand their own risk profile and birth setting options based on their clinical needs, as well as their personal preferences to choose the most suitable care and birth setting. Surveys often indicate that people of childbearing age don't have sufficient knowledge of the differences among different birth settings to consider options other than the hospital (Declercq et al., 2013).

Care in freestanding birth centers includes the standard components of prenatal care plus longer prenatal visits with time to develop relationships with midwifery care providers (Figure 2). Birth center prenatal visits last thirty minutes or longer and include clinical and holistic status assessments and individualized education. Discussion and time for questions with midwives is the norm in birth center care. This model of care supports relationships between clients and their families, and midwives and staff in the birth center, which reduces stress and promotes trust. Benefits include continuity of care with a known midwifery provider, which has been shown to improve outcomes (Sandall et al., 2015).

Labor and birth in the birth center begins with spontaneous onset and progress of labor. No medical stimulation of labor may occur in the birth center. Walking and position changes are encouraged. Once the birth occurs, the mother or childbearing person and newborn are not separated. Skin-to-skin care is encouraged as long as is desired and feeding is facilitated. Most newborn care can be provided while the baby is being held. The number of support people and family members is determined by the childbearing person, unless limited by Covid policies. The birth center is a birth setting that holistically embodies the same principles as the Healthy Birth Practices of Lamaze (Lothian & DeVries, 2017).

Care in birth centers is provided as an integrated part of the healthcare system. One challenge still needing to be overcome in some communities is that local physicians and hospitals are resistant to collaborate and develop ideal communications with birth centers. This collaboration is needed to create a fully integrated system where transfers, when needed, can be seamless and as safe as possible for the childbearing person and newborn. Consultation or referral with physicians and acute care facilities is a part of the birth center model of care. Continuous assessment of risk status throughout the various phases of care is key to achieving the best outcomes in community birth.

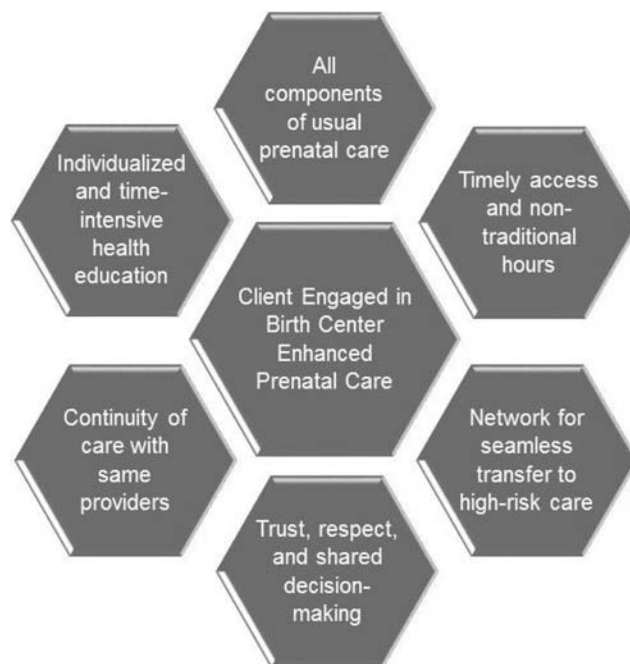

Figure 2. Birth center model of enhanced prenatal care.

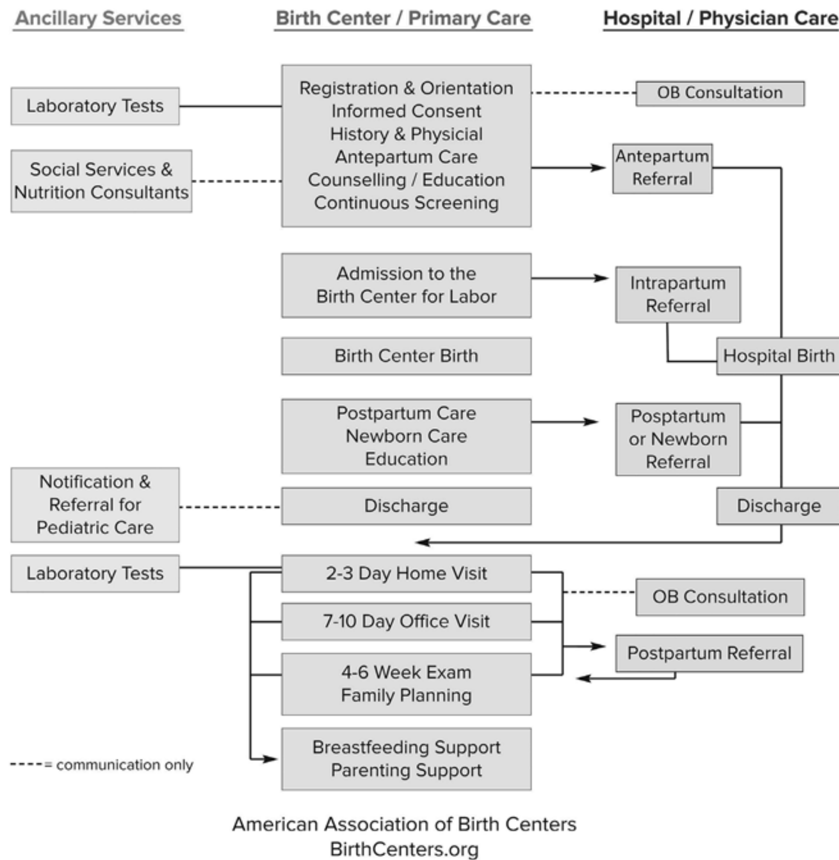

Figure 3. The birth center. Primary care in an integrated health care system.

Figure 3 shows the interaction between the birth center, ancillary services, and hospital and physician care throughout the perinatal period from registration/orientation to postpartum, breastfeeding, and parenting support. Consultations with prenatal social services, mental health care, and nutritionists are provided as needed. Many birth centers have in-house lactation consultation throughout pregnancy and postpartum, and all provide access to collaborating lactation support services as needed. Birth center care includes at least 3 postpartum visits with a 2–3 day home visit, 1–2 weeks mother/baby office visit, and a 4–6 week visit.

RESEARCH AND OUTCOMES

Birth center care is consistently associated with lower cesarean rates, fewer medical interventions, and higher rates of breastfeeding and satisfaction with care (Alliman & Phillippi, 2016; Alliman et al., 2019; Dubay et al., 2020; Jolles et al., 2017; Stapleton et al., 2013). In the Strong Start study, preterm and low birthweight births, cesarean births, and other medical interventions were reduced with birth center care, and a significant cost savings was identified for Medicaid participants (Alliman et al., 2019; Dubay et al., 2020; Jolles et al., 2017). The cost of care for each mother-baby dyad in birth center care in this study saved an average of $2,000 compared to those with similar risk profiles in the same counties receiving typical care (Dubay et al., 2020). This was true even for those who had prenatal care in the birth center and were either transferred or chose the hospital setting for birth (Alliman et al., 2019).

Disparities in preterm birth, low birthweight, cesarean birth, and breastfeeding initiation were significantly reduced among racial and ethnic groups in the Strong Start study (Table 1). The midwifery birth center model can help to meet these challenges. However, more work is needed to eliminate disparities, and that will include addressing social

TABLE 1

National Health Indicators by Race for American Association of Birth Centers Strong Start Medicaid Participants 2013–2017 Compared to National Data for Same Period

	AABC Strong Start all races[a] %	US all races %	AABC Black/US Black %	AABC Hispanic/US Hispanic %	AABC White/US White %
Preterm birth %	4.4	9.9[b]	5.1/13.8[b]	7.0/9.5[b]	4.2/9.0[b]
Low birth weight %	3.3	8.2[b]	5.9/13.7[b]	2.9/7.3[b]	1.3/7.0[b]
Cesarean birth %	12.3	31.9[b]	15.1/35.9[b]	13.4/31.7[b]	10.6/30.9[b]
Breastfeeding initiation %	92.2	83.2[c]	89.1/69.4[c]	91.2/84.6[c]	91.0/85.9[c]

[a]AABC Strong Start Data, 2013–2017.
[b]Martin 2018, Final Birth Data for 2016.
[c]Centers for Disease Control and Prevention National Immunization Survey, 2009–2015 (2018).

determinants and structural racism throughout the entire healthcare system.

Data show that when pregnant people with a low-risk status appropriate for birth center care are admitted to the hospital for labor, they have a higher risk of cesarean birth than people who choose the birth center for labor and birth (Jolles et al., 2017; Thornton et al., 2017). Studies also show higher rates of medical procedures including induction of labor and continuous electronic fetal monitoring for low risk birth center participants who choose a hospital admission for labor (Jolles et al., 2017; Stapleton et al., 2013; Thornton et al., 2017).

IMPLICATIONS FOR EDUCATORS

Given the benefits of the birth center model and the evidence supporting utilization of birth centers by lower risk people, educators and providers should include this option in discussions about choice of provider and birth settings.

Ideally, all childbearing people should receive education about care provider and birth options before pregnancy, or at the least in early pregnancy. This education should include risks and benefits of various options and should be provided in an individualized manner taking into consideration their needs and preferences. Birth centers have mechanisms in place to accept transfers of low risk childbearing people during pregnancy because some people only learn about the birth center option after they have started prenatal care.

When counseling a person or family about options for their birth setting, it is important for them to understand that for hospital, home, and birth center, each setting has risks and benefits for the childbearing person and their newborn. No setting for birth is risk free, and all birth settings can improve risk by working on quality improvement in that care model (National Academies of Science, Engineering, and Medicine [NASEM], 2020). For people with low medical risk status, considering a birth center birth is appropriate, and they can be counseled regarding this option (NASEM, 2020).

Offering the choice of birth center care will assist people with knowing all their options and possibly reducing their risk of some unnecessary interventions and cesarean birth (Table 1). The model of care is associated with reduced risk of preterm and low birthweight birth. (Table 1). Birth center care increases the likelihood of successful breastfeeding at birth and continuing at 6 weeks postpartum (Table 1). When choosing a birth center, asking about accreditation status, licensure, and whether the birth center follows AABC Standards of Care provides information on the quality of care provided in that birth center.

CONCLUSION

The freestanding birth center with midwifery care is a good option for low risk childbearing people to consider for their perinatal care. The midwifery model of care is practiced in the birth center setting with longer prenatal visits, individualized care, and education. This time intensive and relationship-based care midwifery model is proposed as a key mechanism for improved outcomes. The evidence shows outcomes of birth center care are better for maternal outcomes and better or similar for neonatal outcomes as compared to hospital care for low risk childbearing people. Some of these include lower cesarean rates, fewer medical interventions such as induction of labor and epidural anesthesia for maternal outcomes. Neonatal benefits include lower preterm and low birthweight births, higher initiation of and longer terms of breastfeeding. Disparities in preterm and low birthweight birth, cesareans and breastfeeding are reduced among racial and ethnic groups in birth center care.

Birth center numbers have grown in the last decade but considering the benefits of improved maternal and infant health, cost savings, and improved experience of care, birth centers are underutilized in the United States. Educating more childbearing people about all options including the birth center will promote access to person-centered care for all.

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