Testimony for S. 18-Vermont Senate Health and Welfare

Good morning Senators and Staff of the Senate Health and Welfare Committee. Thank you for the opportunity to testify today. My name is Jill Alliman, and I am a certified nurse-midwife. I provided clinical care in a rural freestanding birth center for 27 years. Then, I was the Project Director for the CMS funded Strong Start Initiative for Birth Centers at AABC from 2013-2017. Currently, I teach graduate nurse-midwifery students at Frontier Nursing University, and work with the American Association of Birth Centers in Government Affairs.

Background of the Need and the Midwifery Model of Care

- The United States has the worst maternal outcomes of any high resource country. Working to improve the maternity care system is challenging given the divergent needs of those with high-risk versus low-risk pregnancies. Most pregnancies (at least 80%) are considered in the lower risk category.
- The midwifery-led birth center model of maternity care has birth occurring in a freestanding facility that is not a hospital but that is integrated into the healthcare system. Risk screening is continuous, emergency equipment is on hand, and staff are trained to manage transfers if needed.
- Outcomes from the US and other countries show that the midwifery model of care can improve outcomes especially for low-risk pregnancies. Midwives are currently underutilized in the US, attending 12% of all births, compared to European countries where midwives attend 60-80% of all births.
- We are facing a growing shortage of maternity care providers and facilities providing this care. This leads to people having to drive further and further for prenatal visits and birth, which leads to less care and worse outcomes. The March of Dimes monitors this growing shortage and writes that 35% of all US Counties are maternity care deserts. March of Dimes states that freestanding birth centers are part of the solution to this problem.

History and Current Status of US Birth Centers

Birth centers started organizing a network and doing research in the early 1980's. They established a robust data collection system and evidence-based Standards for Birth Center Care, as well as an accreditation process through the Commission for the Accreditation of Birth Centers, based on the Standards.

ACOG and the Society for Maternal Fetal Medicine include the Freestanding birth center in their Consensus Statement on Levels of Maternal Care. The recommendations there are that birth centers should follow the Standards for Birth Center Care in staffing and clinical operation.

Freestanding birth centers experienced continued growth but still represent a small percentage of all births in the US at slightly less than 1% of all US births.

At present, we have about 25,000 births in birth centers plus approximately 50% of that number who have prenatal care in birth centers and give birth in hospitals, then return to birth centers for postpartum care. Birth centers also can provide well care and health screenings, basic primary care, and health education.

What do the data show about birth centers safety and benefits?

The American Association of Birth Centers has always encouraged freestanding birth centers to collect de-identified data on care processes and outcomes, with patient consent. The AABC dataset has been used for multiple studies over the past 40 years encompassing the quality of care, outcomes, and patient satisfaction with that care.

Data and outcomes of birth center care.

The first national birth center study was published in 1989 in the New England Journal of Medicine, and the second national BC study in 2013. Both studies showed similar cesarean rates of 6% for women admitted to the birth center in labor. During that same period, the national cesarean rate increased from 23.8% in 1989 to 32.8% currently without any improvement of neonatal or maternal health status.

Transfer rates during labor from birth centers also show consistency over time. Transfers during labor can occur for various reasons, most commonly for inadequate progress of labor or the need for pain medication. While the transfer rate is typically 15-16% during labor, only 2% of transfers are due to emergencies.

The Strong Start study, conducted in 49 birth centers in 17 states, evaluated the care of Medicaid and CHIP participants and found that birth center care participants experienced significant reductions in preterm and low birthweight births, lower rates of cesarean sections, and a cost savings of over $2000 for each mother/baby pair over the first year. This study used a comparison population of women in the same regions with the same risk profiles receiving typical care.

Concerns about birth center impact in rural areas.

My experience is from working in a rural birth center Appalachian TN for 27 years—we had a community hospital 10 minutes away that grew its OB department with a birth center in the county.

Having both a freestanding birth center and a hospital in your county lets people know that your community offers options to childbearing people and their families, and that it is a good place to go for care.

Certificate of Need.

States that require a Certificate of Need for birth centers have fewer to no birth centers. One cannot compare a bed in a birth center to a hospital bed because services the two settings provide are so different. Options and choices for the facility where one wants to give birth should be available to the person and family giving birth. Allowing hospitals to block the licensure of birth centers has been judged anti-competitive by the Federal Trade Commission. More and more states in recent years have made birth centers exempt from the Certificate of Need, including Connecticut, South Carolina, West Virginia, Tennessee, Oklahoma, and Indiana.

Conclusion

The freestanding birth center is a good option for lower 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 model of care is a key mechanism for improving 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 care improves population health, patient experience, and value. The model demonstrates the potential to decrease racial disparities and improve population health. Reduction of regulatory barriers and implementation of sustainable reimbursement are warranted to move the model to scale for women and families nationwide.

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. The families of Vermont deserve access to evidence-based freestanding birth centers in their state, if that is their choice.