FREE STANDING BIRTH CENTERS

OPTIMAL OUTCOMES

BIRTH IN AMERICA

• There are nearly 4 million births each year in the U.S.
  ▪ 99% of births take place in hospitals (86% attended by physicians)
  ▪ 0.3% in birth centers (86% attended by CNM)
  ▪ 85% of women who give birth in the hospital are considered low risk.

CHILDBIRTH IS THE TOP REASON FOR HOSPITALIZATION ACROSS ALL AGES

Percentage of total hospitalizations by reason for men and women of all ages
Health, United States 2009 CDC/NCHS http://www.cdc.gov/nchs/data/hus/hus09.pdf

0 2 4 6 8 10 12
Childbirth 11%
Heart Disease 5%
Injury 3.6%

HOSPITAL BIRTH DATA 2009

• Childbirth is the leading cause of hospitalization in the United States
  ▪ mothers and newborns accounting for 23% of all hospital discharges
• 6 out 10 of the most common hospital procedures were related to maternity care
• Cesarean birth was the most common inpatient surgical procedure
• Pregnancy, birth, and newborn care total:
  ▪ $97.4 billion in hospital charges
  ▪ making it the single largest contributor as a health condition to the national hospital bill

CESAREAN RATES CONTINUE TO INCREASE, WHILE VBAC RATES DECREASE.
ROUTINE HOSPITAL INTERVENTIONS

87% have continuous electronic fetal monitoring
80% receive intravenous fluids
47% have labor artificially accelerated with medications
43% of first-time moms have labor artificially induced
60% of women giving birth in hospitals are not allowed to eat or drink,
76% are restricted to bed
92% give birth lying on their backs


ROUTINE INTERVENTIONS

• "when normal, healthy pregnant women give birth in hospitals, their care often gets swept up into this same medical way of doing things. The philosophy is often 'What if something bad happens?' instead of 'What is happening right now?'"
• Standard protocols, meant to prepare for problems that may never arise, can disrupt normal labor for healthy pregnant women.
• There is strong evidence that routine use of these practices, when carried out without medical indications, has few benefits and many potential harms for healthy mothers and babies


BIRTH CENTER PHILOSOPHY

• Pregnancy and childbirth are healthy, normal life events for most women and babies. In birth centers, midwives and staff hold to the "wellness" model of birth, which means that they provide continuous, supportive care and interventions are used only when medically necessary.


ENTRY AND HALLWAY

TWO BIRTH ROOMS
EXAM ROOM

DINNING ROOM AND KITCHEN

CONVENIENT LOCATION

MINNESOTA BIRTH CENTER STAFF

• All care is provided by CNMs and RNs
• CNM: Certified Nurse Midwives are Advanced Practice Nurse Practitioners and have extensive, post-graduate training in both nursing and midwifery
• CNMs offer obstetric and gynecological services similar to Obstetricians, but with different methodologies and results.
• CNMs Care offer care from puberty to menopause including: Well-women exams, GYN, STI, Family Planning, and Hormone therapy

COMPREHENSIVE PRENATAL CARE

• In house lab draws
  -Courier to ANWH
• In house Limited ultrasounds by CNM
  -Dating
  -Viability
  -AFI
• In house complete ultrasound preformed by an ARDMS ultrasound sonographer at 18 -20 weeks
• Prenatal visits

LABOR SUPPORT

• CNM and RN attend birth
  -NRP certified
• Continuous labor support
• Frequent Position changes
• Hydrotherapy
• Eat and drink
• Music therapy
• Acupressure/Touch
POST PARTUM
• Early Discharge
  • 4-12 hours post-partum
• 24 hour home visit
  • Metabolic Screen
  • Newborn Hearing Screen
• 1 & 6 week post-partum visit

COLLABORATIVE PRACTICE
Collaborating Physicians:
• Steve Calvin
  - Medical Director
• Associates in Women Health
  - ANWH/ Mother Baby Center

SAFE SATISFYING SEAMLESS
• MBC is located across from Abbott North Western and Children’s Hospitals’ Mother Baby Center for quick transfers
• All of the CNMs have privileges at the Mother Baby Center for seamless transfers
• CNMs can admit, deliver and discharge patients independently

BIRTH CENTER REQUIREMENTS
• Attend orientation session
• 18 week ultrasound (gross fetal anomalies and placenta location)
• GDM screening
• Early Discharge class prior to 37 weeks
• Pediatric Provider prior to 37 weeks

MATERNAL RISK FACTORS
• Heart disease
• Pulmonary embolus
• Symptomatic congenital heart defects
• Chronic Hypertension
• Moderate to severe renal disease
• Diabetes mellitus
• Hyperthyroidism
• Bleeding disorder or hemolytic disease
• Sickle cell anemia
• Previous Rh sensitization
• Cardiac diastolic murmur, cardiac systolic murmur III/VI or above
• Evidence of active tuberculosis
• Epilepsy or seizures

ANTEPARTUM RISK FACTORS
• Nonlethal fetal anomaly
• Multiple gestation
• Pre-eclampsia requiring Magnesium Sulfate
• Intrauterine growth restriction
• Oligohydramnios
• Gestation greater than 42 weeks
• Gestational diabetes
• Hematoctit less than 33% at term
• Positive HIV
• Severe mental health problem
• Current alcohol or drug abuse
• Laboratory evidence of sensitization in Rh negative woman
• EFW less than 2500 gm. or greater than 4500 gm.
• Development of any other severe obstetrical, medical or surgical problem
• Per CNM discretion
### INTRAPARTUM RISK FACTORS

- Labor before 37 weeks gestation
- Non-vertex presentation
- Active genital herpes outbreak
- Ruptured membranes greater than 24 hours without active labor
- Significant HR decelerations or bradycardia
- Particulate meconium
- Arrest of dilatation or descent
- Failure to descend in second stage
- Third stage longer than 30 minutes
- Blood loss estimated greater than 500cc
- Cord prolapse
- Inadequate pain relief
- Suspected placental abruption or uterine rupture
- Evidence of infectious process or fever
- Development of other severe obstetrical or medical problems
- Postpartum hemorrhage failing to respond to management
- 3rd and 4th degree laceration
- Per CNM discretion

### BIRTH CENTER SAFETY

- 93% of women who entered the birth center had a spontaneous vaginal birth
  - 6% Caesarean section rate
  - 1% Assisted Vaginal Birth
- 84% admitted to the birth center in labor ended up giving birth at the birth center facility
- 12% Intrapartum transfer rate (most non-emergent)
  - 63% for Prolonged labor/ Arrest of Labor
  - 1.9% were hospital transfers for emergent reasons (50% for PHTN)

### BIRTH CENTER SAFETY (CONT.)

- No maternal deaths
- 0.047% intrapartum fetal mortality rate for the women who were admitted to the birth center in labor (0.47 stillbirths per 1,000 women)
- 0.04% neonatal mortality rate excluding anomalies (0.40 newborn deaths [first 28 days] per 1,000 women)

(The US neonatal mortality rate in 2007 was 0.75/1000 for newborns weighing 2500 g or greater)

### WHERE ARE THE OPPORTUNITIES IN BIRTH CENTERS AND NEW CLINICAL MODELS?

- Quality – 2013 Birth Center Study clearly demonstrates equivalence/superiority
- Experience – Anecdotal at present but new measurement tools will likely show much higher satisfaction levels
- Cost – 2013 Truven study shows that nearly 2/3 of costs are in facility fees for mom/baby

### THE COST OF HAVING A BABY IN THE US

<table>
<thead>
<tr>
<th>Type</th>
<th>Commercial 55%</th>
<th>Medicaid 45%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Delivery</td>
<td>$18,329</td>
<td>$9131</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>$27,866</td>
<td>$13,590</td>
</tr>
</tbody>
</table>

January 2013 - commissioned by Childbirth Connection, Catalyst for Payment Reform, and the Center for Health Care Quality and Payment Reform
**THE PREGNANCY CARE PIE 2013**

- 2/3rd Goes to Facility Fees
  - Professional Fee
  - Facility Fee
  - Anst, Radio, Lab, Pharm

**AFFORDABLE CARE ACT 2011**

- ACA requires government funded health plans to cover services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital
  - Medicare payment at 100% of the physician Fee schedule for certified nurse-midwives (increase from 65%)

**MN statute 256B.0625.Subd. 54. Services provided in birth centers**

- MHCP covers low-risk pregnancy and delivery services provided in a licensed, free-standing birth center if the service is covered when provided in a hospital by a licensed health professional. Free-standing birth centers are licensed health care facilities that perform low-risk deliveries following a low-risk pregnancy by a licensed health professional. A low-risk pregnancy is a normal, uncomplicated pregnancy. A free-standing birth center is not a hospital or licensed as part of a hospital. All free-standing birth centers must be accredited by the Commission for the Accreditation of Birth Centers (CACB). The Minnesota Department of Health (MDH) issues licenses for free-standing birth centers.

https://www.revisor.mn.gov/statutes/?id=256B.0625&year=2010

**MN STATUTE 256B.0625.SUBD. 54. SERVICES PROVIDED IN BIRTH CENTERS**

- Facility services provided by a birth center shall be paid at the lower of billed charges or 70% of the statewide average for a facility
  - Nursery care services provided by a birth center shall be paid the lower of billed charges or 70% of Statewide average for a facility

https://www.revisor.mn.gov/statutes/?id=256B.0625&year=2010

**LEVELS OF CARE IN A BIRTH CENTER CARE MODEL**

- OB Transfer
- Mother/Baby & Midwife in the Hospital
- Mother/Baby & Midwife in the Birth Center

**NEW DIRECTIONS**

- Return to normal birth
  - No scheduled inductions without medical indication
  - Freedom of movement during labor
  - Continuous labor support
  - Non-supine positions for birth
  - No routine interventions
  - No separation of mother and infant after birth
  - Positive media image of normal birth
  - True informed consent
  - No cesareans and induction without medical indication
  - Nursing school education on supporting normal birth

WHY CHOOSE A BIRTH CENTER

• Low risk motivated mothers are ideal candidates for birth center care.
• Pregnancy and birth are viewed as normal family events
• Alternative to home birth
• Reduced use of medical interventions
• Infant mortality similar to low-risk hospital births
• Birth center birth involves supporting the natural processes of pregnancy, labour and birth –while providing for intervention when necessary.

THE POLITICS OF PREGNANCY CARE - SUGGESTIONS

• MDs are not your enemy (some might be their OWN worst enemy…). Work with good ones and nurture relationships.
• Don’t let your enthusiasm and/or patient expectations paint you into risky clinical corners.
• Positive persistence in doing the right thing is an unstoppable force for good.