

Birth Centers in the United States

Kitty Ernst, CNM, MPH, DSc (hon) and Kate Bauer, MBA

The Evolution of Maternity Care in the United States

In the 20th century, the care of childbearing women was greatly improved in the United States.

- For example, maternal mortality has dropped from 600 to 7/100,000.
- Improvement of surgical and anesthesia techniques, blood transfusions, and development of pharmaceuticals like antibiotics have certainly played a role.
- Less easily measured, but equally important, are the socio-economic factors such as availability of sanitation, water, sewage, food, shelter, transportation, and working conditions.
- But perhaps the most revolutionary is the ability of women to control whether or not they will be pregnant.

A major turning point in saving lives came after World War II when:

- The number of medical schools doubled;
- The opportunity to enroll in medical school was supported by the GI Bill for education;
- Employer health insurance for families included maternity care services;
- The Hill Burton Act put a hospital in every eligible community;
- Poor people were cared for under Medical Assistance programs.

The result of the focus developing the specialty of obstetrics for treatment of medical complications of pregnancy and birth and the elimination of midwifery led to the following:

- Birth became a medical event - an illness or an emergency waiting to happen.
- There was no effort to separate healthy woman from women with problems needing the acute care services.
- Subsequently there was an almost 100% shift to the acute care hospital setting which disrupted families with unstudied consequences
- Newborns were snatched from their over-sedated mothers and placed in central nurseries. Breastfeeding declined. Fathers and children were excluded and denied participation in what we are now just beginning to understand as one of the most profound teaching and "bonding" experiences of anyone's life.
- The incidences of infant mortality and low birth weight babies are still higher than in other developed countries.
- Cost has been greatly escalated to the point where increasing numbers of childbearing women are uninsured or are participating in a patchwork of care services and where all governmental efforts to control cost have failed. (Health Systems Agency was established to control duplication of expensive services, and Regional Medical Programs

were created to regionalize care but led to greater centralization. Now we have managed care and have put all payment into the private, for profit sector where costs have continued to escalate. For example, in 2008 Humana reported a \$30 billion dollar profit.)

- Many invasive medical procedures and policies were widely accepted and implemented without adequate study (i.e. routine episiotomy, separation of newborn from mother).
- Electronic fetal monitoring, intravenous fluids, confinement to bed, and restriction of nourishment are still routine in many places in spite of the evidence that these procedures are of little value to healthy childbearing women.
- Epidural anesthesia has become the preferred procedure for pain relief.
- Perhaps most important has been the promulgation of fear eroding women's confidence to give birth.

We now live with new sets of issues.

- Managed care is 80% of all insurance and brings productivity schedules and ever more complicated coding for billing, and delayed or denied payment.
- Liability insurance costs have skyrocketed.
- Fraud and corruption are being exposed.
- Evidence-based practice has become the preferred approach.

To deal with the problems, hospitals have:

- Merged, downsized, and closed obstetrical units;
- Converted to single room maternity units and short stays to contain costs. (Single rooms have not saved money as expected, and short stays without home follow-up have come under fire.);
- Established out-reach clinics to improve access to care;
- Explored the birth center concept;
- Employed or given privileges to nurse-midwives;
- Shifted from not-for-profit to profit.

The impact in the health care professions is just as great.

- Enrollment on obstetrical residency has declined.
- The number of medical student choice of obstetrics has declined.
- Although more women have specialized in obstetrics, they want a different work life style from their male predecessors.
- The number of foreign-trained physicians in obstetric residency programs has increased.
- More family physicians are entering obstetrics.
- Hospitalist physicians have been introduced.

- Funding for midwifery education increased, and programs doubled, but enrollment is still limited by opportunities for clinical training on obstetrical teaching services.

The Development of the Birth Center Innovation

There have been maternity “clinics” in the homes of traditional midwives and physician offices for many years. They were established to serve women who could not afford hospital care, lived too far away for a home birth, or among cultural groups such as the Amish who have preferred their own birth attendants. The modern innovation called the birth center, however, was established to respond to a challenge by healthy, insured, largely upper middle class and educated women seeking a natural and more humane approach to childbirth.

It started in the late 1940s and 50s with women seeking more control of their own birth and in reaction to the “twilight sleep” or “knock'em out - drag'em out” era of obstetrics by the launching of:

- The natural childbirth movement;
- Husband coached childbirth;
- Rooming-in and breastfeeding;
- Increasing access to new information;
- Efforts to change hospital acute care routines to be more family-oriented.

However, progress in changing hospital and medical routines continued to prove disappointing. Along with the anti-establishment and women's movement of the 1960s came a growing demand for non-intervention when the process was normal.

By the early 1970s, activist, educated, insured women turned to “do it-yourself” home birth as the only option that would guarantee the control they desired for their birth experience.

- Some public health and policy makers viewed this a pending public health problem.
- Maternity Center Association (MCA), now Childbirth Connection, viewed it as a systems need for a safe alternative to hospital medical services that embodied the midwifery model of supportive care.
- MCA established the Childbearing Center, a demonstration of the birth center solution, in 1975.
- Evaluation of the MCA Childbearing Center by New York’s largest health care insurer, Blue Cross/ Blue Shield, demonstrated birth center care was safe, satisfying, and offered significant savings to payers.

MCA recognized the need to develop the infrastructure necessary for replication of the concept of the birth center already underway in some states and established the National Association of Childbearing Centers, now the American Association of Birth Centers (AABC), in 1983.

In the 1980s, AABC laid the foundation for the promulgation of the birth center concept when it:

- Convened a research advisory committee to define “low risk” eligibility for care;
- Developed national standards to assure quality care;
- Fostered state licensure regulation;
- Secured liability insurance;
- Promoted reimbursement for services;
- Established a mechanism for accreditation;
- Implementation of Institute of Medicine's report on the Assessment of Birth Settings (1982) recommendations for research which led to AABC's conduct of a large, multicenter prospective study on birth center outcomes, (NEJM 1989). The National Birth Center Study reported that birth centers were safe, satisfying to users, and offered cost benefits to payers.

Birth centers were dealt an almost fatal blow by the liability insurance industry in the mid 1980s when the insurance carrier for nurse-midwives and birth centers withdrew from the liability market. Therefore, it is a process that has evolved over the past four decades.

The determining factors in the survival of the concept have been and continue to be:

SAFETY

SATISFACTION

SAVINGS

It should be recognized that reimbursement has always been a driving force in hospitalization for birth. The principles of screening and triage were not applied in shifting all women to acute care. However, cost was not a factor in the 1950s and 1960s. It must be recognized that cost and payment for services will continue to play an equally critical role in sustaining birth centers and integrating them into the mainstream of the health care system.

The birth center represents primary care, with referral to acute care on medical indication. Some feel that all women should enter the system at the primary care level of a birth center and move to high tech/high cost care only on indication of need. As costs for hospitalization continue to rise, third party payers may come to agree with this point of view, and providers may come to agree that the only way to control overuse of technology is to separate primary care from acute care with distinct standards for each.

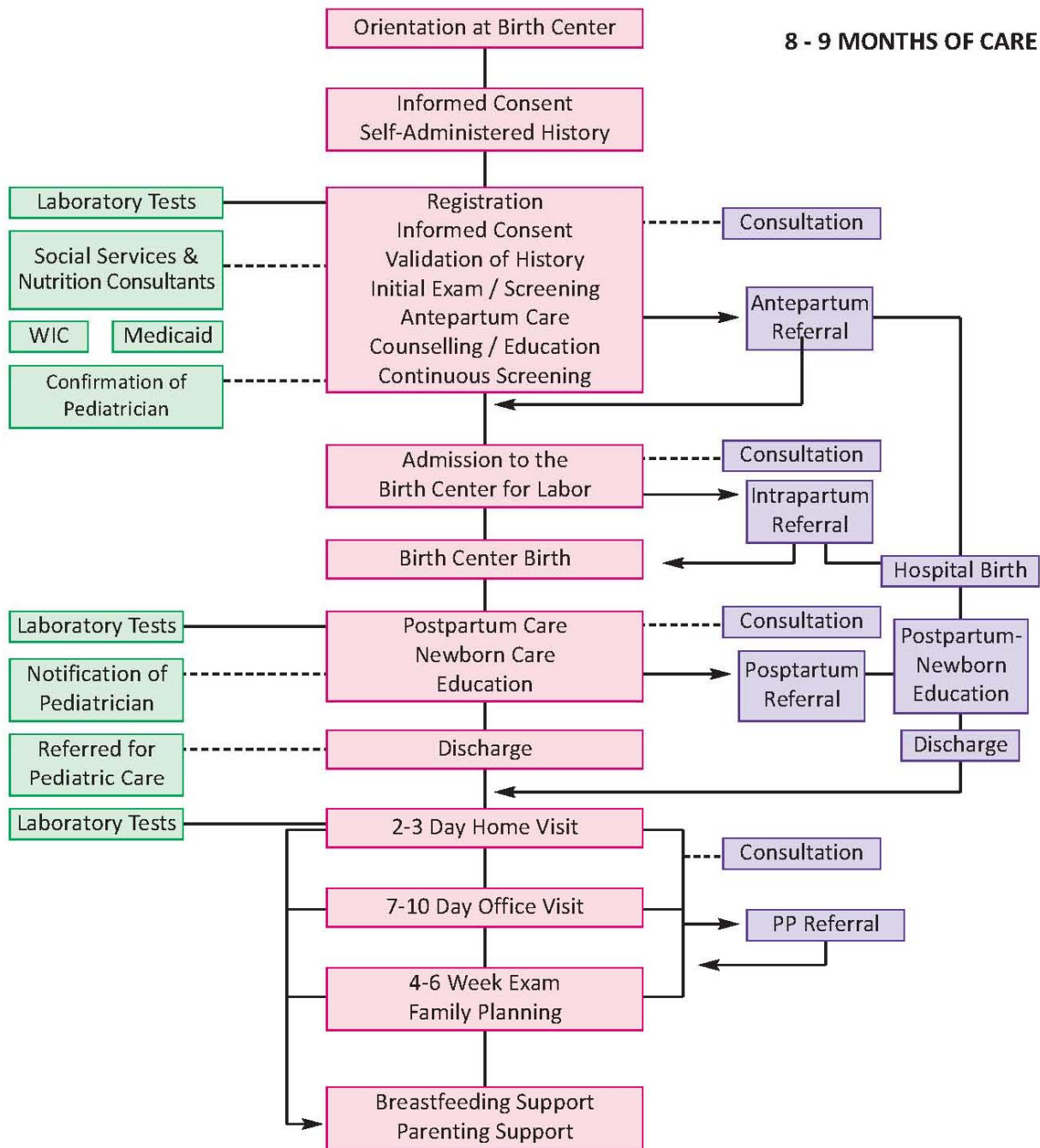
The Birth Center

Primary Care in an Integrated Health Care System

Ancillary Services

Birth Center / Primary Care

Hospital / Acute Care



-----= communication only

Highlights of Four Decades of Developing the Birth Center Concept

1975 - In response to consumer desire for alternative care, Maternity Center Association (MCA) in New York opened the Childbearing Center, a demonstration model with an approved Certificate of Need, Licensure as a Diagnostic and Treatment Center, and a Special Contract with Blue Cross/Blue Shield to study outcomes and cost (Luk J. Canoodt, "Utilization and Economic Analysis of the Maternity Center Association's Childbearing Center," Blue Cross/Blue Shield of Greater New York, Health Affairs Research Department, 1982).

1979 - Tour of 14 centers in 14 states found that all centers experienced the problems of being change agents and needing assistance.

1981 - MCA obtained funds to found the Cooperative Birth Center Network (CBCN) and to fund the first national (retrospective) study of outcomes of care in 14 centers (Anita B. Bennetts and Ruth W. Lubic, "The Free-Standing Birth Center." *The Lancet*, 2/13/82).

CBCN published "Recommendations for Regulation of Birth Centers." American Public Health Association (APHA) published "Position Paper 7924: Alternatives in Maternity Care," supporting the choice of birth centers for women (*American Journal of Public Health*, Vol. 10, No.3, 1980).

1982 - APHA published "Guidelines for Regulating and Licensing Birth Centers." (*American Journal of Public Health*, Vol. 73, No. 3, March 1983). Eighty-two percent of states now regulate birth centers.

The Institute of Medicine published "Research Issues in the Assessment of Birth Settings," a report of research findings on available evidence on birth settings. Findings indicated that there was insufficient evidence for supporting one birth setting over another.

Recommendations for appropriate research methodologies were made. (Out of print - available from AABC on library loan).

Recognizing that birth centers could not grow without nurse-midwives to staff them, MCA formed a task force to explore the feasibility of a distance learning nurse-midwifery education program incorporating preparation for birth center practice.

1983 - CBCN became the American Association of Birth Centers (formerly the National Association of Childbearing Centers) with a multi-disciplinary professional and consumer Board of Directors. Plans for a prospective, multi-center study of care and outcomes were approved by MCA's Research Advisory Council.

1984 – MCA and AABC brought together representatives of birth centers and the disciplines involved in maternity care services in the private and public sectors to write national standards for birth centers and to establish a mechanism for accreditation.

1985 - National Standards for Freestanding Birth Centers were adopted by the membership of AABC. Upon finding that accreditation through the Joint Commission on Accreditation of Hospitals and the Association for the Accreditation of Ambulatory Health Care would not be

feasible, the Commission for Accreditation of Birth Centers was established by AABC as an autonomous agency. A pilot program for the accreditation of 12 centers was conducted with funding from MCA. An Advisory Council to the Commission was established.

Withdrawal of the liability insurance program for birth centers and nurse-midwives had a serious impact on the growth of new centers and the survival of established centers.

Prospective collection of data for the National Birth Center Study is launched despite the lack of funding, and volatility and ferment in the health care delivery market. Eighty-nine centers participated.

1988 – Through the efforts of AABC, the Office of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) recognized the National Standards and the Commission for Accreditation of Freestanding Birth Centers for 100 percent reimbursement of services (Federal Register, Vol. 53, No. 78, 4/22/88). By this time, most major health insurance programs were paying for birth center services.

1989 – The results of the National Birth Center Study were published in the *New England Journal of Medicine* (12/28/89) and concluded that, “Few innovations in health service promise lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety. The results of this study suggest that modern birth centers can identify women who are at low risk for obstetrical complications and can care for them in a way that provides these benefits.”

The pilot of the distance learning program with students on-line, the Community-based Nurse-midwifery Education Program (CNEP), was launched by AABC in Perkiomenville, Pennsylvania, with the collaboration of MCA, the Frontier Nursing University (FNU) and the Frances Payne Bolton School of Nursing, Case Western Reserve University (FPB/CWRU). CNEP is now located on the campus of FNU in Hyden, Kentucky and has graduated over 1,500 nurses for study in communities in all 50 states. It is the only nurse-midwifery education program that requires a course that includes attending a How to Start a Birth Center Workshop and a capstone paper on establishing the business of a birth center.

For information on CNEP contact the Frontier Nursing University at PO Box 528, Hyden, KY 41947. Tel. 606-672-2312; www.frontier.edu.

1990 – A National Prospective Study of VBACs in Birth Centers was proposed by AABC members to provide an alternative for women whose only other option to hospital confinement or a routine repeat cesarean section may be a home birth with a lay midwife. The centers argued that women and home birth midwives actually took the courageous step towards VBAC, and the professional community in birth centers should make an effort to respond to this need and study outcomes. Criteria for the study were established.

1995 – AABC, working with the Centers for Disease Control (CDC), began development of the AABC Uniform Data Set (UDS), a project to establish a uniform data collection system to collect outcome data on birth center care.

Most managed care payment plans were reimbursing birth centers.

1997 – AABC launched the AABC Uniform Data Set (UDS), a DOS-based data collection tool based on the CDC's software EpiInfo.

The decision was made to put birth centers into cyberspace. Centers contributed start-up funds. Jamie Bolane, founder of Childbirth Graphics, donated a full year of her life to work with Kate Bauer, executive director of AABC, to establish the website.

1998 - Birth Centers Online (www.BirthCenters.org) was launched; this was a joint project of the AABC Foundation and the American Association of Birth Centers. Birth Centers Online is one of the most comprehensive multimedia enhanced sites on the web for birth center information for experienced professionals and families.

The first report of outcomes of the San Diego Birth Center Study - a prospective cohort comparison of 1,800 birth center and 1,150 traditional care subjects from 1994-1997 – was released. Conclusions: Study results support the safety, cost-effectiveness, and patient acceptability of a collaborative management freestanding birth center model.

1999 - The Future of Midwifery - a joint report of the Pew Health Profession Commission and the University of California San Francisco Center for the Health Professions was written. The report of a task force convened to review available literature and analyze the health care market concluded that “the midwifery model of care is an essential element of comprehensive health care for women and their families.”

2000 - The DC Developing Families Center opened in Washington, DC. This center is an exciting new model of care that integrates the birth center with other essential programs such as Healthy Mothers Healthy Babies and Early Childhood Development from 6 weeks through the third year of life.

2003 - AABC celebrated 20 years! Several centers celebrated 20+ years of successful operation.

2004 - The National Study of Vaginal Birth After Cesarean (VBAC) in Birth Centers was published in the *American Journal of Obstetrics & Gynecology*. This ten year AABC study of 1,913 women attempting VBACs in birth centers demonstrated that VBACs carry risks that suggest hospital care is best.

2005 - The National Association of Childbearing Centers changed its name to the American Association of Birth Centers (AABC).

2007 - The web-based version of the AABC Uniform Data Set (UDS) went live creating the first online data registry for optimal birth by all providers in all settings. The UDS now has more than 50,000 records.

2008 - AABC launched the National Study of Optimal Birth using UDS data.

ACOG issued a revised statement on homebirth and recommended accredited birth centers as a choice for place of birth.

2009-2010 - AABC worked at the federal level for passage of the Medicaid Birth Center Reimbursement Act (H.R. 2358 / S. 1423) to guarantee Medicaid birth center facility fee payments.

2010 – The Medicaid Birth Center Reimbursement Act was passed into law as part of the Affordable Care Act.

The Institute of Medicine published “The Future of Nursing: Leading Change, Advancing Health” which features the Family Health and Birth Center (FHBC) in Washington DC as a “Midwifery Model of Care (that) Gives Mothers Control and Improves Outcomes” (National Academies Press - www.nap.edu)

2011 - AABC drafted new legislation which would make non-profit birth centers eligible for a range of federal grants similar to the type of grants made to Federally Qualified Health Centers (FQHC). AABC worked at federal level for the passage of the Birth Center and Women’s Health Act.

“Validation of an Online Data Registry: A Pilot Project.” (Stapleton) published in the *Journal of Midwifery & Women’s Health* reported 97% validity of data collected in centers from five regions of the U.S.

Long standing birth centers reported full utilization causing limitation on enrollment for care.

AABC began work with the Arkansas Health Outcomes Group (AHOG) and the National Center for Research on Measurement and Evaluation Systems (NORMES) at the University of Arkansas for a revision of the AABC Uniform Data Set that will:

- o Improve and facilitate downloading of data for analysis and reporting.
- o Improve and better facilitate the ability of contributors to enter UDS data.
- o Improve and better facilitate contributor use of their own data.
- o Build in the ability to receive data from electronic health records (EHRs).

2013 - [The National Birth Center Study II](#) (Stapleton, et al) is published in the *Journal of Midwifery & Women’s Health*. This landmark study shows that birth centers provide first-rate care to healthy pregnant women in the U.S.

The Center for Medicare and Medicaid Innovation awards the American Association of Birth Centers a \$5.35 million four-year grant for the [Strong Start for Mothers and Newborns Initiative](#) to measure outcomes and costs from enhanced prenatal care in birth centers for women enrolled in Medicaid or CHIP who are at risk of having a preterm birth. The birth center model of enhanced prenatal care, known as AABC Strong Start in Birth Centers, will be evaluated in 48 birth center sites, located in 22 states across the US. The initiative will test three evidence-based maternity care models that enhance current care delivery and address the medical, behavioral and psychosocial factors that may be present during pregnancy and may increase risk of preterm birth. Strong start models are 1) birth center care 2) pregnancy home, and 3) group prenatal care.

The Institute of Medicine and the National Research Council convened a workshop “[Research Issues in the Assessment of Birth Settings](#)” to review updates to the 1982 IOM-NRC report

Research Issues in the Assessment of Birth Settings. It highlighted research findings that advance the understanding of the effects of maternal care services in different birth settings (including birth centers and homebirth) on maternal labor, clinical and other birth procedures, and birth outcomes.

2014 – AABC issues position statements on:

- o Birth Center Quality (January)
- o Immersion in Water during Labor and Birth (April)

AABC issues white paper “Improving Access to Freestanding Birth Centers”

AABC Standards Committee begins thorough review and revision of the national Standards for Birth Centers

2015 – AABC approves first state chapters in Texas and New York.

AABC Standards Committee seeks comments draft revisions of the Standards for Birth Centers:

- 1) Solicits feedback from AABC membership, and 2) Convenes meeting of experts from midwifery, obstetrics, maternal-fetal medicine, nursing, and consumers to review.

2016 – After a 2 year revision process, the revised AABC Standards for Birth Centers are approved by the AABC membership.

AABC issues position statement on Birth Center Licensure and Regulations (April)

AABC changes its logo to better represent the diversity of the AABC membership.



2017 - Birth centers continue to grow. There are now more than 345 freestanding birth centers in the United States in 37 states and DC. This represents growth of 76% since 2010.

