October 17, 2014

Celeste Pierre
The Joint Commission
Standards and Survey Methods
Proposed Requirements for Perinatal Care Certification
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Letter via email to: cpierre@jointcommission.org

Re: Proposed Perinatal Care Certification Requirements

Dear Ms. Pierre:

On behalf of the Coalition for Quality Maternity Care (CQMC), a group of national professional, consumer, and human rights organizations that promote high-quality maternity care for all women and newborns, we appreciate the opportunity to provide comments on The Joint Commission's "Proposed Requirements for Perinatal Care Certification Program," (hereinafter "Certification Requirements) released for public comment on September 5, 2014.[1] We hope that you find our comments helpful and look forward to your response in the final version of the Certification Requirements.

General Comments

The members of the CQMC are pleased that The Joint Commission has incorporated into the September 5 proposal many of the comments we submitted with regard to the February 12, 2014 initial draft. Specifically, the greater focus on care for healthy, low-risk women was a welcome change. In our present comments we emphasize the need for these certification standards to ensure that programs focus on developing the capacities to foster routine access to skilled care that promotes, supports, and protects the innate, hormonally-driven processes of labor onset, parturition, and successful postpartum and newborn transitions and adaptations, including, whenever possible, the same care for women and fetuses/newborns needing specialized care.

[1] See: http://www.jointcommission.org/standards_information/field_reviews.aspx?StandardsFieldReviewId=GQvjvWwjaNJO3yd3277X26XNNptq%2BResu%2BtC%2FIJZ4BM%3D

Providers who seek this certification should be able to optimize these normal physiologic processes. Their doing so will reduce or eliminate the need for interventions that can interfere with innate processes and which themselves carry risks of adverse outcomes. There is a significant amount of research demonstrating the value of an approach that fosters these innate processes and their short and long range impacts on the health and wellbeing of mothers and infants.[2]

We strongly believe that incorporation of requirements to support access to this type of care into the Certification Requirements will help hospitals provide the high value, high quality care that women and babies deserve and which The Joint Commission seeks to foster.

Specific Comments

Standard and Element Number (Line Number)	Recommended Change	Rationale
PNPM 1 Element 2	We recommend editing this element so that it reads, "The program's leaders are empowered by the organization's leaders to provide the care, treatment and services in these standards and elements of performance."	We believe it important to specify that the care, treatment and services outlined in this document must be provided in order to obtain the certification.
PNPM 1 Element 6	We recommend editing this element so that it reads, "Program leaders create opportunities for the interdisciplinary team, including childbearing women, to participate in the design of the care, treatment, and services provided."	We believe it important to include the childbearing woman as part of the care team. Note that the NQF has consistently defined a care team to include patients and family members.
PNPM 3 New Element	We continue to recommend inserting the following new element: "The program has a registered nurse staffing plan, including an "on-call" or back-up staffing plan, to respond to fluctuations in the volume of women and nurse absenteeism and assure adequate levels of nursing care consistent with national staffing recommendations. The nurse staffing in relation to the number of women receiving care is assessed at regular intervals within a 24 hour period." If The Joint Commission has refrained from adding this element because of staffing requirements contained in other requirements to which hospitals are subject, we recommend including a reference to such requirements.	See: Guidelines for Professional Registered Nurse Staffing for Perinatal Units, from the Association of Women's Health, Obstetric and Neonatal Nurses, 2010.
PNPM 2 Element 2	We recommend editing the fourth bullet under this element so that it reads, "Provides patient education and information about perinatal care services available to meet mothers' and newborns' needs so that mothers can make informed decisions about their care, consistent with current standards of informed consent/refusal and shared decision making.	Informed consent/refusal standards are not currently applied in a consistent way across the country. See Holly Goldberg, "Informed Decision Making in Maternity Care," Journal of Perinatal Education, 2009, Winter; pp. 32-40.

[2] Childbirth Connection Programs at the National Partnership for Women & Families will release a major report on this topic this fall. It will be available at: http://transform.childbirthconnection.org/reports/physiology/

PNPM 3 Element 3	We recommend editing this element so that it reads, "The program provides the mother and her family education or information about care, services, and alternative options available to meet the mother's and newborn's needs and the mother's preferences, consistent with current standards of informed consent/refusal and shared decision making.	See rationale offered in the line above.
PNPM 3 Element 11	We recommend editing this element so that it reads, "The program follows its written policies for consultation and transfer arrangements, including receiving transfers from settings offering care with a lower level of acuity, such as birth centers or home births. The needs of the population served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements."	A fully integrated system is safest for women and babies and respectful of women's care choices. The program should be able to offer consultation, collaborative care, transfer of care, and transport from lower level hospitals, birth centers, and planned home births. Just as the program needs places to help women and babies whose situation falls outside of its scope of care, so do others have need for the program's scope of care. Also see our rationale below with regard to PNPC 5 New Element.
PNPM 3 New Elements	We recommend The Joint Commission include a requirement that the program be able to do the following: - Demonstrate the ability to effectively and efficiently triage (initial assessment and prioritization for full evaluation) women presenting for care; - Refrain from performing inductions or augmentations of labor without an evidence-based clinical indication; - Encourage nourishment (food and drink) during labor as the woman desires; - Provide freedom of movement in labor and the woman's choice of birth position; - Provide skilled non-pharmacologic methods for coping with labor pain for all women; - Allow an appropriate length of time for first (both latent and active phase), second and third stages of labor; - External cephalic version; - Encouraging vaginal birth for twins; - Sparing use of ultrasonography in the third trimester for purposes of estimating fetal weight. - Support for the initiation of breastfeeding. PNPM 4 should be revised to require the program to have policies in place to support the provision of these services.	This comment is supported by the joint statement on normal physiologic birth discussed above. In addition, we recommend The Joint Commission align its requirements with the joint statement by ACOG and SMFM entitled "Safe Prevention of the Primary Cesarean Delivery," wherein the two societies discuss appropriate duration of various phases of labor, limiting induction to medically indicated conditions, continuous one-on-one labor support (such as a doula), external cephalic version, limiting use of sonography and encouraging vaginal birth for twins. We also recommend that The Joint Commission align its requirements with AWHONN's new statement discouraging elective induction and augmentation, available at http://onlinelibrary.wiley.com/doi/10.1111/1552-6909.12499/pdf. We also recommend that The Joint Commission review the statement by the American Academy of Nursing which discourages the use of continuous fetal monitoring for low-risk women and instead favors intermittent auscultation. This statement notes that continuous fetal monitoring among low-risk women is associated with higher rates of cesarean birth. See: http://www.choosingwisely.org/american-academy-of-nursing-announces-engagement-in-national-choosing-wisely-campaign/
PNPM 4 Introduction	We recommend editing the introductory text for this performance standard so that it reads, "The program uses clinical practices originating from evidence-based national guidelines or up-to-date systematic review of existing evidence, whenever available, to deliver or facilitate the delivery of clinical care, treatment, and services."	As noted in our rationale for PNPM 6, New Element, it is critical that programs consistently and continuously work to integrate the latest evidence into their practice. They must have a mechanism for identifying evolving evidence and ensuring that it results in appropriate changes to their practice.
PNPM 4 Element 1	We recommend editing the first sentence of this element so that it reads, "The program has	See the comments we made above in the introduction to this letter.

	policies and procedures that support its clinical practices along the entire perinatal continuum, including routinely providing access to skilled care that promotes, supports and protects the innate hormonally-driven process of parturition and postpartum/newborn transitions."	
PNPM 4 Element 1	We recommend that the eleventh item in the list supplied in Element 1 be revised to read, "Newborn feeding policies (for example, support for establishment of early and continued exclusive breastfeeding whenever feasible and acceptable, gavage feeding, formula and breast milk preparation and storage)"	There is an extensive literature conclusively demonstrating that breast milk is the best nutritional option for infants and that breastfeeding carries with it a range of positive effects for the mother. The certification standards should be written in such a way as to encourage breast milk feeding as the first choice.
PNPM 5 New Element	We recommend adding a new element, early in the list of the elements associated with this standard, reading thus; "Staff members minimize risk of harm by avoiding use of interventions without a well-supported indication and by addressing challenges with less invasive practices before resorting to more consequential practices."	As noted in our rationale for PNPM 6, New Element, it is critical that programs consistently and continuously work to integrate the latest evidence into their practice. They must have a mechanism for identifying evolving evidence and ensuring that it results in appropriate changes to their practice.
PNPM 5 Element 5	We recommend adding "anti-hypertensives" to the list of drugs in this element.	These drugs are likely to be encountered among the population of pregnant women and programs should be prepared to manage their use as appropriate.
PNPM 6 New Element	We continue to recommend the addition of the following new element: "The program fosters critical appraisal of skills and supports clinicians in understanding and valuing better-quality evidence, gaining access to it, and prioritizing its use in clinical care. This includes making good use of the abundant better-quality systematic reviews about effects of pregnancy and birth care practices."	We encourage The Joint Commission to incorporate into PNPM 6 the spirit and principles of The Sicily Statement on Evidence-Based Practice, available here. The Institute of Medicine has identified systematic reviews as the best way of *Finding What Works in Health Care*. Programs need to inculcate a culture of evidence-based care and train their personnel to seek out and modify their practice patterns to conform to evolving evidence. Training in existing patterns might not be evidence based and training consistent with current best evidence may become obsolete. Practitioners should specifically be trained to incorporate new evidence into their practice as rapidly as possible to avoid the type of unacceptable delays that have occurred in the past. A particularly vivid example of this can be seen in the rate of early elective inductions in this country. Over the past two decades the occurrence of such inductions has shifted the average gestational age by a full week. Only recently has the rate of early elective induction begun to shift, despite the fact that an ACOG position statement discouraging early elective induction has been available for many years.
PNPM 6 New Element	We recommend that a new element be added, that reads thus: "Program leaders should ensure that providers possess, retain, and make available essential skills and knowledge for supporting promoting, and protecting the innate, hormonally-driven processes of labor onset, parturition, and successful postpartum newborn transitions and adaptations, including whenever possible for women and fetuses/newborns needing specialized care. . These should include: - External cephalic version	These evidence-based practices foster safety when they avoid the need for surgery and enable care providers to respond competently to unexpected situations. They are a hallmark of woman- and family-centered care as they enable women to make informed choices among evidence-based care options. Many of these skills are identified in the recent joint statement from ACOG and SMFM (see: http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery) If these skills are not fostered, then women and infant who

	- Skilled assisted vaginal birth (forceps and vacuum) - Vaginal birth after cesarean - Vaginal breech birth - Vaginal twin births - Intermittent ausculation - Comfort measures for pain relief coping with labor, including making continuous one-on-one support available (doulas) - Non-pharmacologic measures for labor progress	would otherwise benefit from their availability are much more likely to have a cesarean birth, with all of its attendant complications.
PNPM 6 Element 4	In accord with our comment on PNPM 3 above, we recommend that program leaders be responsible for training and orienting program staff regarding the following items, that should be listed under Element 4: - Encouraging nourishment (food and drink) during labor as the woman desires; - Providing freedom of movement in labor and the woman's choice of birth position; - Skilled non-pharmacologic methods for coping with labor pain for all women; - Allowing an appropriate length of time for first (both latent and active phase), second and third stages of labor. - External cephalic version; - Vaginal birth for twins; - Sparing use of ultrasonography in the third trimester for purposes of estimating fetal weight; - Skills to support the initiation of breastfeeding. Element 6 within PNPM 6 should be modified to include these same items.	See the rationale offered above for PNPM 3, New Element. Clearly, in order for a program to offer the services outlined in PNPM 3, staff must be trained in the provision of those services.
PNPM 6 Element 6	We recommend that early on in the list of items on which program staff should be trained, the following be included: "Skills and knowledge to support innate hormonally-driven parturition processes of women and fetuses/newborns from late pregnancy through labor and birth to maternal-newborn transitions and adaptations in the postpartum/newborn period." We also recommend adding an additional item to this element, to require that the program to orient and train team members to be able to "- Triage of pregnant and postpartum women presenting for care."	See the comments we made above in the introduction to this letter. With regard to our second recommendation under this Element, occasionally Programs will receive women for whom they are unable to access previous health information. It is therefore important that program staff know what is required to appropriately triage these patients.
PNPM 6 Element 7	We recommend that this Element be revised to read, "Leaders support the team member's participation in continuing education, including in--services, training, and other activities, relevant to the program's scope of services. <u>Leaders evaluate effectiveness of orientation and training for staff on an ongoing basis.</u>"	It is important for leaders not only to support team members' training relative to the program, but also to evaluate the effectiveness of that orientation and training to ensure that it is accomplishing the desired goals.
PNPM 7 Element 2	We recommend adding the following item to the list under this Element, "- At least one staff member who has expertise in providing staff support when there is a sentinel event."	See rationale offered below under PNPI 6, New Element.
PNPM 7 Element 4	We recommend adding the following item to the list under this Element, "Need to maintain adequate levels of interdisciplinary staffing,	See rationale under PNPM 3, New Element.

	taking into account staffing plans for emergency situations and disasters."	
PNPM 8 Element 2	We continue to believe that it is important for the Certification Requirements to require programs to have policies and practices in place that encourage all staff to speak up to improve patient safety.	See also: Audrey Lyndon', et. al., "Predictors of likelihood of speaking up about safety concerns in labour and delivery," *BMJ Quality & Safety*, 22 (2): 182. It is particularly important, in a setting with a recognized hierarchy, for all members of the team to feel that their observations and input are valued and taken seriously. The program should have a policy that fosters such input.
PNPC 2 Element 4	We recommend that the last sentence of this element be edited to read, "Information includes related risks, benefits, and alternatives, including the possibility of no action/watchful waiting."	Fostering innate hormonal processes frequently requires patience and watchful waiting. If the possibility of no action/watchful waiting is not explicitly presented as an option, the fact that there is an alternative that does not involve interventions may be masked, and as such, the information presented would not constitute a fully informed decision making process.
PNPC 2 Element 5	We recommend editing this element to read: "The program actively involves mothers and, as appropriate, families in decisions about the delivery of the mother's and newborn's care. At a minimum, mothers are able to choose their preferences, including those regarding prenatal care, screening tests, labor and delivery care practices, newborn care, immunizations, and postpartum care. Programs should provide mothers with better-quality information about care options and the possible benefits and harms of each (including the option of watchful waiting), help women consider their values and preferences relative to the care options; and support women's informed personalized care decisions. This applies to **all** decisions about their care and the care of their newborns." In addition, we continue to recommend that this element require that the program has a written protocol and SOP for women who disagree with medical advice after proper informed consent and be required to continue caring for such women with compassion and respect regardless of their decisions.	Shared decision making is increasing recognized as the optimal way to engage women in their care decisions. These processes and use of available high-quality decision aids and related tools would be a hallmark of a high-performing program. Simply allowing women to choose, without providing them full, balanced, current information about the various available options is not informed consent. ACOG's Committee Opinion 439, published in August 2009 notes that informed consent entails comprehension and understanding of options in addition to free consent. This same committee opinion states that informed consent "ensures the protection of the patient against unwanted medical treatment." (See: http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20140426T0406259778
PNPC 3 Element 4	We recommend editing this element to include the following: – permitting labor to begin spontaneously and progress without augmentation; – fostering non-pharmacologic pain management techniques; – utilizing intermittent auscultation rather than continuous fetal monitoring; – providing nourishment (liquid and food) as desired; - Providing freedom of movement in labor and the woman's choice of birth position; - Skilled non-pharmacologic methods for coping with labor pain for all women; - Allowing an appropriate length of time for first (both latent and active phase), second and third stages of labor.	These generally facilitate innate hormonally-driven processes of parturition in women and fetuses/newborns and help avoid the use of unnecessary interventions that carry with them potential adverse complications. We recommend that The Joint Commission review the statement by the American Academy of Nursing which discourages the use of continuous fetal monitoring for low-risk women and instead favors intermittent auscultation. See: http://www.choosingwisely.org/american-academy-of-nursing-announces-engagement-in-national-choosing-wisely-campaign/

PNPC 3 New Element	We recommend that the program consistently demonstrates commitment to the following: 1. Help mothers initiate breastfeeding within one hour of birth. 2. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants. 3. Give infants no food or drink other than breast milk, unless medically indicated. 4. Encourage breastfeeding on demand. 5. Give no pacifiers or artificial nipples to breastfeeding infants. 6. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital. 7. Do not provide free formula to mothers unless medically indicated.	This is another important way that programs with the Certification can signal to women and the public that they are providing exemplary care.
PNPC 4 Element 2	We recommend inserting an additional item within this element, to read: "—Identification and documentation of the woman's goals for her care and that of her baby."	Elsewhere in the Certification Program, there are requirements to involve the mother in informed decision making. It will be important to begin that process as part of the initial patient assessment, as each step in her care will necessarily involve choices that she should be a part of. To help her know what the options are related to her specific aims, the program should understand her goals at an early point in its interaction with her.
PNPC 4 Elements 4 and 5	In consonance with our prior comments emphasizing the desirability of supporting innate hormonal processes, we believe that these two elements should be revised to require that the program consider and document not just risk factors, but also the mother/fetus' strengths, assets, and capabilities.	
PNPC 5 New Element	Element 11 requires the program to have a method for transferring women and infants to settings where more appropriate levels of care are available. The incidence of birth center and home births are increasing in the United States and a small number of women choosing to give birth in these settings will need to be transferred to a hospital. We recommend that programs be required to have in place protocols for receiving transfers from the birth center and home settings, and allowing for their chosen provider to continue to accompany them and provide appropriate information and data regarding the mothers progress to the point of transfer.	A fully integrated system is safest for women and babies and respectful of women's care choices. The program should be able to offer consultation, collaborative care, transfer of care, and transport in from lower acuity hospitals, birth centers, and planned home births. Just as the program needs places to help women and babies whose situation falls outside of its scope of care, so do others have need for the program's scope of care. In specifying the availability of 24/7 anesthesia services, the Certification Recommendations clarify that facilities with this designation will be in a position to enhance the safety of childbearing women and newborns by collaborating with settings offering care at a lower level of acuity in the community, including some hospitals, and birth centers and home birth services. We do not believe that the designation should be given to facilities that do not make this commitment to an essential element of a safe, integrated maternity care system. It is unethical to expect other facilities to help with transport and transfer beyond a facility's scope of care without in turn offering the same to women and babies receiving care in lower acuity settings in the community. The Joint Commission should endorse and require facilities with the designation to adapt for local conditions the recently developed multi-disciplinary

		"Best Practice Guidelines: Transfer from Planned Home Birth to Hospital," available at: http://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf
PNPC 5 Element 1	In accord with our comment above on PNPC 2, Element 5, we continue to recommend that the following be added to the language of this element: "Care plans should be developed in cooperation with the woman. The program should ensure that the woman has access to clinical evidence related to the potential benefits and harms of the various possible interventions and that she takes this into account when developing her care plan."	Many women are not aware of the known potential harms of the various interventions they may experience. Without access to appropriate information to inform her choices, a woman may inadvertently accept interventions that she would otherwise decline.
PNPC 5 Element 7	We recommend revising this element to read, "The program provides education, training, and support to the mother and family based on the woman's health literacy. The program should provide childbirth classes, taught by a CERTIFIED instructor, using evidence-based curriculum."	Education and training should be evidence-based and seek to be as applicable to the individual as possible.
PNPC 5 Element 7	We recommend that the first item under this element be revised to read, "Physiology of pregnancy, labor, birth and the initial postpartum/newborn hours and days, and practices that can support or disrupt those processes."	See prior rationales for focusing on innate, hormonally-driven processes.
PNPC 5 Element 11	We recommend that the fourth item in this list be revised to read, "- Providing timely triage, assessment, stabilization, and treatment prior to transfer, which includes having a system in place to ensure that maternal transports occur when indicated in order to avoid transporting high-risk newborns after birth."	See rationale offered under PNPM 6, Element 6 and also PNPM 3, New Elements.
PNPC 7 Element 2	We recommend that the text of this element be revised to state that the post discharge discussion include provision of information about contraception decision making and counseling about birth spacing, which may involve provision of contraception prior to discharge or follow up plans or appointments to address contraception.	An expert panel on maternal health convened by CMS included as one of its recommendations that CMS take steps to "adopt contraception and family planning measures as a gateway to inter-conception care." See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Crosswalk-of-Activities.pdf A significant number of women do not come to postpartum visits. Discharge discussions, therefore, can be an important point at which long acting contraception or other forms of contraception can be discussed and/or provided. This can help ensure optimal spacing between births.
PNPI 1 New Element	We continue to believe that The Joint Commission should revise this standard to include a new element that requires programs to have in place mechanisms to identify and curb incidence of overuse and unwarranted practice variation.	There is a significant body of evidence showing variation in the use of maternity care interventions across the country and, indeed, among hospitals that may be in very close proximity to each other. Many interventions are routinely used in the absence of clinical standards supporting that behavior. (See, for example, "Kozhimannil, Law and Virnig, "Cesarean delivery rates vary ten fold among hospitals; Reducing variations may address quality and cost issues, in *Health Affairs*, vol. 32, no. 3, March 2013, pp. 527-35).

		See also, data on early elective deliveries provided by the Leapfrog group at: http://www.leapfroggroup.org/tooearlydeliveries
PNPI 2 Element 1	We recommend including a new item in Element 1 requiring the program to collect data on "issues related to the process of receiving mothers and newborns who are transferred to the program from a setting offering care at a lower level of acuity in the community, including birth centers and residences, including mortality and morbidity during the transfers."	See the rationale offered above for PNPC 5, New Element.
PNPI 2 Element 2	We continue to recommend that The Joint Commission also include the NQF-endorsed Healthy Term Newborn measure in the list of performance measures for which the program collects data. Note that this measure is being improved and renamed as Unexpected Newborn Complications. We further recommend that as The Joint Commission or the NQF finalize measures related to perinatal care, that there be a mechanism in place to revise the Certification Requirements to incorporate those new measures.	This measure examines the percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care. It is a useful measure for evaluating how well the hospital is performing with regard to the quality of its perinatal services. (The revised version conversely identifies the proportion of low-risk newborns that experience complications during or shortly after birth.)
PNPI 2 Element 6	We recommend that the language of this Element be revised to read, "The program collects ~~patient satisfaction~~ data that is specific to the patient's experience of care, treatment, and services it provides.	The broader concept of experience (as in the CAHPS surveys) is now considered the standard, rather than "satisfaction."
PNPI 5 Introductory Text	We recommend that the introductory text to PNPI 5 be revised to read, "The program analyzes its patient transfer process, as well as its process for receiving transfers from settings offering care at a lower level of acuity within the community, to identify opportunities for improvement."	See rationale offered above for PNPC 5, New Element.
PNPI 5 Element 1	We recommend that the language of Element 1 be revised thus: "The program develops a process for reviewing records related to women and newborns who are transferred to the program from another setting of care, as well as those related to women and newborns who are transported from the program to a higher level of care, to identify opportunities for improvement."	Please see previous comments, e.g., at PNPC 5 New Element. We believe that it is important for certified programs to work well with other care settings in their area to ensure that their services are available to women and infants who need them who have chosen to initiate birth in a lower acuity setting such as a birth center or residence.
PNPI 6 New Element	We recommend adding a new element that reads, "The program has a process for sensitively and respectfully disclosing the occurrence of a sentinel event to the woman and the family and for taking appropriate accountability."	Among the elements listed under this performance standard there is not currently a requirement for disclosure of the sentinel event to women and families. Increasingly, it has been recognized that such disclosure is not only the appropriate thing to do, but is also more likely to lead to lower levels of litigation than an approach that emphasizes silence or release of minimal details. The standard of disclosure of sentinel events to patients and families is outlined in detail in The Joint Commission's own *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* at www.jointcommission.org/assets/1/18/Medical_Liability.pdf

		See also: Conway, J., Federico, F., Stewart, K., Campbell, MJ, "Respectful Management of Serious Clinical Adverse Events (Second Edition)," IHI Innovation Series white paper. Cambridge, Massachusetts, Institute for Healthcare Improvement, 2011.

Again, thank you for providing us with this opportunity to comment on this very important document, which has the potential to improve birth for the majority of women, who have uncomplicated pregnancies and deliveries. Should you have any questions, please feel free to contact Jesse Bushman at jbushman@acnm.org or 240-485-1843.

Signatory Organizations
American College of Nurse-Midwives
American Association of Birth Centers
Association of Women's Health, Obstetric and Neonatal Nurses
Childbirth Connection Programs, National Partnership for Women & Families
Lamaze International
Midwives Alliance of North America
National Association of Certified Professional Midwives
National Women's Health Network
United States Breast Feeding Committee