Stakeholders Meeting on Perinatal Health
Presentation to the Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
Rockville, Maryland
Thursday, March 17, 2011

By Lorrie Kline Kaplan, CAE, Executive Director
American College of Nurse-Midwives

We extend our sincere thanks to HRSA and MCHB for convening this meeting and for your leadership in bringing visibility to the important issues regarding the health of our nation's women, children, and families.

The American College of Nurse-Midwives (ACNM) is the oldest women's health organization in the United States, with roots dating back to 1929. Our members—certified nurse-midwives (CNMs) and certified midwives (CMs)—attended 317,627 births in the US in 2008, 96.1% of which were in hospitals.[1] This represents 7.5% of all births in the US. CNMs and CMs are primary care providers who specialize in lifelong gynecologic, perinatal, intrapartum, postpartum and newborn services. ACNM believes that every woman deserves access to high quality care that supports her physiologic capacity to labor, birth, and breastfeed, and that providing such access would greatly reduce maternal and newborn mortality and morbidity.

Birth is a life event we all have in common. In 2008, there were more than 4.2 million births in the US.[2] Maternity care accounts for nearly one in four hospital discharges and represents the most common and costly hospital condition paid for by Medicaid and private insurers, yet surprisingly little attention has been paid to perinatal care as a priority for quality improvement. In the past 20 years, maternal mortality, preterm birth, and low birthweight rates in the US have increased. Racial, ethnic, and socioeconomic disparities in maternal and newborn outcomes persist. The use of surgical and medical interventions without indication has increased, and costs have skyrocketed. Breastfeeding rates remain unacceptably low, and fall far short of the Healthy People 2020 objectives.

---

[1] Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Matthews TJ, Osterman JK. Births: Final data for 2008. National vital statistics reports; vol 59 no 1. Hyattsville, MD: National Center for Health Statistics. 2010.
[2] Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2008. *National Vital Statistics Reports* 58(16) Hyattsville, Maryland: National Center for Health Statistics, April 2010.

ACNM Priority Issues

Research has clearly demonstrated that labor, birth, and breastfeeding have significant physiologic benefits to mothers and their newborns, and that medical and surgical interventions carry inherent risks and should be avoided in the absence of medical indication. ACNM promotes maternal-child health protocols that support birth and the postpartum period as fundamentally healthy physiologic events, and that improve quality and reduce disparities through measurement and implementation of evidence-based practices. We support strategies to reduce the use of costly non-medically-indicated interventions in childbirth, such as elective induction of labor and elective or unnecessary cesarean sections, and to increase the incidence of breastfeeding.

The current US maternity care system offers only limited access to evidence-based practices that promote healthy physiologic labor; instead our system primarily offers medicalized approaches designed for women at high risk of complications. The application of high-risk strategies to a predominantly low-risk population has had deleterious effects on the quality and outcomes of prenatal care in the US. Areas of particular concern include:

- **Labor Induction.** Preterm births have been rising in the past 20 years in the US, and much of this increase is in late preterm births (34-36 weeks) which have been attributed to elective inductions of labor. Studies have shown that rates of induction of labor vary significantly from one institution and maternity care provider to the next, with little or no relation to the needs of mothers and newborns. The rate of low birthweight has also been rising over a quarter century, from 6.7% to 8.2% in 2008. State rates range from 5.7% to 12.3%. Non-Hispanic black infants experience much higher rates of both preterm birth and low birthweight compared to other ethnicities.
- **Cesarean Birth Rates.** The 2009 cesarean rate of 32.9% was the thirteenth consecutive year of increase and marked an all-time US record high. Cesarean delivery is now the most common operating room procedure in the US, with rates as high as 75% in some hospitals. Concurrently, maternal mortality doubled from 1987 to 2006. Women in the US have a higher risk of dying of pregnancy-related complications than in 40 other countries.

  While a cesarean delivery clearly can be a lifesaving procedure, cesarean birth poses greater short-term and long-term risk to both the mother and infant and the outcome of future pregnancies compared to vaginal birth. The World Health Organization has recommended an optimal cesarean birth rate of 10-15%.[3] In other words, according to that recommendation, for every woman who receives a necessary cesarean delivery in the US today, two to three others receive one unnecessarily. Intermountain Healthcare, a leading health system with a 21% cesarean delivery rate, recently reported that health care costs would be

[3] World Health Organization. Appropriate technology for birth. *Lancet* 1985; 2: 436-7.

reduced by $3.5 billion annually if the national rate came down to their level. Using data from the AHRQ-HCUP of the US Department of Health and Human Services, Intermountain estimates that "every one percent decrease in the nation's C-section rate could save more than $300 million in maternal charges."[4]

- **Vaginal Birth After Cesarean.** As cesarean delivery rates have skyrocketed, access to vaginal birth after cesarean (VBAC) has sharply declined. Since 1996, approximately one-third of hospitals and one-half of physicians no longer offer trial of labor. Among women with a prior cesarean delivery, VBAC rates vary by racial/ethnic status, medical condition, region of the country, type and location of hospital, and may vary by type of provider. According to the National Institutes of Health (NIH) Consensus Statement on Vaginal Birth After Cesarean, the available evidence supports providing a trial of labor for women with a previous cesarean. The NIH panel notes that both VBAC and repeat cesarean delivery have risks and benefits, and advocates for a shared decision-making process in which the woman's preference is honored whenever possible. The panel recommends that hospitals, maternity care providers, healthcare and professional liability insurers, consumers and policymakers collaborate on the development of integrated services that could mitigate or even eliminate the current barriers to trial of labor.[5]

Breastfeeding. Optimally healthy for mothers and babies, breastfeeding provides a host of lifelong health and economic benefits, yet only 75% percent of infants are initially breastfed, and by six months, rates fall to 43%, with only 13% of infants exclusively breastfed. Among African-American babies, the rates are significantly lower. Fifty-eight percent start out breastfeeding, and 28% breastfeed at six months, 8% exclusively, far below Healthy People 2020 objectives. As an evidence-based intervention, breastfeeding is grossly underutilized due to a lack of experience, understanding, and support on the part of women, health care professionals, institutions, and society. The US Surgeon General advocates for increased research, education, and community awareness and support for breastfeeding, incorporation of Baby-Friendly Hospital Initiatives, and access to lactation support both postpartum and in the workplace.

ACNM Initiatives to Improve Perinatal Care

"Evidence-Based Maternity Care," cites midwife-led care as one of the top "underutilized strategies" for improving the outcomes of childbirth in the US. Midwives

---

[4] Intermountain Healthcare. 2011. Intermountain shares trends of 300,000 births over 10 years (press release). Available at http://intermountainhealthcare.org/about/news/Pages/home.aspx?NewsID=641 (accessed January 26, 2011).

[5] Cunningham FG, Bangdiwala S, Brown SS, Dean TM, Frederiksen M, Rowland Hogue CJ, King T, Spencer Lukacz E, McCullough LB, Nicholson W, Petit N, Probstfield, JL, Viguera AC, Wong CA, Zimmet SC. National Institutes of Health Consensus Development Conference Statement: Vaginal Birth After Cesarean: New Insights. March 8-10, 2010. Obstetrics & Gynecology. 2010; 115(6):1279-1295. The evidence report prepared for this conference through AHRQ is available on the web via http://www.ahrq.gov/clinic/tp/vbacuptp.htm.

are experts in the support of physiologic birth and labor, and have amassed a consistent record of birth outcomes as good as or better than their physician counterparts, with lower rates of surgical and medical intervention.[6] ACNM's perinatal care initiatives are designed to promote access to healthy physiologic childbirth practices. This includes promotion of expanded access to midwifery care, as midwives are the leading experts in normal birth. The following is just a subset of current initiatives, organized based on the strategic goals of our organization.

1. **Strategic Communications:**
    a. "**Evidence-Based Practice: Pearls of Midwifery,"** a fully-referenced presentation for clinicians that details the research and evidence on which practices promote healthy, physiologic childbirth.
    b. **Mymidwife.org and** "**Team Midwife**"—programs that help consumers become more informed and involved in the promotion of healthy, physiologic childbirth.
    c. **Position papers and clinical bulletins**, and the peer-reviewed *Journal of Midwifery & Women's Health*, that focus on clinical practices that promote healthy, physiologic childbirth.
    d. **Normal Birth Taskforce** – an inter-organizational consensus development process to define the fundamental elements of "normal" childbirth.
2. **Reducing Barriers to Practice**:
    a. Promoting bundled payment models for the full episode of maternity care
    b. Eliminating outdated legal impediments to midwifery care on the federal, state, and institutional level, ranging from discriminatory hospital privileging practices to physician supervision, and more. These barriers to practice have a significant affect on access to midwifery care.
3. **Expanding the National Midwifery Workforce**
    a. Advocating for greater funding for midwifery education.
    b. Promoting innovative educational models that support workforce expansion.
    c. Improving access to sustainable clinical sites.
4. **Improving Quality of Care:**
    a. Leading the formation of the Coalition for Quality Maternity Care (CQMC), to create a single, strong voice to advocate for national strategies to improve maternal and newborn health.
    b. Promote the development and implementation of standardized quality measures for perinatal care that emphasize healthy, physiologic childbirth and breastfeeding.
    c. Participating in joint patient safety initiatives with ACOG, AAFP, and others.

What Can HRSA do?

---

[6] American College of Nurse-Midwives. 2008. Nurse-Midwifery in 2008: Evidence-Based Practice. Available at http://www.midwife.org/siteFiles/news/nurse_midwifery_in_2008.pdf (accessed January 26, 2011.)

HRSA should make improved perinatal care a top priority. Here are some suggestions on how to do it:

1. **Develop a national maternity care workforce strategy** designed to best enhance access to healthy, physiologic childbirth and breastfeeding.
    a. Promote inter-professional and collaborative education and practice models that maximize the return (quality, value, access, and continuity of care) from our maternity care workforce.
    b. Actively implement this strategy in FQHCs and other settings that provide care to vulnerable populations.
    c. Increase support for education programs that educate maternity care providers who are most skilled in promoting healthy, physiologic childbirth and breastfeeding.
2. **Assist in educating consumers on evidence-based practices** which best promote healthy, physiologic childbirth and breastfeeding—particularly those in vulnerable populations.
3. **Adopt National Quality Forum-endorsed perinatal care measures** in HRSA-funded settings, and support the expansion of national quality measurement initiatives in perinatal care.
4. **Designate maternity-care shortage areas and loan repayment programs** for clinicians serving in these areas.
5. **Drive the expansion of birth centers and group models of care** as a key strategy for improving access and improving quality and value of maternity care services to vulnerable populations.
6. **Champion improved inter-agency coordination** on issues related to perinatal care.
7. **Promote bundled payment models** that neutralize the incentive for over-treatment.