BIRTH SETTINGS IN AMERICA:

OUTCOMES, QUALITY, ACCESS, AND CHOICE (2020)

Conclusion 7-1: Quality improvement initiatives—such as the Alliance on Innovation in Maternal Health and the National Network of Perinatal Quality Collaboratives—and adoption of national standards and guidelines—such as the Maternal Levels of Care of the American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine; the American Academy of Pediatrics' Neonatal Levels of Care; and guidelines for care in hospital settings developed by the Association of Women's Health, Obstetric, and Neonatal Nurses, the Society of Obstetric Anesthesia, and the American College of Nurse-Midwives—have been shown to improve outcomes for pregnant people and newborns in hospital settings.

Conclusion 7-2: Providing currently underutilized nonsurgical maternity care services that some women have difficulty obtaining, including vaginal birth after cesarean, external cephalic version, planned vaginal breech, and planned vaginal twin birth, according to the best evidence available, can help hospitals and hospital systems ensure that all pregnant people receive care that is respectful, appropriate for their condition, timely, and responsive to individual choices. Developing in-hospital low-risk midwifery-led units or adopting these practices within existing maternity units, enabling greater collaboration among maternity care providers (including midwives, physicians, and nurses), and ensuring cultivation of skills in obstetric residency and maternal-fetal medicine fellowship programs can help support such care.

Conclusion 7-3: Efforts are needed to pilot and evaluate high-value payment models in maternity care and identify and develop effective strategies for value-based care.

Conclusion 7-4: Integrating home and birth center settings into a regulated maternity and newborn care system that provides shared care and access to safe and timely consultation; written plans for discussion, consultation, and referral that ensure seamless transfer across settings; appropriate risk assessment and risk selection across settings and throughout the episode of care; and well-qualified maternity care providers with the knowledge and training to manage first-line complications may improve maternal and neonatal outcomes in these settings.

Conclusion 7-5: The availability of mechanisms for all freestanding birth centers to access licensure at the state level and requirements for obtaining and maintaining accreditation could improve access to and quality of care in these settings. Additional research is needed to understand variation in outcomes for birth centers that follow accreditation standards and those that do not.

Conclusion 7-6: The inability of all certified nurse midwives, certified midwives, and certified professional midwives whose education meets International Confederation of Midwives (ICM) Global Standards, who have completed an accredited midwifery education program, and who are nationally certified to access licensure and practice to the full extent of their scope and areas of competence in all jurisdictions in the United States is an impediment to access across all birth settings

Conclusion 7-7: Ongoing risk assessment to ensure that a pregnant person is an appropriate candidate for home or birth center birth is integral to safety and optimal outcomes. Mechanisms for monitoring

adherence to best-practice guidelines for risk assessment and associated birth outcomes by provider type and settings is needed to improve birth outcomes and inform policy.

Conclusion 7-8: To foster informed decision making in choice of birth settings, highquality, evidence-based online decision aids and risk-assessment tools that incorporate medical, obstetrical, and social factors that influence birth outcomes are needed. Effective aids and tools incorporate clinical risk assessment, as well as a culturally appropriate assessment of risk preferences and tolerance, and enable pregnant people, in concert with their providers, to make decisions related to risk, settings, providers, and specific care practices.

Conclusion 7-9: Access to choice in birth settings is curtailed by a pregnant person's ability to pay. Models for increasing access to birth settings for low-risk women that have been implemented at the state level include expanding Medicaid, Medicare, and commercial payer coverage to cover care provided at home and birth centers within their accreditation and licensure guidelines; cover care provided by certified nurse midwives, certified midwives, and certified professional midwives whose education meets International Confederation of Midwives (ICM) Global Standards, who have completed an accredited midwifery education program, and who are nationally certified; and cover care provided by community-based doulas. Additional research, demonstration, and evaluation to determine the potential impact of these state-level models is needed to inform consideration of nationwide expansion, particularly with regard to effects on reduction of racial/ethnic disparities in access, quality, and outcomes of care.

Conclusion 7-10: Ensuring that levels of payment for maternity and newborn care across birth settings are adequate to support maternity care options across the nation is critical to improving access.

Conclusion 7-11: Research is needed to study and develop sustainable models for safe, effective, and adequately resourced maternity care in underserved rural and urban areas, including establishment of sustainably financed demonstration model birth centers and hospital services. Such research could explore options for using a variety of maternity care professionals—including nurse practitioners, certified nurse midwives, certified professional midwives, certified midwives, public health nurses, home visiting nurses, and community health workers—in underserved communities to increase access to maternal and newborn care, including prenatal and postpartum care. These programs would need to be adequately funded for evaluation, particularly with regard to effects on reduction of racial/ethnic and geographic disparities in access, quality, and outcomes of care.

Conclusion 7-12: To improve access and reduce racial/ethnic disparities in quality of care and treatment, investments are needed to grow the pipeline for the maternity and newborn care workforce—including community health workers, doulas, maternity nurses, nurse practitioners and physicians' assistants, public health nurses, family medicine physicians, pediatricians, midwives, and obstetricians—with the goal of increasing its diversity, distribution, and size. Greater opportunities for interprofessional education, collaboration, and research across all birth settings are also critical to improving quality of care.

CONCLUSION The challenges facing the current U.S. maternity care system, while urgent, are not insurmountable, and opportunities for improving the systems that support childbirth exist. To improve maternal and infant outcomes in the United States, it is necessary to provide economic and geographic access to maternity care in all settings, from conception through the first year postpartum; to provide

high-quality and respectful treatment; to ensure informed choices about medical interventions when appropriate for risk status in all birth settings; and to facilitate integrated and coordinated care across all maternity care providers and all birth settings. Achieving these objectives will require coordination and collaboration among multiple actors— professional organizations, third-party payers, governments at all levels, educators, and accreditation bodies, among others—to ensure system-wide improvements for the betterment of all women, newborns, and families.

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