AABC
AMERICAN ASSOCIATION OF BIRTH CENTERS

POSITION STATEMENT

Birth Center Licensure and Regulations

The American Association of Birth Centers (AABC) is a multidisciplinary membership organization comprised of birth centers, individuals and organizations that support the birth center model. Members include certified nurse-midwives (CNMs), certified midwives (CMs), certified professional midwives (CPMs), physicians, nurses, women and their families. Founded in 1983, AABC is dedicated to developing quality holistic services for childbearing families that promote self-reliance and confidence in birth and parenting in the wellness model of care.

Freestanding birth centers achieve better outcomes than hospitals on quality measures such as cesarean rate for low risk women, elective delivery prior to 39 weeks, and breastfeeding. Birth Centers are a safe option for women experiencing a low risk pregnancy. Birth centers use fewer medical interventions; this saves health dollars and reduces the risk of complications.[i,ii]

REGULATION COMPONENTS THAT ARE RECOMMENDED

Based on Standards and Evidence. AABC believes that licensure and regulations for freestanding birth centers (FSBCs) should be based on evidence and national industry standards that have been proven safe and effective. AABC established the National Standards for Birth Centers to provide a tool for measuring the quality of services provided to childbearing families in birth centers.[iii] The Standards are owned by the AABC. They are reviewed periodically to assure that they remain consistent with evolving evidence-based maternity care. The Commission for the Accreditation of Birth Centers (CABC) has developed specific indicators for assessment and compliance with the Standards. [iv]

CABC Accreditation. AABC supports CABC accreditation as one basis for state licensure. Several states have successfully demonstrated that when birth centers achieve and maintain licensure through CABC accreditation, they are high quality facilities for low risk birth. CABC accreditation provides concrete indications that a birth center meets high evidence-based standards, widely recognized benchmarks, and current best practices for maternity care, neonatal care, business operations, and safety. This, in turn, provides important and warranted assurance to clients (both women and their families), states, insurers, consulting providers, and hospitals. Increasingly, states are granting “deemed status” to CABC accredited birth centers, thus saving the State the cost of inspecting birth centers. [3]

Facility Specific. Regulations for birth centers should be specific to the facility and not include regulations regarding providers. All maternity care providers in birth centers should be held to the same

regulations for birth center practice, regardless of their educational preparation.[v] For scope of practice issues, it is best for providers to be regulated under those practitioners' individual licensing boards and not in birth center regulations.

Guidelines for Transfer. Regulations should require practice guidelines and policies that include plans to transfer to an acute care hospital with maternity and newborn services should circumstances warrant. Guidelines for transfers should include plans for emergent and non-emergent situations for both mothers and newborns, antepartum, during labor, and postpartum. These guidelines should also include indications for transfer, and plans for communication with the receiving hospital both during and after transfer has been achieved. Hospitals should be expected to cooperate in planning transfer arrangements, and not to place barriers in the way of safe transitions of care when they are needed.

Physical Layout. Regulations for the physical layout of birth centers should be based on business occupancy requirements and should not require enhancements that increase cost but do not improve safety.[vi] Because care provided in freestanding birth centers is limited to low risk maternity and newborn care, business occupancy construction standards are the acceptable level. There is no need for facility construction to be at the level of hospitals or ambulatory surgery centers to safely meet the needs of the low risk women and infants served in birth centers.

REGULATION AND LICENSURE REQUIREMENTS THAT ARE NOT RECOMMENDED

Some state regulations include requirements that are not shown by evidence to promote safety of the birth center for the mother or baby or to increase the quality of care in the birth center. These requirements are outdated and counterproductive to safe clinical care provided in the birth center, facility to facility consultation, and seamless transfer.

Written contract or agreement with transfer hospital. It is the goal of all birth centers to have plans in place for smooth transfers to hospital care when this is needed. Having written policies and procedures that outline plans for hospital transfers does make birth center care safer. Poor communication between birth centers and hospitals does not facilitate safe care. However, requiring written contracts or agreements with transfer hospitals reduces access to birth center care when hospitals refuse to enter into such written agreements. Vital Statistics data show that states with this requirement have fewer birth centers and fewer birth center births than states without the requirement.[vii]

Certificate of Need (CON). The CON was designed in the 1970s to control health care costs by requiring planning of new healthcare facilities. These laws now tend to focus on outpatient facilities that are in direct competition with hospital facilities.[9] CON laws should not be applicable to birth centers because birth centers have only 2 to 4 beds which are limited to low risk maternity care. They do not provide the same services as a hospital bed in the same community and should not be counted toward the total hospital beds in a community. There is no capability for surgical birth, or regional or general anesthesia in a freestanding birth center, but there is provision of services not normally provided in the hospital, such as intensive support for physiological birth and home visits. States with CON laws still in place have limited access to birth centers for women in those states compared to states with no CON laws.[viii,ix]

Physician as Medical Director. State requirements that birth centers have a physician as Medical Director are not associated with better outcomes. Physicians are rarely trained in birth center birth. Few physicians are trained in out-of-hospital birth. The CABC states that birth centers should have a Clinical Director, but that Clinical Director may be a midwife *or* physician.[3] All birth centers want to have good working relationships with consulting physicians for the safety of their mothers and infants. But, in communities or states where no physician will agree to serve as Medical Director, there is no access to birth center care. [7,8]

Written agreement with physician. Requirements that birth centers have a written agreement with a collaborating physician decrease access to birth centers for the same reasons that requiring physician medical directors does. All birth centers desire good collaborative relationships with physicians to consult when needed. However, most physicians do not want to sign written agreements with birth centers because they believe this will increase their risk of liability.

SUMMARY

The American Association of Birth Centers is committed to ensuring safe, high-quality, family-centered options for birth center care. Women and families are choosing birth centers in increasing numbers every year.[8] Access to the birth center option for pregnant families depends on public trust and viable birth center models, along with regulation and licensure that ensure quality and safety but do not block access to care.

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[i] American Association of Birth Centers, Birth Center Outcome Data from AABC Perinatal Data Registry, Perkiomenville, PA. Unpublished data. Retrieved February, 2016.

[ii] Hill, Ian et al. (2016). Strong Start for Mothers and Newborns II Second Annual Evaluation Report. Retrieved April 5, 2016, from https://downloads.cms.gov/files/cmmi/strongstartenhancedprenatalcare_evalrptyr2v2.pdf

[iii] American Association of Birth Centers. *Standards for Birth Centers*. Perkiomenville, PA: American Association of Birth Centers; 2014.

[iv] Commission for the Accreditation of Birth Centers. Accreditation and Regulation. Retrieved April 12, 2016. https://www.birthcenteraccreditation.org/accreditation-and-regulation/

[v] American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine. Obstetric Care Consensus No. 2: Levels of Maternal Care. *Obstet Gynecol*. 2015;125(2):502-515.10.1097/01.AOG.0000460770.99574.9f.

[vi] National Fire Protection Association. NFPA 101 (R) Life Safety Code. 2015 Edition. Section: A.3.3.190.3 Business Occupancy 2014. Quincy, MA.

[vii] American Association of Birth Centers, Internal Data on Regulations by State. Unpublished. 2016.

[viii] Joyce A. Martin. Natl Vital Stat Rep. 2015;64:1. Retrieved April 12, 2016 from: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf

[ix] National Conference of State Legislatures. Certificate of need: State health laws and programs. Retrieved February 15, 2016 from: http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx