







Hospital Guide to Integrating the Freestanding Birth Center Model

Purchaser Business Group on Health

Primary Maternity Care

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About this Report

About the authors

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About the Purchaser Business Group on Health

Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing nearly 40 private employers and public entities across the United States that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. PBGH has a 30-year track record of incubating and scaling new, disruptive operational programs that lower health care costs and increase quality.

About Primary Maternity Care

Primary Maternity Care (PMC) is a service design and consulting firm with a mission to enable integrated, high quality reproductive and perinatal care by strengthening systems for patient engagement, quality improvement, value-based payment, and community-based care delivery.

PMC works with stakeholders across the system to design and implement innovative solutions that improve outcomes, equity, and cost.

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Note on terminology
This report will use the terms birthing person, parent, woman, and mother to acknowledge the diversity of identities encompassed when discussing pregnancy and birth care.

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Executive Summary

Executive Summary

The *Hospital Guide to Integrating the Freestanding Birth Center Model* collates critical tools, information and resources to help hospitals and health systems adopt the birth center model. Despite strong evidence about the safety of birth centers and their potential role in solving the U.S. maternal health crisis, hospitals lack resources to support effective integration and collaboration with birth centers. This guide fills that gap in efforts to improve maternal and infant health outcomes nationally.

Successfully integrating birth center care with hospitals requires reimagining how we deliver care to pregnant and birthing people. This guide centers the experience of birthing people, particularly historically marginalized populations, by operationalizing concepts of birth justice. Strategies for facilitating patient choice and respecting bodily autonomy, the core of the birth center model, are woven throughout this guide.

The guide is organized into four sections based on the lessons learned and expressed needs of hospitals and birth centers throughout the country:

- (1) Assessing Readiness for Birth Center Integration,
- (2) Partnership or Ownership? Understanding Integration Approaches,
- (3) Establishing and Maintaining Quality, and
- (4) Financial and Business Case Considerations.

The sections flow chronologically, but feel free to start wherever makes sense.

The Assessing Readiness for Birth Center Integration chapter outlines five steps to developing an integration plan specific to health systems' priorities and the needs of local communities. In this section, hospitals and health systems learn about the birth center model, identify birth centers operating locally, conduct a community needs assessment and recruit champions. This section offers guidance on combining these learnings into an integration strategy that considers the market conditions and community priorities unique to your health system.

The Partnership or Ownership? Understanding Integration Approaches chapter helps to determine the appropriate integration strategy based on previously identified needs and priorities within your health system and local community. This section defines the necessary components of a successful integration strategy (staff time, education, a culture of collaboration, referrals and an investment in safety and quality) and describes in detail the strategic pathways to hospital adoption of the birth center model—partnership (smooth transfers and investment) or ownership (acquisition or building new).

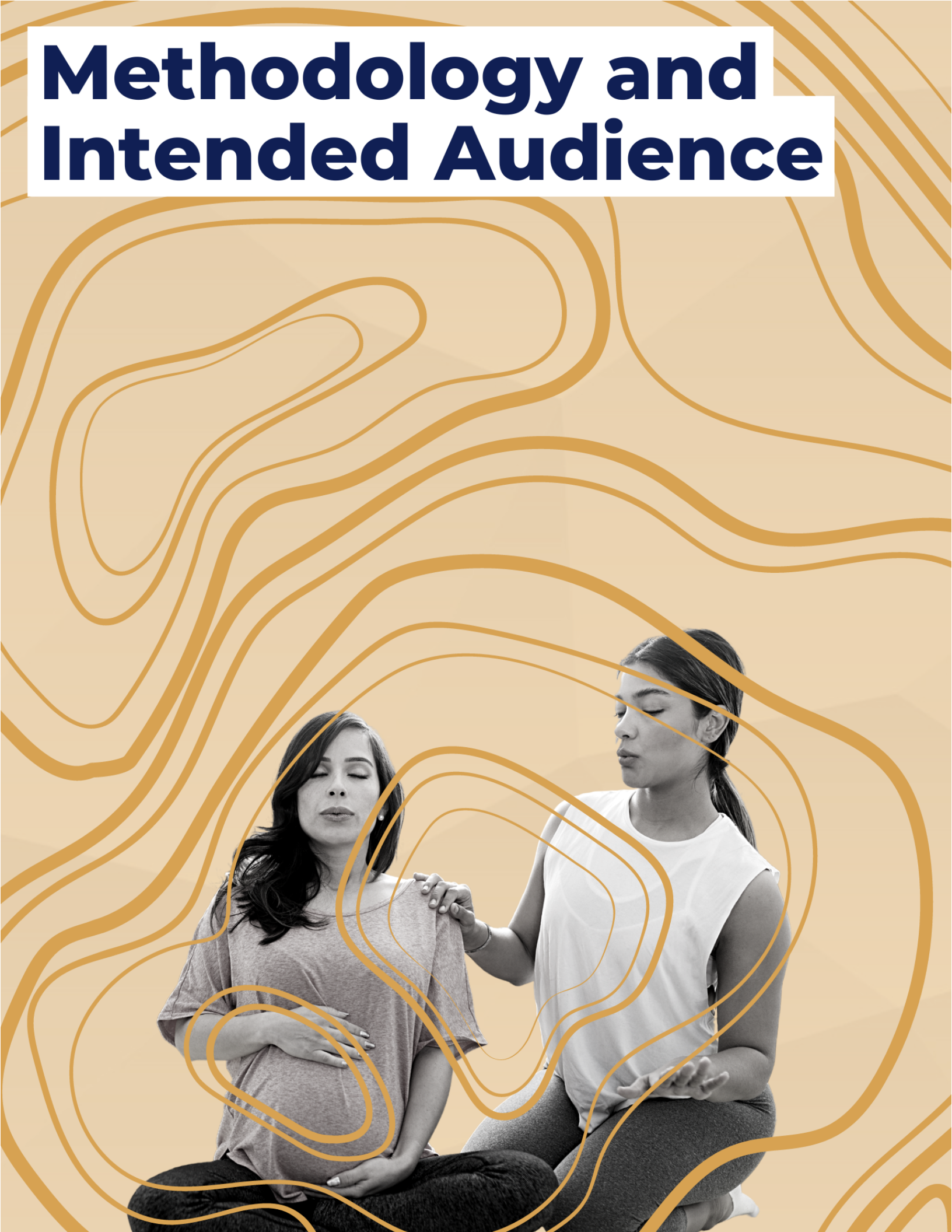
The Establishing and Maintaining Quality chapter focuses on critical tools and tactics to support and manage the delivery of high-quality care, with a particular focus on smooth and

positive transfers. This section examines the role of hospitals in fostering relationships between facility providers and implementing processes and protocols that promote collaboration and lead to better outcomes. This chapter details the drills, training and chart review necessary to achieve high-performing collaborative relationships between a hospital and birth center.

Finally, the Financial and Business Case Considerations chapter examines the many practical, how-to realities of promoting financially sustainable birth centers. This chapter outlines the critical components to assembling a birth center budget, contracting with payors, and structuring payment to promote consultation and collaboration among providers. The section culminates by looking toward innovative payment models that promote birth center integration.

Throughout all sections of the guide, you'll encounter Tools  that will help you implement best practices, and Spotlights  to explore innovative examples of integration initiatives. You'll also find quotes from survey and interview participants to highlight key points.

Methodology and Intended Audience



Methodology and Intended Audience

Methodology

Beginning in 2021, the Purchaser Business Group on Health (PBGH) and Primary Maternity Care (PMC) fielded surveys of California hospital and birth center leaders, conducted focus groups of providers and patients, and engaged with a state-wide interdisciplinary technical expert panel to identify opportunities to strengthen collaboration between birth centers and hospitals. This work led to identification and development of several of the tools included in this guide, and generated the idea for a hospital-facing resource that supports effective integration and collaboration with birth centers.

While developing the *Hospital Guide to Integrating the Freestanding Birth Center Model*, we interviewed leaders from over a dozen additional hospitals and birth centers to collect best practices and lessons learned from their experiences working together. We also surveyed birth centers that identified as having strong or significantly improving hospital partnerships. The learnings generated from this body of work as well as the authors' clinical and operational experiences informed this guide.

Intended Audience and Guiding Principles

Our research demonstrated that hospitals often struggle to engage with the birth center model of care and lack implementation resources that address their unique operational, cultural, and financial contexts. We developed this guide focused on the needs of hospitals and hospital-based providers.

While this guide is hospital focused, we were guided by principles of birth justice and sought to center the needs of pregnant and birthing people, with an emphasis on those who experience marginalization and mistreatment in the current system and those who face access barriers. We did this by conducting focus group research with patients and specifically eliciting experiences of people of color, and by ensuring input and review from diverse stakeholders including patients and health equity experts. Given the strong evidence for birth center care, we also prioritized maintaining fidelity to the birth center model as defined by the American Association of Birth Centers (AABC).

This guide is designed for facilities seeking to expand access to the birth center model of care and integrate its unique care approach into their service lines. If your facility is solely focused on supporting safe transfers of care, we recommend starting with resources from the AABC and

state and regional quality collaboratives that have generated best practices and adaptable tools. (See Table 4 in Establishing and Maintaining Quality.) Providers, hospitals, and health systems have an ethical and professional duty to establish a reliable safety net for birth center patients and ensure timely, respectful care to all.

This guide is designed for people who are exploring or championing the birth center model within health systems, and assumes some baseline understanding of freestanding birth centers and midwives. Key attributes of the birth center model are reviewed in the Introduction. See "Resources for Learning About Birth Centers" for more information about the model.

Resources for Learning About Birth Centers

Web: The American Association of Birth Centers (AABC) website provides birth center standards, research, and implementation resources including workshops and toolkits.

Book: *Freestanding Birth Centers: Innovation, Evidence, Optimal Outcomes* by Linda Cole and Melissa Avery is a comprehensive guide to the evolving role of birth centers, clinical and cost outcomes, regulatory and legal issues, provider and accreditation issues, and the future of the birth center model.

Report: *Improving Our Maternity Care Now Through Community Birth Settings* is a comprehensive report from the National Partnership for Women and Families on evidence and policy priorities related to birth centers and home birth.

Film: The film Aftershock investigates the Black maternal mortality crisis and how midwifery and birth center care are key parts of the solution.

Continuing Education (CE): HiveCE Transfer Tools includes online CE courses for midwives, emergency services personnel, nurses, and receiving hospital providers.

Introduction

In this section:

- Introduction
- Why now?
- Understanding the freestanding birth center model
- Why integration matters
- Myths and facts about birth centers
- Systemic barriers to birth center sustainability

Introduction

The freestanding birth center offers a well-established, evidence-based care model wholly underutilized in the United States. In a system plagued by rising costs, worsening outcomes, and growing inequities, clinicians' and pregnant people's interest in the birth center model is growing quickly. There is an emerging consensus among providers, payors, purchasers and patients that birth centers and collaboration with midwives are the way forward.

As institutions with clinical authority and purchasing power, hospitals and health systems can help pave a smoother path for birth center adoption and utilization by embracing the model. Investing in and building a collaborative practice with birth centers requires trust, communication and the understanding that midwives and birth centers serve an essential role in meeting the diverse needs of patients. Doing so often requires reexamination of current assumptions about how best to deliver maternity care in this country and humbly learning from the midwives and birth centers who have been delivering this model of care for decades.

While this journey may not be simple or straightforward, it is in the best interest of your patients. We are excited to help you through the process.

The *Hospital Guide to Integrating the Freestanding Birth Center Model* offers step-by-step instruction and specialized tools to help hospital leaders integrate birth center care into their service lines. Using this guide will help your facility develop and deepen collaborative and mutually beneficial relationships with existing freestanding birth centers in your community. If there is not a birth center to partner with, this guide will help you build a birth center with fidelity to the freestanding birth center model, evidence-based standards, and best practices.

Our research indicates that no single perfect model for hospital-birth center integration exists, and that the recipe for success depends on the particular ingredients available to your community and health system (Assessing Readiness for Birth Center Integration). This guide walks you through potential ways to integrate birth centers (Partnership or Ownership? Understanding Integration Approaches) based on the unique needs of your community and health system.

As this work requires significant patience, persistence, and staff time, we developed these resources with longevity in mind. This guide will help you build a high-quality partnership or birth center (Establishing and Maintaining Quality) that is financially sustainable (Financial and Business Case Considerations).

Why now?

Embracing the birth center model can help your hospital address pressing market and industry challenges in a way that aligns with your health system's overall strategy.

Meet growing demand for wellness-focused, personalized care with a tested model.
Birth centers provide a unique model of care that is in high demand. Nearly 40% of respondents in a 2018 survey of California mothers indicated being open to or definitely interested in birth center care.[1] The birth center model is one of the most rigorously studied innovations in maternity care and has shown improved outcomes and patient experience, narrowed racial disparities in key outcomes, and reduced cost of care.[2]

Optimize services and resources across levels of care.
Caring for people with uncomplicated vaginal births in a birth center maximizes availability of hospital beds for others who need higher levels of care and who generate higher revenue. According to a consensus statement on maternal levels of care, accredited birth centers are part of a comprehensive system offering care across the spectrum of patient risks and preferences.[3]

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[1] Sakala, C., E.R. Declercq, J.M. Turon, et al., *Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report* (National Partnership for Women & Families: Washington DC, 2018). *https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf*.
[2] Sakala, C., S. Hernández-Cancio, and R. Wei, *Improving Our Maternity Care Now Through Community Birth Settings* (National Partnership for Women & Families: Washington DC, 2022). *https://www.nationalpartnership.org/our-work/resources/health-care/maternity/improving-maternity-community-birth-settings.pdf*.
[3] ACOG, "Obstetric Care Consensus Number 9: Levels of Maternal Care." *Obstetrics & Gynecology* 134 (2) (2019): e41-55. *https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care*

As health systems navigate declining birth volumes, increasing patient acuity, and staffing challenges, many are creating integrated networks that incorporate community-based access to ensure maximal reach with available resources.

Research Shows Birth Centers Provide High-Quality, High-Value Care

Strong Start was a four-year federal research study examining the outcomes of over 42,000 Medicaid recipients receiving care in three different innovative care models. People in the birth center model had the best outcomes and lowest costs. Compared with similar people receiving typical care, Strong Start Birth Center participants had:

- **26%** lower chance of preterm birth
- **20%** lower chance of low birth weight
- **40%** lower chance of a cesarean birth
- **94%** higher chance of successful vaginal birth after cesarean
- **21%** lower childbirth costs

For all measures and all racial and ethnic groups, birth center outcomes outperformed national benchmarks, and a narrowing of racial disparities was seen for some measures, including preterm birth.[4] Birth center participants had high satisfaction and reported feeling heard, having time for questions, being involved in decision-making, and being treated with respect.[5]

Create a pipeline for ancillary and specialty services.

Birth centers often refer out for imaging, lab, specialist, and other services that are revenue generating for health systems. In addition, approximately one-third of patients enrolling in birth center care will ultimately need hospitalization because they develop

[4] Alliman, J., S.R. Stapleton, J. Wright, et al., "Strong Start in birth centers: Socio-demographic characteristics, care processes, and outcomes for mothers and newborns." *Birth* 46 (2) (2019): 234-43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6594238/.

[5] Hill, I., C. Cross-Barnet, B. Courtot, et al., "What do women in Medicaid say about enhanced prenatal care? Findings from the national Strong Start evaluation." *Birth* 46 (2) (2019): 244-52. https://onlinelibrary.wiley.com/doi/abs/10.1111/birt.12431.

risk factors or complications or desire pain relief.[6] By aligning closely with a birth center, hospitals can maintain volume and market share while bringing new patients into the health system.

> "We cast a wide net for who comes to the birth center. Many of these folks would have never used our collaborating hospital for ultrasounds, labs, etc., or selected to have their care there. We estimate that **75% of our transfers** are individuals who would not have delivered at that hospital if they had not come to the birth center."
>
> —Midwife owner of an independent birth center

Safely address unmet demand for out-of-hospital birth.

As the popularity of out-of-hospital birth grows, many hospitals have seen a rise in transfers—and these have not always gone smoothly. (See "Reframing the train wreck" in Establishing and Maintaining Quality.) Birth centers that have strong relationships with hospitals are often seen as "the best of both worlds" for people exploring alternatives to hospital care, and this model helps ensure that those who want low-intervention care can still access hospital-based services safely when needed.

Build trust and support culturally responsive care for historically marginalized communities.

Coercive and paternalistic medical approaches have fostered distrust of the medical system among Black and Indigenous people of color (BIPOC), LGBTQ+ people and other marginalized groups in the United States.[7] Community-based birth centers, especially the small but growing number of BIPOC-led centers, can offer relationship-based care that integrates and has reverence for cultural experience and identity. A community-centered birth center model is associated with high levels of trust and has been shown to be protective against experiences of discrimination and mistreatment.[8] Investing in and respectfully integrating this model can help health systems serve their populations and address health inequities.

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[6] Stapleton, S.R., C. Osborne, and J. Illuzzi, "Outcomes of care in birth centers: demonstration of a durable model." *Journal of Midwifery & Womens Health* 58 (1) (2013): 3-14. *https://pubmed.ncbi.nlm.nih.gov/23363029/*.

[7] For more on the history of racism in obstetrics, we recommend the following reading: the National Partnership's Improving Our Maternity Care Now Through Community Birth Settings and ACOG's Joint Statement: Collective Action Addressing Racism.

[8] Almanza, J., J.'Mag Karbeah, K.M. Tessier, et al., "The Impact of Culturally-Centered Care on Peripartum Experiences of Autonomy and Respect in Community Birth Centers: A Comparative Study." *Maternal and Child Health Journal* 26 (2022): 895-904. *https://link.springer.com/article/10.1007/s10995-021-03245-w*.-

Spotlight: Growing and Sustaining BIPOC-led Birth Centers

Birth Center Equity (BCE) is a nonprofit that was created to make birth center care an option in every community, by growing and sustaining birth centers led by Black, Indigenous, and people of color (BIPOC). Less than 5% of birth centers in the United States are led by people of color, limiting access to the safe and culturally relevant midwifery care that is a key solution for reversing the maternal health crisis.

To address birth equity explicitly, BCE defines community birth centers as birth centers that provide safe, culturally reverent, midwifery-led maternal health care for all. Racial inequities in funding and investment capital create a barrier to BIPOC opening and sustaining community birth centers. BCE catalyzes their development through network building, grant making, capital investments, and innovations in economies of scale. BCE has grown a network of more than 30 established and developing BIPOC-led birth centers.

The resources hospitals and health systems can leverage in a partnership with a BIPOC-led birth center are significant and go beyond transfer to include care coordination, augmentation of services for hospital patients, and EHR access, for example. Grants and program-related investments can be especially effective in helping to support the growth and sustainability of BIPOC-led birth centers. Hospital and health system leaders can find a directory of BIPOC-led birth centers on the BCE website.

Restore access in maternity deserts.

Birth centers are critical to the strategy for meeting access needs in areas with low or declining volumes of births.[9] According to the 2022 *Maternity Care Deserts Report* from

[9] Jolles, D., S. Stapleton, J. Wright, et al., "Rural resilience: The role of birth centers in the United States." *Birth* 47 (4) (2020): 430-7. *https://pubmed.ncbi.nlm.nih.gov/33270283/*.

the March of Dimes,[10] 2.2 million women of childbearing age are living in maternity care deserts—areas where there are no providers or facilities offering maternity care. Because birth centers require relatively low overhead compared with hospitals, they can function as satellite ambulatory women's and perinatal health sites to reach dispersed populations of pregnant people and newborns, encouraging earlier and more frequent prenatal visits and referring to specialty care when clinically appropriate. Similar ambulatory models have flourished in surgery and other specialities.[11]

Transition to value-based payment.

Birth centers reduce the cost of care primarily through improved outcomes.[12] In addition, birth centers perform well on measures of interest to value-based purchasers, such as those related to preterm birth, cesarean birth, lactation, patient experience, neonatal length of stay, and cost of care. Hospitals with integrated birth centers may therefore have expanded opportunities to participate and succeed in value-based payment initiatives.

Support reproductive choice and autonomy.

Finally, in the wake of the *Dobbs* decision, we must recognize how reproductive and bodily autonomy intersects with birth choice. Respecting the right to choose when and how to parent includes honoring that individual's birth choices. Hospitals and providers have an obligation to offer safe and respectful care to all patients, no matter whether, where or how they decide to give birth.

Patient choice is at the heart of the birth center model. As AABC eloquently describes, "the birth center respects and facilitates a woman's right to make informed choices about her health care and her baby's health care based on her values and beliefs."[13] This guide is intended to spread these principles of patient choice by making birth center care a safe and accessible care option for all who seek it.

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[10] Brigance, C., R. Lucas, E. Jones, et al., *Nowhere to Go: Maternity Care Deserts Across the U.S.* (March of Dimes: Arlington VA, 2022). https://www.marchofdimes.org/maternity-care-deserts-report.
[11] Ibid.
[12] Dubay, L., I. Hill, B. Garrett, et al., "Improving Birth Outcomes and Lowering Costs for Women on Medicaid: Impacts of 'Strong Start for Mothers and Newborns'." *Health Affairs (Millwood)* 39 (6) (2020): 1042-50. https://pubmed.ncbi.nlm.nih.gov/32479222/.
[13] AABC, "What Is a Birth Center?" (2022). https://www.birthcenters.org/what-is-a-bc.

> "If a hospital is looking to meet patients where they are, I'm surprised we don't see more hospitals introducing birth centers as part of their service line."
>
> Administrative director of a hospital-owned birth center

Understanding the freestanding birth center model

A freestanding birth center is both a type of facility and a model of care. Birth centers are staffed and equipped for low-risk birth and associated outpatient services. (See Table 1 - Selected Features of Birth Center Facilities and Equipment.) The birth center model extends across the entire maternity episode with a program of comprehensive primary maternity care that is rooted in a midwifery philosophy of care. (See Table 2: Maternity Services Included in the Birth Center Model.)

The midwifery philosophy of care includes an understanding of pregnancy, birth, and the postpartum period as normal biological processes that carry significant meaning for birthing people, families, and communities. Care is designed holistically to address social, emotional, cultural, spiritual, psychological, and physical needs. Midwifery care promotes, protects, and supports human, reproductive and sexual health and rights, and is based on the ethical principles of justice, equity and respect for human dignity.[14]

Although midwives practice in hospitals, the structure and culture of hospitals can be at odds with the midwifery philosophy of care, and staffing may not allow midwives to provide continuity of care in this setting. Midwifery-led freestanding birth centers offer an opportunity to provide the complete package of midwifery care and support with access to advanced medical and surgical care when it is needed.

[14] International Confederation of Midwives, *Philosophy and Model of Midwifery Care* (International Confederation of Midwives: The Hague, 2014). https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-philosophy-and-model-of-midwifery-care.pdf.

What about birth centers inside of hospitals?

Throughout this guide, when we use the term birth center, we are referring to the AABC definition[15] of a freestanding birth center:

The birth center is a healthcare facility for childbirth where care is provided in the midwifery and wellness model. The birth center is freestanding and not a hospital.

As a freestanding facility, the birth center is located outside and separate from the hospital building. This separation helps preserve the processes and culture associated with the birth center model and enables birth centers to reach further into the community, enhancing access—including in maternity deserts. Hospitals may sometimes market their usual maternity services as a "birth center," which can create confusion for consumers and may not adhere to the birth center model.

An emerging model is an "alongside midwifery unit" (AMU), which operates within the hospital but separate from labor and delivery and acute care services, and where low-intervention care is practiced under specific guidelines that enable midwifery-led labor support and continuity of care. While we endorse hospitals expanding midwifery services and implementing low-intervention care in the hospital setting (and include recommendations for doing so in "Partnership or Ownership? Understanding Integration Approaches"), planning and operating AMUs is outside of the scope of this guide.

[15] AABC (2022). https://www.birthcenters.org/what-is-a-bc.

Table 1: Selected Features of Birth Center Facilities and Equipment

GENERALLY PRESENT	OFTEN PRESENT	GENERALLY ABSENT
• 2-4 private birthing suites with space to accommodate labor support companions and a private full bathroom✪ • Large tub(s) for hydrotherapy and water birth • Props and tools for mobility and comfort • Maternal and neonatal emergency kits, medicines, and transport protocols✪ • Co-located midwifery or multi-specialty clinic • Client and family waiting and nourishment areas✪ • CLIA-certified laboratory for microscopy and/or point-of-care testing✪ • Designated areas for clinical supplies and clean and soiled laundry✪	• Nitrous oxide • Injectable or intravenous medications for pain relief • Ultrasound capabilities • Classroom(s)	• Capabilities to perform cesarean or operative vaginal births⛔ • Anesthesia capabilities other than local anesthesia for routine laceration repair⛔ • Continuous fetal monitoring in the birthing suite (intermittent auscultation is used for fetal assessment) • Separate newborn nursery⛔ • Advanced imaging, laboratory, or blood bank

✪ The Commission for the Accreditation of Birth Centers (CABC) requires these attributes for accreditation.
⛔ CABC forbids these services/equipment in accredited birth centers.

Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement, http://birthcenters.org/whitepaper-payment. Reprinted with permission.

Why do patients choose birth center care?

Generally, people who seek birth center care have put a lot of thought into the decision and they are aware of the evidence-based benefits of midwifery care and the birth center model, such as an increased likelihood of vaginal birth. Many are interested in avoiding unnecessary intervention or medications and their side effects. A review of qualitative literature showed a range of additional reasons for giving birth outside the hospital, including concerns about

hospital safety, desire for a trusting relationship with the birth attendant and a preference for control over the birthing environment.[16]

All birthing people deserve to make care choices that align with their values and unique social and clinical needs. Especially for those who are vulnerable or marginalized, giving birth outside the hospital can be the safer and healthier choice. For example, an individual with history of child sexual abuse may choose birth center care to avoid interactions she may perceive as re-enactments of abuse (strangers touching her, loss of bodily autonomy). An indigenous person may decide to deliver at a birth center to be cared for by a familiar and culturally resonant midwife who honors particular cultural or spiritual beliefs surrounding the birth process.

Whatever the reason, by embracing the birth center model, you agree to honor, respect and facilitate a pregnant person's personal care choices.

[16] Goer, H., and A. Romano, "The Place of Birth: Home Birth." *Optimal Care in Childbirth: The Case for a Physiologic Approach* (Peanut Butter Publishing: Seattle, 2012).

Table 2: Maternity Services Included in the Birth Center Model

Note: Services in bold are uncommon in physician-led/hospital-based care models and represent points of differentiation for birth centers.

PRENATAL	LABOR & BIRTH	POSTPARTUM & NEWBORN
10+ prenatal visits, **30-60 minutes** each (**90-120 min group visit option** is common). **Relationship-based care** with an individual or small team of midwives. Risk screening and coordination of necessary social, behavioral, clinical, or mental health services. Routine and indicated labs, typically including a comprehensive prenatal panel, genetic testing based on risks and preferences, third trimester blood work, and infection screening. Birth centers have a limited point-of-care lab and send most specimens to third-party labs. Routine and indicated imaging, typically including 1 comprehensive and 1-3 limited ultrasound scans in a low-risk pregnancy. Birth centers may perform ultrasounds in-house, or refer out. **Comprehensive pregnancy, childbirth, and postpartum/ parenting education or programs.** May be offered in-house or referred to community educators, but generally required for birth center birth. 24/7 access to a midwife and consulting physician including **assessment and management at the birth center for limited urgent care needs.**	Telephone triage and early labor encounter(s) for maternal and fetal assessment. Use of a **spacious birthing suite designed for mobility and comfort.** **Continuous midwifery care** in active labor, birth and early postpartum/newborn period. Presence of an additional skilled provider (RN, additional midwife, or specially trained/certified birth assistant) during active labor, birth, postpartum. **Hydrotherapy** **Nitrous oxide** Administration of antibiotics and first-line medications for common complaints. Initial management, stabilization, and coordination of transport for emergencies, e.g. resuscitation, hemorrhage protocol. Risk screening throughout labor and birth and **coordination of transport and transfer of care** when higher level of care is needed. **Short stay** in the birthing suite (typically 6-12 hours, up to 24). Postpartum routine care including suturing or lacerations. Newborn exam and routine medications. Comprehensive pre-discharge education and lactation support.	24/7 access to midwife and consulting physician including **assessment and management at the birth center or at home for limited urgent care** needs for the mother or newborn. **Home visit** on day 1 postpartum for mother/baby assessment, newborn screening tests, and coordination of follow-up care. One or more additional postpartum office or home visits including family planning counseling, lactation support, and mental health screening and referral. Ongoing gynecological, family planning, **lactation,** and primary care after the initial 6-8 week postpartum period. Risk screening throughout postpartum/ newborn period and coordination of necessary social, behavioral, mental health, and clinical services.

Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement, http://birthcenters.org/whitepaper-payment. Reprinted with permission.

Why integration matters

Over the course of their entire pregnancy, birth and postpartum period, a childbearing person and their newborn will get many forms of care in different settings. Integration provides a cohesive and convenient experience for the patient, avoids duplication of services and enables seamless care transitions between facilities or levels of care.

Across the United States, community-based midwives and birth centers have historically been marginalized and poorly integrated with hospital-based health services.[17] These patterns are beginning to change, with growing understanding of the importance of integration for access, equity, safety, patient experience and professional satisfaction.

Integration is particularly important in the birth center model because a substantial number of patients will naturally "risk out" of birth center care and need hospitalization. (See "Transfer Rates.") The majority of transfers are non-urgent, commonly for pain relief or need for induction or augmentation of labor. Birth centers must have a plan for all types of transfers and work with local transport services and their collaborating hospitals to ensure smooth transitions, especially in case of emergencies.

Transfer Rates

Transfer rates vary based on birth center eligibility criteria, patient population and other factors. A national study reported that among people who initially met eligibility criteria and booked into birth center care, more than one-third ultimately needed hospital-based care.

Transfer Rates in the National Birth Center Study II[18]

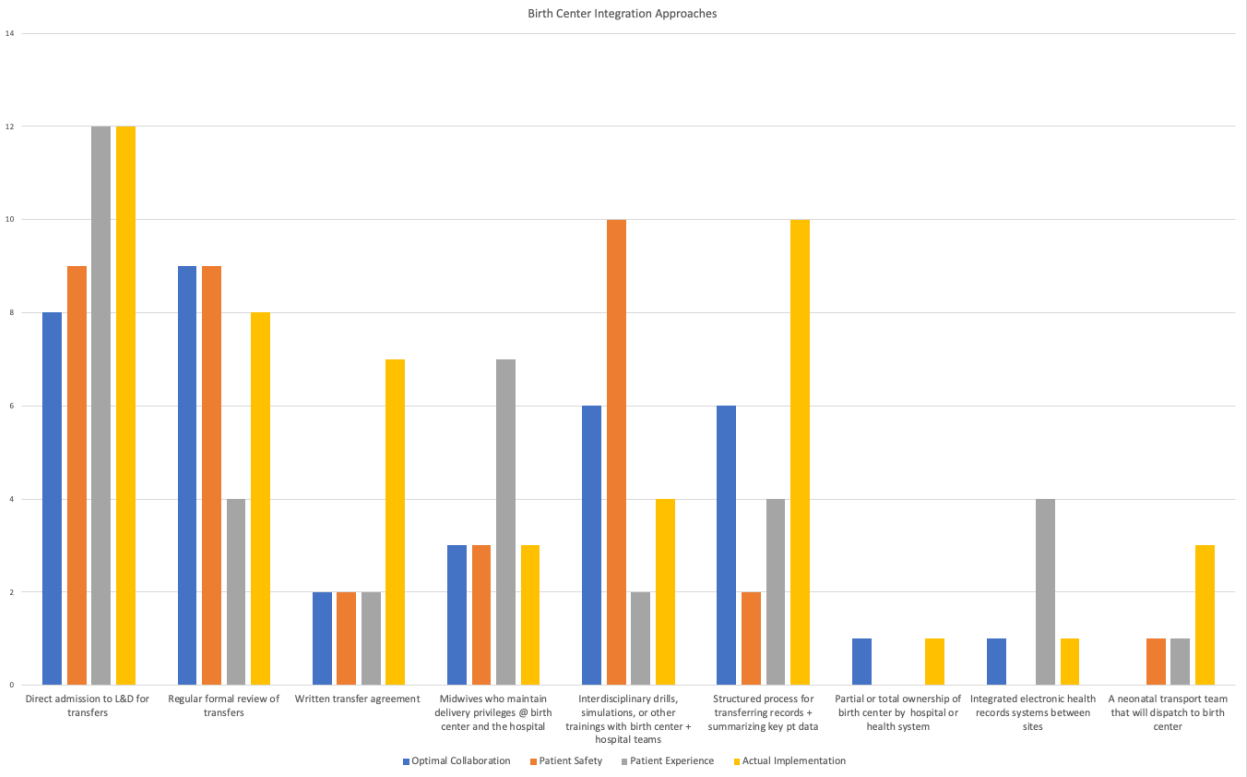
- First trimester pregnancy loss: 4.2%
- Antepartum: 13.7%
- Intrapartum (IP): 4.5% pre-admission + 12.4% post-admission
  - Emergency: 0.9% (7.6% of all IP transfers)
- Postpartum (PP): 2.4%
  - Emergency: 0.5% (21% of all PP transfers)
- Newborn: 2.6%
  - Emergency: 0.7% (28% of newborn transfers)

[17] Scrimshaw, S.C., and E.P. Backes, eds., *Birth Settings in America: Outcomes, Quality, Access, and Choice* (National Academies of Sciences, Engineering, and Medicine: Washington DC, 2022). https://nap.nationalacademies.org/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice.
[18] Stapleton, Osborne, and Illuzzi (2013). *https://onlinelibrary.wiley.com/doi/10.1111/jmwh.12003*.

Data from Integrated Birth Centers

We identified 13 birth centers with exceptionally strong or significantly improving relationships with a hospital in their community and surveyed the birth center teams to explore experiences with different forms of integration. Respondents indicated the integration activities they had implemented with hospitals and identified the activities they believed were the most important for collaboration, safety and patient experience. (See graph for detailed results.)

Graph: Perceived Importance and Implementation of Birth Center Integration Approaches



Respondents said these were the four most important activities for birth center integration:

- Direct admission to Labor & Delivery during transfers
- Interdisciplinary drills, simulations and other trainings with the hospital
- Regular formal review of transfer cases
- Structured processes for transferring records and summarizing patient histories

We have developed and collated resources related to all four of these elements in Establishing and Maintaining Quality. Beyond the more process-oriented approaches to integration, respondents expressed a need for additional investment in building trust between facilities and hospital education about the birth center model. We address both of these integration

opportunities in Partnership or Ownership? Understanding Integration Approaches, and build further understanding about birth centers by debunking some common myths below.

Myths and facts about birth centers

To ensure that everyone starts with the same baseline understanding of birth centers, we must first dispel some commonly held beliefs, notions and assumptions about birth center care.

Myth: *Birth centers compete with hospitals for the same birth volume.*
Fact: Birth centers typically draw people into the health system. Because of the unique care offering and relatively low number of birth centers in most regions, it is common for them to serve a large geographic radius and bring new patients into the system.

Myth: *Giving birth outside of the hospital is unsafe.*
Fact: Many studies have demonstrated that the birth center model, which includes specific guidelines for patient eligibility and processes for transfer of care, is as safe for babies and likely safer for birthing people than hospital care.[19] The model is in fact associated with important health benefits including reduced preterm and cesarean birth rates and is endorsed by ACOG as a safe setting for birth.[20]

Myth: *Transfers frequently go poorly and involve conflict.*
Fact: Emergency transfers are rare and can go smoothly with advanced preparation and teamwork. There are many examples of successful efforts to improve interprofessional collaboration during transfers leading to better outcomes and more integrated experiences for patients and families. See Establishing and Maintaining Quality for best practice resources.

Myth: *Midwives and other community birth providers can cultivate distrust in hospitals and doctors.*
Fact: There are many reasons that birthing people, especially BIPOC, LGBTQ+ and other marginalized groups, may lack trust in the mainstream health care system, especially given the growing awareness of the poor performance of the U.S. maternity care system and the rising rates of maternal mortality and severe morbidity disproportionately affecting Black and Indigenous people. Birth centers prioritize and uphold bodily autonomy and informed choice, which can create conflict when intersecting with hospital policies and standards. In well integrated systems grounded in interprofessional mutual respect and patient-centeredness, midwives can help patients understand and accept medical care when it is needed, enhancing trust in the overall system.

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[19] AABC, "Research and Data Collection" (2022). *https://www.birthcenters.org/research-data*.
[20] ACOG, "ACOG Statement on Birth Settings" (2020). *https://www.acog.org/news/news-releases/2020/04/acog-statement-on-birth-settings*.

Systemic barriers to birth center sustainability

Awareness of the challenges that have historically interfered with birth center expansion can help your health system design a more sustainable integration strategy. We more deeply explore the following barriers throughout this guide and offer strategies to address them. Dismantling these barriers is a win for hospitals, birth centers and, most importantly, for birthing people and their infants.

- Complex and nonstandard processes for facility payment. Birth center facility negotiations, contracting and payment vary by state, regional, and specific payor policies. For more information about facility payment and best practices to address this challenge, go to Financial and Business Case Considerations.
- Low reimbursement related to structural issues in maternity care payment. Health systems often subsidize the professional global maternity fee by capturing supplemental revenue through additional interventions, encounters and billable procedures. In contrast, birth center care focuses on supporting physiologic labor, birth and postpartum/newborn transition by embracing longer appointments and less intervention. See Financial and Business Case Considerations for more information on payment and strategies for making birth center care financially sustainable.
- Complex regulatory environment for birth centers and midwives. Not all states license birth centers, and those that do have vastly different rules and regulations with varying levels of applicability to the freestanding birth center model. See Assessing Readiness for Birth Center Integration for more information about licensing and accreditation.
- Perceived risks and liability. Despite a preponderance of evidence about the safety of the birth center model for low-risk pregnancies, hospital providers and medical malpractice companies have exaggerated perceptions of the risk associated with birth centers. To learn more about liability issues go to Partnership or Ownership? Understanding Integration Approaches. For strategies on mitigating risk, see Establishing and Maintaining Quality.
- Chronic disinvestment and marginalization. The U.S. health care system's chronic disinvestment in midwifery and birth centers has created weak infrastructure that makes it difficult for birth centers to thrive.[21] Birth center providers encounter a spectrum of beliefs and reactions when engaging with the medical establishment, ranging from highly supportive to openly hostile. Such mistreatment may impact birth center midwives' willingness to partner closely with hospitals. This guide is dedicated to reversing this problem by strategically directing investment in birth centers and promoting their inclusion.

[21] You can read more about the history of midwifery in the U.S. here.

The hospital's role in integration

Hospitals and hospital-based personnel have the power to overcome and dismantle the above barriers to birth center integration. Hospitals often serve as gatekeepers to achieving smooth transfers and accessing hospital-based services as needed. (See "Smooth Transfer" in Establishing and Maintaining Quality.) Investing in the model and partnering with birth centers can help health systems advance strategic priorities while centering the needs and well-being of the communities they serve. (See "Why now?" in Introduction.) In the upcoming section, you will start to focus on your own hospital and health system and explore the opportunities in your own community. You'll refine your understanding of how your hospital can play a role in optimizing access to risk appropriate care across the spectrum of perinatal preferences and needs.

> "The collaboration goes beyond the transfer of patients. We work at all levels to create a cohesive team from the birth center to all aspects of the hospital system. We do the work on the back end so that patients feel continuity when they need our services and the midwife team trusts us to support the care they provide and create a safe environment when transfer is needed."
>
> —Medical director of a birth center operated as a joint venture with a health system

Assessing Readiness for Birth Center Integration

In this section:

Assess Your Readiness in 5 Steps

1. Get familiar with birth centers and the unique model of care they offer
2. Learn what your community wants and what options are currently available
3. Determine how well positioned your hospital is to meet these expressed needs and close gaps
4. Identify your champions and skeptics and begin to engage them
5. Bring it all together and develop your strategy

Tools Highlighted:

National Standards for Birth Centers

Toolkit for Best Practices in Birth Center Regulation

AABC Birth Center Onboarding Modules

PBGH Guide: How To Successfully Integrate Midwives Into Your Practice

Undisturbed Labour and Birth Index (ULaB)

PMC Template Stakeholder Planning Map

Assessing Readiness for Birth Center Integration

In this chapter we outline a step-by-step approach to gathering information and analyzing potential barriers and facilitators before choosing to move forward. This information will also help you determine which approach—partnership or ownership—makes the most sense for your hospital.

Step 1:
Get familiar with birth centers and the unique model of care they offer

Start by visiting or virtually exploring existing birth centers and learning about birth center licensing and accreditation regulations in your state. Most birth centers post robust information about their practices online and offer both virtual and in-person tours for prospective clients and community members. This simple and essential step will help familiarize you and other hospital or health system leaders with the birth center care experience.

If you tour a center in person, schedule a time to meet in advance with birth center leaders, and explain your interest in furthering collaboration and expanding access to the model. While visiting the birth center, take note of what's different from your hospital unit and anything you are surprised to see. To get a sense of what a patient might be looking for when they visit a birth center, we recommend checking out the resource *What to Ask When Visiting a Birth Center* from the National Partnership for Women and Families.

Birth Center Search Tools

If you don't have a specific birth center in mind, search for centers with one of these tools:

- American Association of Birth Centers Membership Directory—search for existing and developing centers that are members of AABC, the standard-setting organization
- Commission for Accreditation of Birth Centers Verification Tool—search for centers that have been accredited by CABC
- Birth Center Equity provides a directory of BIPOC-led birth centers (established and developing), some of which would welcome hospital collaborations

Questions to Ask While Visiting a Birth Center

1. How many babies are born here a year?
2. Are there certain communities you serve or hope to serve?
3. Who is eligible to give birth at the center?
4. Do you accept insurance? What is your payor mix?
5. Is the center accredited by the Commission for Accreditation of Birth Centers? Is it licensed by the state as a birth center?
6. How do you staff the facility? What is the composition of the birth team?
7. Do you provide services other than prenatal, birth and postpartum/newborn care?
8. What types of labs and imaging do you perform here?
9. Do you have any referral relationships in our community?

10. What kind of equipment, medications and supplies do you stock for medical needs and emergencies?
11. How do you maintain safety and quality?
12. What does a typical care timeline look like for your patients? When do they enter care? How long do you care for postpartum patients and newborns after the birth?
13. What are your transfer rates and what are the most common indications for transfers?
14. What are your processes for urgent transfers?
15. Do you have data on your outcomes or patient experiences?
16. What does your ideal relationship with an area hospital look like?

Spotlight: Exposing OBGYN Residents to the Birth Center Model of Care

In one training hospital, OBGYN residents make annual visits to a local birth center to familiarize themselves with the birth center midwives and the model of care, and how it differs from the care they are trained to provide. During the site visit residents tour the center, and review what medical supplies the center stocks and what procedures the staff perform routinely and in cases of emergency. This helps residents be better informed about the care transfer patients have received before coming to the hospital.

Understanding Birth Center Standards, Accreditation and Licensing

Next, get to know birth center accreditation and licensing requirements. Note that some birth centers may be licensed but not accredited, or vice versa. We discuss the difference between the two below. In general, although licensing is often required, accreditation from the Commission for Accreditation of Birth Centers (CABC) is a more robust framework for assessing compliance with birth center standards, as outlined in the table below. However, the fees and the administrative burden associated with accreditation may be a barrier for some centers. Grants are available from the AABC Foundation to defray these costs for centers serving low-income or rural populations.[22]

[22] AABC Foundation, "Changemaker Accreditation Grants" (2022). *https://www.aabcfoundation.org/accreditation*.

Table 3: What is the difference between licensing and accreditation?

CABC ACCREDITATION	STATE LICENSURE
Consistently applied in all states	Different in every state, including 10 states with no licensing mechanism
Aligned with AABC National Standards	May or may not be aligned with AABC National Standards or best practices.
Continuously updated based on multi-disciplinary review of new evidence	Not frequently updated. Many states' regulations are decades old.
Birth center-specific	May include requirements intended for more complex facilities or for hospitals, including highly restrictive Certificate of Need requirements.
Comprehensive, addressing: • philosophy and scope of service • planning, governance and administration • human services • facility, equipment, and supplies • the health record • research • quality evaluation and improvement	May focus narrowly on the physical plant, infection control, and personnel practices with insufficient attention to emergency preparedness, quality of care, or compliance with clinical standards.

Source: Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement, *http://birthcenters.org/whitepaper-payment*. Reprinted with permission.

Tool Highlight: *National Standards for Birth Centers*

Description: The AABC sets the National Standards for Birth Centers. These standards address philosophy and scope of service; planning, governance and administration; human resources; facility, equipment and supplies; the health record; research; and quality evaluation and improvement. The National Standards for Birth Centers are determined by a multi-disciplinary committee that includes obstetricians, neonatologists, midwives, birth center administrators and other experts, using a robust consensus process to ensure that they remain consistent with evolving evidence-based maternity care. The standards have been endorsed by multiple professional societies and are recognized by many states and health plans.

How to Use: Use and reference standards as needed to build understanding among different stakeholders of the birth center model of care.

Developed by: American Association of Birth Centers

Tool Highlight: *Toolkit for Best Practices in Birth Center Regulation*

Description: This toolkit from AABC is intended for birth center advocates who are looking to introduce or improve birth center licensure in their states. The tools include model regulatory language to align birth center licensing with best practices and national standards.

How to Use: Use the fact sheets and resources to educate policymakers about birth center regulation best practices and leverage model regulatory language to modernize birth center licensing in your state.

Developed by: American Association of Birth Centers and Primary Maternity Care

Regulatory Compliance for Birth Centers

In addition to accreditation, birth centers are subject to various forms of regulation and oversight. Managing quality includes ensuring compliance with these regulations, which typically include:

- Birth center facility licensure
- Midwifery and nursing licensure
- Clinical Laboratory Improvement Amendments (CLIA) certification for laboratory activities
- Health Insurance Portability and Accountability Act (HIPAA) and related privacy rules
- Occupational Safety and Health Administration (OSHA) and other federal workplace rules
- Local policies and ordinances
- Regulations governing participation in Medicaid and other government health programs

Tool Highlight: *AABC Birth Center Onboarding Modules*

Description: Interactive, self-paced online training for providers, clinical support staff and administrative staff of birth centers, covering key compliance training needs with curricula that are specific to the birth center model of care.

How to use: Purchase for birth center staff and keep a copy of continuing education certificates in staff members' personnel files.

Developed by: American Association of Birth Centers and Primary Maternity Care

Step 2:

Learn what your community wants and what options are currently available

- **Review available data** about service gaps and meet with community-based organizations that have data and insights about community priorities.
- **Design and disseminate a short online survey** for pregnant and postpartum parents and/or existing patients about their birth preferences for insights into care patterns and trends.
- **Host focus groups** with diverse groups of birthing people from your community.
- **Set up a community advisory board** that meets regularly to offer input.

Ideally, health systems will develop services and programs based on the needs and priorities of the communities they serve. You may already have data or feedback from the community about services they are seeking. As you begin your research, you may also discover community organizations that have insights or data about gaps. Partner with these groups to incorporate these insights.

Spotlight: One Health System's Approach to Assessing Community Demand

A nonprofit health system in Pennsylvania recognized demand in one of its regions for alternatives to hospital-based care for low-risk birth.

The leadership sought to understand whether it made sense to open a freestanding birth center as part of the system's community-based outpatient health care services, and engaged consultants to assist in evaluating potential strategies. The team conducted a landscape review and strengths, weaknesses, opportunities and threats (SWOT) analysis and developed and fielded a survey of patients and community members. The results yielded insights that validated community interest in the birth center model and helped identify key priorities for community members and improvement opportunities in prenatal, birth and postpartum/newborn care across the service line.

Next, analyze your data and insights and present your findings to leadership. Highlight the gaps between what your community wants and services your health system delivers. These learnings will serve as opportunities in your SWOT analysis and inform the vision/mission for your birth center project (see Step 5).

Questions to consider when looking at the data:

- In what ways does birth center care address these unmet needs?
- Are these needs being met by other systems or providers outside of my hospital? How? Can we partner?
- How might our hospital's participation boost and expand existing birth centers' market reach?
- How else can we enhance the work already being done by community-led organizations?

Step 3:
Determine how well positioned your hospital is to meet these expressed needs and close gaps

Assuming the community has expressed interest in birth center care, this step will walk you through the strategic considerations you need to review, including your health system's resources, staffing, philosophical alignment, political willpower and regulatory concerns. This will help you develop the right approach to integration and identify where strategic partnerships will be necessary and beneficial.

During your data gathering, you may have identified demand not just for birth center care, but for midwifery care and low-intervention options in all settings. It can help to figure out the extent to which you have integrated midwifery and birth choices generally in your system. The successful integration of the freestanding birth center model requires, at minimum, respect for the unique expertise midwives can offer to your patients and your hospital. Assessing the "midwife-friendliness" of your hospital policies will offer insight into the cultural work you need to do to get your hospital ready for birth center integration.

Review the list below and consider what your hospital is already doing well, where you can improve and how the birth center model will strengthen patient care in these domains.
If, when reviewing, you only check a few boxes, we recommend starting with PBGH's *Midwifery Integration Guide* before working on birth center collaboration.

Tool Highlight: *PBGH Guide: How To Successfully Integrate Midwives Into Your Practice*

Description: This guide helps medical groups and hospitals establish, expand or strengthen collaboration with midwives in their organizations. The guide translates the literature and conceptual frameworks on midwife-physician collaboration into straightforward step-by-step actions developed based on real working models. The guide is divided into four sections: Secure Leadership and Stakeholder Support; Establish the Practice; Create a High-Performing Integrated Practice Team; and Create a Plan to Monitor and Sustain Success.

How to use: Use this guide including the appendix of tools and templates to build collaborative practices that offer women and their families the benefits and expertise of both midwives and physicians in the hospital setting.

Developed by: Purchaser Business Group on Health

Examples of *Midwife-Friendly* Hospital Policies

- Hospital has bylaws in support of midwife admitting and clinical privileges, medical staff membership and independent practice.
- Midwives practice at the top of their license and are recognized for the unique clinical expertise they offer patients.
- Clear processes exist for midwife-physician consultation, collaboration and referral.
- Midwives have leadership roles in the unit and are represented in critical hospital functions.
- Staffing of midwives is done with consideration for midwife-led primary labor support and continuity of care.
- Hospital has a policy for intermittent auscultation (IA), and staff training and documentation systems support IA.
- Hospital rooms have tubs and showers for hydrotherapy and water birth.
- Nitrous oxide is available for comfort/pain relief.
- Hospital has existing transfer arrangements with freestanding birth centers and home birth providers to support timely access to higher levels of care.

Tool Highlight: *Undisturbed Labour and Birth Index (ULaB)*

Description: The ULaB is a more formal tool for evaluating how a hospital unit incorporates midwifery and midwifery practices, developed using evidence-based practices endorsed by national professional organizations. The ULaB is a facility-level measure composed of indicators that either support or detract from physiologic labor and birth. The index outlines 18 domains to help facilities focus their quality improvement initiatives on cost-effective services to support spontaneous birth.

How to use: Download the tool from the Birth Place Lab

Developed by: The Birth Place Lab

Next, identify existing internal processes and structures from other service lines that can serve as models or lend support to the birth center integration process—for example, inter-facility transfer guidelines for non-birth transfers, referral management for ultrasounds with other community-based providers or maternal-fetal medicine (MFM) and neonatology transport conferences for transferring providers from other hospitals. Avoid reinventing the wheel by recognizing that relevant processes may already exist in your health system.

Spotlight: Regional Interdisciplinary Transfer Planning

A referral hospital serving a rural region in the Northeast had a program where a neonatologist, a maternal-fetal medicine specialist and a transfer coordinator traveled to meet with all of their transferring facilities annually to review cases, troubleshoot challenges and improve communication and trust. When a birth center opened in the region, they used this same structure to ensure smooth transfers and coordinated follow-up for birth center transfers.

Finally, make your own list of the top challenges your hospital needs to address to successfully integrate a birth center and your top strengths that will support the process. Understanding where your hospital excels in delivering midwifery-led care and where you have opportunities for growth will offer a better sense of your hospital's readiness to integrate a birth center. You will address these challenges and opportunities in your strategic plan. (See Step 5.)

Step 4:
Identify your champions and skeptics and begin to engage them

Early in the process, you must assemble your team and identify those within your organization who will champion the project and help navigate obstacles and recruit support and resources.

Odds are you will also encounter some skeptical colleagues as you begin to spread the idea of developing a birth center. Pat the anesthesiologist may just not be able to grasp why a patient would want to "suffer" through an unmedicated birth. Tina from quality has a best friend whose sister-in-law's daughter tried to have a birth center delivery and ended up in the hospital after hours of pushing. Skeptics can slow down your initiative and sow concern and discontent in the organization if their concerns are not being addressed.

In interviews with birth centers and health systems that reported strong relationships, several suggested a subtle reframing from asking *whether* skeptics want a birth center to send patients to their hospital to *how* they want these incoming transfers to proceed.

> "Talk about it like, 'This IS happening in our community. This EXISTS, and we will receive these transfers. What are we going to do about it? How will we collaborate to ensure we have processes in place for communication for transfer and transport when it is appropriate and necessary?'"
>
> —Physician leader at referral hospital collaborating with an independent birth center

Frequently, concerns are rooted in a lack of understanding about midwives and birth centers, so education about the model of care, evidence of effectiveness, safety and quality standards and approaches to integration help close these knowledge gaps and reassure skeptics. (See Resources for Learning About Birth Centers on page 12.) However, concerns may also be rooted in real operational or cultural challenges that deserve attention.

"Through our birth center collaboration, we learned that you cannot get meds out of the Pyxis unless the patient is in the system, and that newborns need to be manually entered into the system if they are not born in the hospital. This is not a lesson you want to learn the hard way in the middle of a newborn resuscitation. It took working closely with colleagues from the NICU and emergency department as well as the birth center team to design a process that would be smooth and safe."

—Hospital leader overseeing birth center partnership

In addition to actively listening to concerns, use these tips to engage with skeptics:

- Data! Always have a fact sheet ready that highlights what we know from robust scholarly and academic data on the safety and quality of birth center care.
- Present transfer data along with overall data to demonstrate the effectiveness of the model.
- Tell patient stories, emphasizing that for some birthing people birth center care is the healthier choice. Include quotes and examples from the community.
- Point to success stories, examples of where birth center integration is occuring safely, both in the United States and abroad.
- Use the Myths and Facts in the Introduction to address common concerns with fact-based information.

Tool Highlight: *PMC Template Stakeholder Planning Map*

Description: Use this tool to systematically assess or anticipate the concerns and interests of different stakeholders, and to brainstorm approaches to address those concerns and interests.

How to use: Download and complete individually or as a small group as you plan your birth center strategy and choose your approach.

Developed by: Primary Maternity Care

Step 5:
Bring it all together and develop your strategy

In this step you will compile the information you've gathered into frameworks that will help you assess the best timing and strategy for integrating birth center care into your hospital's service line, anticipate challenges and troubleshoot solutions.

Start by conducting a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. SWOT is a commonly used tool to help organizations assess their competitive advantages and identify critical focus areas to develop strategy. Looking in a systematic way at both internal factors (organizational strengths and weaknesses you started to identify in step 3) and external factors (opportunities and threats in the broader landscape you collected in steps 1 and 2) can help inform whether pursuing a birth center strategy makes sense in the current context. It can also help elucidate whether a build, buy or partner strategy makes the most sense.

Explore questions like the following when conducting your SWOT:

Strengths / Weaknesses (internal to organization)

- What is the level of staff interest in and philosophical alignment with the birth center model? (Remember to consider all relevant constituencies such as anesthesia, neonatology and pediatrics.)
- How much staff and institutional bandwidth is available for complex new initiatives?
- What are the relevant ownership and governance structures? (For example, can advanced practice practitioners participate in ownership models and organizational governance?)
- What infrastructure exists for outpatient quality management and clinical and administrative integration across care settings?
- What current programs and organizational assets can be leveraged? Are there analogous programs in other service lines that provide models/infrastructure for collaborative care and patient transfer, such as urgent care and skilled nursing facilities?
- What is the hospital or health system's commitment to birth equity?

Opportunities / Threats (external or in the broader landscape)

- What is the level of community demand and what choices are available in the marketplace?
- What advocacy initiatives and community organizing efforts are possible?
- How do policy restrictions shape nursing and midwifery practice?
- What is the regulatory environment for birth centers?

- What is the state of play in payment practices and emerging payment models?
- How are national standards and accreditation handled?
- What implementation tools and support resources are available?
- Where are there sources of external funding/financing or strategic partners for birth center initiatives?
- What birth centers are already established and developing in the local market?

> "When we started this, hospital births in our county and state were flat or declining but the number of women choosing birth centers was increasing nationally. We need to provide access to patients who are looking for it and we need to do it the right way."
>
> —Administrative leader of a hospital-owned birth center

Partnership or Ownership?

Understanding Integration Approaches

In this section:

- Partnership versus ownership
- Selecting an approach
- No matter what, build the foundation
- **In Depth:** What's involved in developing a partnership
- **In Depth:** What's involved in building a birth center
- **In Depth:** What's involved in buying a birth center

Tools Highlighted:

PMC Template: Hospital-Birth Center Transfer Agreement

PMC Template: Birth Center Job Descriptions

PMC Template: Staffing Model

Partnership or Ownership? Understanding Integration Approaches

Congratulations! You have done the groundwork for integrating birth center care into your hospital. You've identified and begun engaging your champions and skeptics, perhaps visited a birth center, gathered data and insights from your community about their care preferences, and conducted a SWOT analysis. In this section you will review the options for integration, select an approach, and begin implementation. Regardless of which approach you choose, strong, trusting relationships will be the key to successfully integrating a birth center with your hospital service line.

Partnership versus ownership

Essentially, a hospital has two choices when approaching birth center integration: partnership or ownership. In a *partnership* model, the hospital works with an existing independent birth center to identify ways the institution can enhance or expand birth center care to ensure seamless access to your health system's services. In an *ownership* model, the health system either builds its own birth center *outside* the hospital facility or purchases a local birth center that is interested in selling. When partnering, the birth center remains a distinct entity from the health system, functioning autonomously and with financial independence. If the health system owns the birth center, it functions as part of the hospital's service line and care flow.

Based on our conversations with hospitals and birth centers, we strongly encourage you to consider a partnership approach first. We heard many cautionary tales about costly blind spots and avoidable mistakes in hospital attempts to build or buy birth centers. We heard from physicians and midwives who fundamentally believe hospitals cannot succeed in birth center ownership models because of difficult cultural challenges and conflicting incentives in our healthcare system. Even so, ownership may be the best available option in some geographies, and some populations may be better served by a fully integrated model. If you choose to pursue an ownership approach, use this guide to learn from the efforts of other hospitals to avoid repeating the same mistakes, and commit to creative problem solving and persistence toward a clear vision.

> "It's important the hospital does not apply the rigid medical model toward midwifery care. You need supporting infrastructure that goes along with birth center integration."
>
> —Medical director of a birth center

Selecting an Approach

The right model for your health system depends on many considerations and a dynamic, changing landscape. To help determine the strategy that works best for your health system, we have summarized the opportunities and challenges associated with each approach. Later in this section you will find more in-depth information about what is involved with each strategy and have an opportunity to learn from real-world examples that illuminate the opportunities and challenges associated with each.

Table 4: Opportunities and Challenges Faced by Hospitals for Each Integration Option

	NON-FINANCIAL PARTNERSHIP	BUY OR INVEST IN EXISTING	BUILD FROM SCRATCH
Opportunities			
Meet demand for an array of care preferences and risk levels	✓	✓	✓
Capture revenue from transfers and referral services (labs, imaging, specialists)	✓	✓	✓
Potential to positively influence culture and evidence-based practices within the hospital (e.g. intermittent auscultation, hydrotherapy)	✓	✓	✓
Manage quality and risk through careful design and ongoing testing of processes for transfer and interprofessional collaboration	✓	✓	✓
Potential for fully integrated EHR to facilitate smoother transport		✓	✓
Market differentiation		✓	✓
Capture facility revenue		✓	✓
Include birth center in value-based contracts (See Financial and Business Case Considerations)		✓	✓
Co-locate with other services to improve convenience/patient experience			✓
Avoid vicarious and direct liability for birth center practices	✓		
Challenges			
Significant upfront and ongoing costs		✓	✓
Low familiarity with birth center care model, contracting/billing and accreditation requirements leading to inefficiencies		✓	✓
Maintaining fidelity to midwifery birth center model with health system pressures (e.g. productivity standards) and hospital regulations		✓	✓
Staffing complexity		✓	✓
Unable to conduct joint sentinel event reviews unless permitted under state regulations	✓		

No matter what, build the foundation

Regardless of which approach you choose, strong trusting relationships will be the key to successfully integrating a birth center with your hospital service line. Every example of birth center integration we encountered extended from at least one strong relationship between staff members at the hospital and birth center. Nurturing these relationships will be critical to the success of your model.

> "Hospital providers are experts, community birth providers are experts, and if we can treat each other as experts, our patients will be better off for it. The institution should be built around the idea that other providers will play a role in this patient's care and bridging this gap of understanding that we're both experts in."
>
> —Hospital-based provider in a partnership with an independent birth center

Allocate Staff Time

First, identify and resource staff to oversee this investment. Whether strengthening partnerships with community birth centers or building your own, properly managing the diverse stakeholders involved while nurturing cultural cohesion among all facilities and departments takes time and coordinated effort. Identify hospital team members who should participate in joint quality management, and build time into their schedule to do so.

Spotlight: A Hospital Point Person for Matters Related to Community Birth

A hospital within an academic medical center has assigned a midwife with administrative time the role of liaison to home birth and birth centers. The liaison, also a practicing CNM and professor of OB/GYN, is the point person to field questions, referrals and transfers from community birth providers throughout their area. The liaison also oversees coordination of internal education about community birth and warm hand-offs with internal hospital staff.

Educate

Throughout this process your team should be prepared to educate hospital and health system staff about the value, safety and core tenets of birth center care. Community birth centers are frequently misunderstood, and many in the health field may harbor some bias about the care approach. (See Introduction.) More often, though, confusion about the birth center model leads to decisions and processes that interfere with providers' ability to deliver care that is patient-centered and true to the birth center model. Use your educational efforts to create clarity about the quality of care you are trying to deliver to your patients by integrating a birth center.

For resources to educate stakeholders, see Assessing Readiness for Birth Center Integration.

> We all have a shared goal of a healthy outcome for mom and baby and to support and empower patients to start or grow their family in the best of health."
>
> —Medical director of a birth center owned by a health system

Invest in a Culture of Collaboration

Relationships based on communication, trust and mutual respect are the building blocks of collaboration. PBGH's *How To Successfully Integrate Midwives Into Your Practice* further defines the characteristics of midwife-physician collaboration and outlines activities to strengthen these relationships.[23] We highlight some key activities below.

[23] Hughes, B., and B. Rubinstein, *How To Successfully Integrate Midwives Into Your Practice* (PBGH: San Francisco, 2021). *www.pbgh.org/wp-content/uploads/2021/09/How-To-Successfully-Integrate-Integrate-Midwives-Into-Your-Practice.pdf*.

Develop a shared vision. Post it in a public spot where everyone can see it, like the break room, and highlight it regularly during staff meetings. Interdisciplinary collaborative teams function best when they are working toward a united goal or vision.[24]

Invest in fostering multiple relationships. Partnerships that are reliant on personal relationships risk dissolving if key people leave or retire.

Extend hospital privileges to the birth center midwives, if staffing allows and the birth center is interested. Ensure that all members of the Labor and Delivery team know that the birth center midwifery staff has privileges and are familiar with the scope of these privileges.

Carve out a distinct leadership position for midwifery and community birth and assign administrative time to the role. This position will help ensure that the birth center perspective is represented in health system decision making.

Celebrate wins and acknowledge when the team delivers outstanding care and smooth transfers. Reinforce good collaboration as it happens.

Facilitate non-transfer opportunities for engagement between the staff of the birth center and the hospital to strengthen relationships. For example, a lead midwife at a community birth center in the San Francisco area is sitting on the nearby hospital's Climate and Health Committee to get to know providers and the administrative team better.

Arrange for hospital physicians or MFMs who will accept transfers of care to take phone consults from the midwives. Engaging in consults for prenatal and birth questions can encourage positive, trust-building conversations between midwife and physician colleagues.

Identify training opportunities where you can collaborate. Do you offer neonatal resuscitation training to hospital staff? Ask if the birth center would like to send their midwives, nurses or birth assistants. Loop their staff into upcoming grand rounds or other educational opportunities open to hospital staff. Ask the birth center if they have specific training needs that are difficult to meet, such as an ultrasound clinic to allow midwives to receive more experience in limited scans.

[24] Nancarrow, S.A., A. Booth, S. Ariss, et al., "Ten principles of good interdisciplinary team work." *Human Resources for Health* 11 (May 10, 2013). www.ncbi.nlm.nih.gov/pmc/articles/PMC3662612/.

> "Some of it was about socialization and getting in the same room. People are a lot different when they're in the middle of stressful and acute situations. It feels different the next time you pick up the phone if you've had dinner with them in between."
>
> —Birth center clinical director

Cultivate Referrals in All Directions

Identify which services your health system offers that augment the birth center the most, and dedicate time to establishing strong referral relationships and workflows with each service line and assist in helping midwives refer to preferred specialists within the hospital system.

Consider services such as:

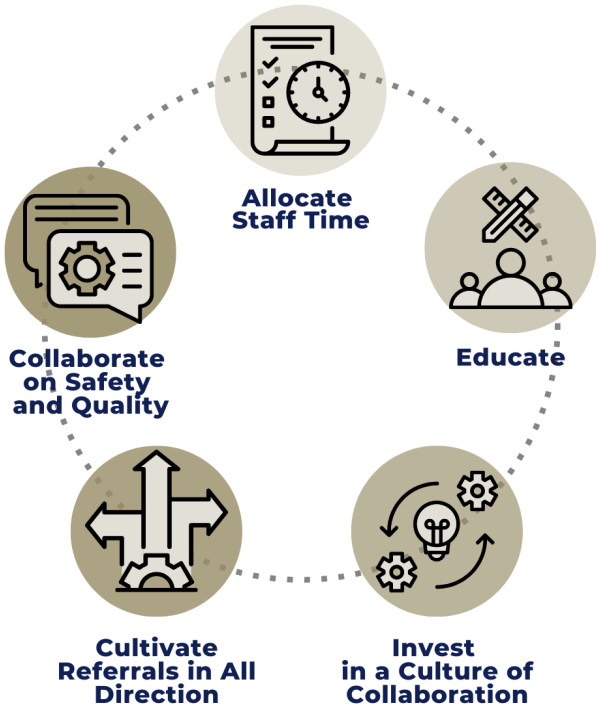
- Laboratory (routine and/or specialty)
- Genetic counseling
- Antenatal testing and imaging
- Maternal fetal medicine specialists
- Nutrition and diabetes management services
- Behavioral health
- Mental health services
- Pediatrics and family medicine
- Lactation and parenting programs
- Other specialists (e.g. cardiology, endocrinology, urology, gynecology)

Birth centers also offer many services that can be valuable to patients planning to give birth in the hospital. Leverage wraparound services from the birth center, such as childbirth education classes, lactation classes or appointments, postpartum parent groups and more. Collaborate with the birth center to promote these offerings to hospital patients and referring providers.

Collaborate on Quality and Safety

Coordinate regular meetings to discuss and review issues that arise in patient transfer, consultation referrals or communication between hospital and birth center staff. For an in-depth discussion of birth center quality, see Establishing and Maintaining Quality.

Building the Foundation for Successful Integration



In Depth: What's involved in developing a partnership

The partnership model is more widely used because it is easier to operationalize and does not require capital outlay or ongoing financial commitment from the hospital. This partnership approach also retains the independence of the community birth center, which can help protect the fidelity of the care model and build trust with the community.

In many respects developing a partnership with a birth center looks similar to any other outpatient service, like a referral relationship with an independent outpatient specialty clinic or surgical center. This guide focuses on those partnership-building activities specific to midwifery-led birth centers, including warm transfers and ideas for investing in independent birth centers.

> "It's a very collaborative effort, we are a stand alone center but we are still part of the team. We worked hard to develop relationships with the providers at the hospital, midwives, nursing, imaging. There is a collaborative feeling—we don't hesitate to call the doctors. We have a natural birth center experience with a really nice safety net at the hospital."
>
> —Birth center clinical director in an independent partnership model

A focus on managing transfers

Create a plan for transfers to ensure the experience is seamless and respectful for the patient and staff involved at both sites. (See Establishing and Maintaining Quality for transfer-related resources.)

Although a written transfer agreement is not required under AABC standards, some states and payors may mandate such an agreement. A written agreement can clarify the nature of the partnership as collaborative rather than supervisory, reducing exposure to liability.

Because it is a separate entity in the partnership model, the birth center will likely not have access to the hospital electronic health record (EHR), so it is critical to have clear processes for ensuring data and clinical information follow the patient when the site of care changes. The following are tips to ensure the information is available to hospital-based staff when needed:

- **Collaborate on a structured transfer form** to accompany birthing people and newborns, organizing key clinical content. Use templates provided in the Smooth Transitions Toolkit.
- **Offer pre-registration at the hospital** to birth center clients in case of a transfer. This reduces the amount of information needed at admission.
- **Consider birth center EHR access for hospital admissions staff.** This can be achieved by executing a Business Associates Agreement (BAA) and setting up training time for hospital staff to learn the system. Identify what pieces of information they will need upon transfer.

Tool Highlight: *PMC Template: Hospital-Birth Center Transfer Agreement*

Description: This template agreement delineates hospital and birth center responsibilities in a partnership model without imposing financial or oversight burdens.

How to use: Download the editable document and adapt as needed.

Developed by: Primary Maternity Care

Non-ownership ways to invest in independent birth centers

You may conclude that you want to partner with an independent birth center rather than build or acquire one. However, a non-ownership financial investment might still make strategic sense or help address concerns within the health system about collaborating with community-based midwives. Investment can include support for specific activities, such as accreditation, staff training or quality management programs.

Many birth centers are nonprofits and can accept grant funding. If your hospital has a foundation or other philanthropic entity, explore if local birth centers can apply for grant support as part of your partnership. Newly developing BIPOC-led birth centers are more likely to be nonprofits than established birth centers, and grant opportunities can make a significant impact on their viability and the communities they serve.

In addition to grants, health systems may wish to explore other non-ownership ways to financially align with both for-profit and nonprofit centers, such as investing in real estate or providing certain management services for free or at a discounted rate.

If you do not have a birth center near your hospital, you may consider connecting with an independent midwifery practice in your community to assess their interest in receiving investment to build a birth center. Think critically about the populations such a birth center would serve and how to work in partnership with local communities to co-create a birth center to ensure it is appropriately situated, geographically and culturally.

Reframing vicarious liability

Vicarious liability is a legal concept often cited as a barrier to establishing a relationship with a midwifery practice or birth center. Of course, every health system, hospital and practitioner should seek legal counsel specific to their circumstances as well as state and local regulations, but a basic understanding of the concept can help frame the issue.

Generally, vicarious liability means that employers or entities can be held financially responsible for mistakes made by their employees and agents. Under the doctrine, "[t]he vicariously liable party has not committed any breach of duty to the plaintiff but is held liable because of the legal imputation of responsibility for another's wrongdoing. This kind of liability depends directly upon the existence of a relationship whereby the vicariously liable person is in control (or should be in control) of the actions of the wrongdoer, and the wrongdoer is acting at the behest of that other person."[25]

Importantly, vicarious liability does not typically apply to consultative relationships. A hospital or birth center *employing* a midwife could be held liable for the midwife's actions while rendering clinical care. On the other hand, the hospital likely could not be held vicariously liable for the clinical care provided by a midwife working at the facility as an *independent contractor*. The hospital could still be held to legal standards related to breaches of other duties and obligations to patients, but generally not under the vicarious liability doctrine if an employer/employee relationship does not exist.

Avoidance of vicarious liability is a major benefit to hospitals of a partnership model versus owning the center and/or employing the clinical staff. Generally, a hospital or practice that maintains an independent consultative relationship with a midwife would be protected from vicarious liability concerns as long as they have documentation, such as a collaborative practice agreement, that spelled out both parties' independence and refuted the assertion that an employer/employee or principal/agent relationship existed.

With this in mind, your integration initiative should leverage hospital legal and risk management teams to fully understand the local regulatory and legal landscape given material differences between states. Review your hospital bylaws to understand whether they create vicarious liability through midwifery oversight requirements that are not based on scope of practice or state regulations. Do not let *assumptions* about vicarious liability interfere with birth center partnership. Tackle the topic head on and determine *actual* risk and legal exposure.

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[25] Booth, J., "An Update on Vicarious Liability for Certified Nurse-Midwives/Certified Midwives." *Journal of Midwifery & Women's Health* 52 (2) (2007): 153-7. https://pubmed.ncbi.nlm.nih.gov/17336822/.

Finally, improved communication and investment in quality improvement efforts with birth centers can protect the hospital from liability. See Establishing and Maintaining Quality to learn more.

In Depth: What's involved in building a birth center

While building new birth centers has historically been a less common approach, hospital interest is growing. Building a freestanding birth center involves important design decisions related to constructing a physical space, establishing a staffing model and promoting a collaborative culture with fidelity to the midwifery model of care. Only pursue this option if you are committed to investing and nurturing the midwife-led freestanding birth center and have the financial and administrative resources to invest in the integration for years to come. If you attempt to build a birth center but are not committed to the foundational principles of the model, you risk an unsuccessful and costly experience and dissatisfied patients and staff.

> "[The] other thing we've tried to do is pull together three access points for a pregnant mom: the family practice group, the OB/GYN physician group, or the birth center midwives. We restructured our website so that a mom who is expecting could choose which path they want to go on, the benefits of each, and how to access it. If you get someone who chooses one path that's not appropriate or they want to transfer between, we have a hand off process."
>
> —Service line leader for a hospital-owned birth center

Tool Highlight: *PMC Template: Birth Center Job Descriptions*

Description: Sample job descriptions for birth center clinical director, administrative director, medical director, and laboratory director consistent with national standards. Start with these templates and adapt for your health system and any state requirements.

How to use: Download the editable document and adapt as needed.

Developed by: Primary Maternity Care

The Do's of the Build Approach:

- **Respect the differences in clinical practice** between the out-of-hospital birth center and your inpatient L&D and maintain birth center-specific clinical guidelines
- **Hire a midwife to lead or co-lead the center** alongside an administrator, be clear on role responsibilities, and provide administrative support
- **Consider hiring a consultant** that specializes in freestanding birth centers to support contracting, staffing and service line development
- **Explore interest of a local independent midwifery practice or birth center** in joining a joint venture opportunity
- Structure payment and reimbursement to **limit competition between providers** (see Financial and Business Case Considerations)
- **Obtain CABC accreditation**; many care practices will be guided by the accreditation standards. (see Establishing and Maintaining Quality)
- Fully **consider space needs** and any other services that would be beneficial to co-locate at your intended site
- **Invest in marketing** that highlights the birth center and integrated care model (see Financial and Business Case Considerations)
- Encourage hospital staff to **tour a birth center** and educate them on the model of care (see Assessing Readiness for Birth Center Integration)

The Don'ts of the Build approach:

- **Don't dismantle the birth center care model by excluding certain elements**. For example, removing the ability to practice intermittent auscultation rather than continuous fetal monitoring may make sense to a hospital administrator, but would dilute the midwifery-led model leading to lower utilization and reduced benefits.
- **Don't automatically apply all hospital practices and policies to the birth center.** While hospitals must follow state and national regulations, explore which practices you need to keep and which you need to change, such as updated credentialing standards or adapted laboratory and infection control practices. CABC accreditation standards can help inform operational best practices.
- **Don't apply the same productivity standards used elsewhere in L&D.** This care model is relationship-based and will not achieve the volume output expected in other parts of L&D. Most birth centers have annual birth volumes between 100 and 300.
- **Don't evaluate the value to the health system on revenue and costs alone.** Instead, incorporate brand, market differentiation and community investment/benefit.

Additional questions you'll need to consider:

- **Open or closed model?** Open birth center models operate the facility and provide privileges to providers who wish to attend births at the facility. In these cases, typically the center bills for facility services while the private practice handles professional billing. Closed models only allow their own providers to attend births, and bill for both professional and facility services. You'll need to consider the local regulatory landscape, hospital bylaws, staffing availability and the hospital's preferences when deciding between the two approaches.
- **Staffing structure and which staff work at which site?** If applicable, will hospital and birth center midwives be privileged to attend births at both sites? Will L&D nurses and birth center birth assistants float between the two sites or be required to choose one or the other?

Tool Highlight: *PMC Template: Staffing Model*

Description: This tool helps to identify midwifery staffing needs (in full time equivalent (FTE) units) with adjustable inputs for appointment length, administrative overhead of clinical staff and birth volume.

How to use: Enter the birth and appointment volume you are planning, and update appointment lengths and administrative overhead FTE to identify staffing needs for midwives.

Developed by: Primary Maternity Care

In Depth: What's involved in buying a birth center

As you connect with birth centers in your area, you may find that one is actively engaged in succession planning or open to discussions around acquisition. Buying an established birth center requires an implementation approach similar to building one, although your work starts further downstream, as the space is built and likely already licensed and/or accredited. You will need to fold birth center care into your service line and your health system more broadly while building awareness and respect for the birth center model among your staff. Again, only pursue this option if you are committed to investing and nurturing the midwife-led freestanding birth center long-term.

> "The birth center originally discussed acquisition with the regional health system…but after the pandemic hit that system had an acquisitional freeze. During that time the birth center leadership was having a lot of meetings with the local community hospital and mentioned the acquisition opportunity. The local hospital was interested right away—they wanted to own the birth center in their community.
>
> —Birth center director

Before thinking about buying a birth center, consider the following questions. Be sure to integrate any identified challenges and opportunities into your SWOT from Assessing Readiness for Birth Center Integration.

- How to meaningfully communicate the new ownership to the existing birth center patient base and ensure you continue to offer the high touch care model they expect.
- How existing relationships with the birth center will impact the merger. Are there tensions among staff? Is collaboration strong? Actively think about pain points up front and plan to tackle them head on.
- How to onboard existing staff. Examine their qualifications to determine if hospital bylaws need to change to extend privileges to midwives.
- How your hospital can address the challenges the birth center is currently facing. (See Financial and Business Case Considerations for more information.)

> "They were already doing a good job and our job was to come in and see where we could maximize value (purchasing discounts, EHR investments, economies of scale, etc.)."
>
> —Hospital administrator overseeing acquired birth center

Establishing and Maintaining Quality

In this section:

- Foundations of birth center quality
- The hospital's role in birth center quality
- Smooth transfer
- Dos and Don'ts when designing transfer processes
- Joint quality management in hospital-owned birth centers

Tools Highlighted:

PMC Birth Center Eligibility and Midwife-Physician Collaborative Care Guidelines

PMC Template: Birth Center Checklists

PBGH Resource: Maternity Transfer Planning Template

Transfer Tools

Establishing and Maintaining Quality

Foundations of birth center quality

Regardless of which integration model your health system chooses, the birth center will need systems for quality management. The hospital plays a key role in helping manage overall quality and safety. (See Table: Roles of the Birth Center and Hospital in Managing Quality Across Facilities.) A robust birth center-hospital quality management program has several components and should focus on ensuring that people receive respectful, risk-appropriate care that meets their evolving needs and preferences.

Birth center accreditation provides the most comprehensive framework for establishing and maintaining quality care while maintaining fidelity to the birth center model. CABC developed and maintains performance indicators for all of the National Standards for Birth Centers established by AABC and offers a rigorous accreditation process that includes a detailed self-assessment, outcome reporting, chart review, stakeholder interviews and a facility inspection. CABC accreditation is widely recognized by health insurance companies and Medicaid programs, a growing number of state licensure bodies, liability insurance underwriters and maternity care professional organizations, including the American College of Obstetricians and Gynecologists, the Society for Maternal Medicine and the American Hospital Association.[26]

[26] ACOG (2019). *https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care*.

Written eligibility requirements for birth center admission and home discharge following a birth center birth are another foundational tool of birth center quality. Assessing birth center eligibility is a continuous process that occurs during entry into care, throughout pregnancy, on admission to the birth center in labor, and regularly during labor, birth and the postpartum and newborn period. Your hospital should have similar written practice guidelines in place for determining eligibility for midwifery-led and collaborative care within the hospital practice. PMC's template Birth Center Eligibility and Midwife-Physician Collaborative Care Guidelines can help you determine, document and communicate eligibility for birth center and midwifery care.

Tool Highlight: *PMC Template: Birth Center Eligibility and Midwife-Physician Collaborative Care Guidelines*

Description: Template and guide to help birth centers and collaborative practices determine, document and communicate patient eligibility for birth center and midwife-led care and expectations for consultation, collaboration, referral and transport.

How to use: Download and adapt as needed. Engage interdisciplinary team members to give input on eligibility criteria and guidelines. Disseminate the completed template.

Developed by: Primary Maternity Care

Tool Highlight: *PMC Template: Birth Center Checklists*

Description: Standard safety checklists for birth center admission, second stage/birth, discharge and transfer.

How to use: Download and adapt as needed. Complete the checklists for each patient admission and scan/upload to the patient chart.

Developed by: Primary Maternity Care

Table 5: Roles of the Birth Center and Hospital in Managing Quality Across Facilities

COMPONENTS OF A BIRTH CENTER QUALITY MANAGEMENT PROGRAM	BIRTH CENTER'S ROLE	HOSPITAL'S ROLE
Birth center eligibility and clinical guidelines	Develop and maintain eligibility and clinical guidelines using a structured process that incorporates input.	Birth centers should establish these guidelines independently. Hospitals may provide input.
Staff credentialing, onboarding and performance management	Develop and maintain personnel systems including training and competency assessment for key skills.	Birth centers should establish these systems based on birth center standards and needs. Hospitals may provide input or training/performance management resources.
Clear processes for consultation, collaboration, referral and transport	Design, test and continuously improve these processes, engaging with the hospital(s), EMS and other transport and referral partners.	Participate in designing, testing and continuously improving these processes. Assist in engaging EMS and other transport and referral partners.
Regular review of outcomes and experience data	Develop measures to assess quality and track needed data. Share and review transfer-related data and participate in identifying and acting on improvement opportunities.	Participate in developing measures to assess quality. Review transfer-related data and participate in identifying and acting on improvement opportunities.
Communication and documentation standards: huddles, debriefs, hand-off communication tools	Conduct huddles and debriefs regularly and after transfers or unusual events. Develop hand-off communication tools with input.	Participate in debriefs after transfers. Review and give input on hand-off communication tools, such as transfer documentation templates.
Review of cases, transfers and sentinel events	Establish a reliable system to identify and compile cases and transfers in need of review. Conduct reviews according to birth center policies and procedures. Complete necessary reporting of sentinel events to CABC and other regulators.	Participate in regular review of transfers and participate in sentinel event reviews to the extent possible under relevant state regulations and hospital bylaws
Drills and emergency preparedness	Lead and conduct regular emergency drills. Maintain necessary emergency equipment and supplies. Set standards for training.	Participate in simulated transfers and interdisciplinary training for skills such as neonatal resuscitation. Hospitals may assist the birth center to procure emergency supplies when needed.
Checklists, algorithms and clinical decision support	Develop and utilize tools to guide standard care based on birth center policies and procedures.	Participate in developing and reviewing algorithms and tools related to transfer or accessing hospital services.
Facility quality assurance such as checking medications and emergency kits/carts and compliance with safety ordinances	Ensure all facility and equipment checks are complete and the facility remains compliant with standards and regulations.	Hospitals may provide facility and inventory management services such as housekeeping, supply ordering and clinical equipment maintenance.

The hospital's role in birth center quality

Even if a hospital owns the birth center, birth center standards should guide the approach to quality. Hospitals should empower birth center teams to manage quality in their own department while collaborating with other parts of the organization to facilitate integration. Regardless of the integration model, the hospital or health system's quality efforts should focus on ensuring smooth transfer, positive transfer experiences and coordinated access to hospital services.

Smooth transfer

Among people admitted to birth centers in labor, about one in five will require hospitalization during labor or in the postpartum or newborn period. (See "Transfer Rates" in Introduction.) Although only a small minority of transfers are urgent or emergent, delays and gaps in care related to transitioning a patient can lead to harm, as well as negative experiences for patients and professionals alike.

Smooth transfer involves coordinating seamless care across two facilities and a dynamic team that includes professionals from the birth center, transport service and hospital. It is critical to plan in advance and engage all relevant stakeholders in designing a smooth transfer process. Although intrapartum (during labor) transfers are the most common, be sure to map out and test all types of transfer processes as well as workflows for accessing hospital-based services during the prenatal and postpartum periods.

Tool Highlight: *PBGH Resource: Maternity Transfer Planning Template*

Description: Template to help determine, document and communicate standard processes for incoming transfers from birth centers or home birth providers.

How to use: Download and adapt as needed. Engage interdisciplinary team members to give input on transfer processes. Disseminate the completed template and test each process through a simulated transfer.

Developed by: Purchaser Business Group on Health

Dos and Don'ts when designing transfer processes

Do: Design for each type of transfer.
Transfers can occur in each phase of care: prenatally (antepartum), in labor (intrapartum) or after birth for the parent (postpartum) or newborn. Each of these types of transfers will have distinct workflows and may require input from different departments and stakeholders. Begin with the PBGH Maternity Transfer Planning Template to determine and document the processes for each type of transfer, including both urgent and non-urgent transfers in each phase: antepartum, intrapartum, postpartum and newborn.

Do: Engage closely with EMS and other transport partners.
Emergency Medical Services (EMS) and inter-facility transport services are key partners for ensuring safe and smooth transfer, especially in emergencies. The AABC Toolkit Coordination and Collaboration with EMS for Safe, Timely Transfers provides specific tools and templates for engaging EMS stakeholders in birth center planning and operations.

Don't: Rely solely on existing hospital transfer infrastructure.
Although referral hospitals may have well developed infrastructure for managing inter-facility transfers for other types of patient care, perinatal transfers in general and birth center transfers in particular require unique adaptations. It is important to consider circumstances such as dyad transfers (transferring the birthing parent and infant together) and the plan to gather necessary patient data from the parent's birth center chart for a newborn's admission.

Don't: Reinvent the wheel.
There are many tools and best practice resources available to support smooth transfer. Learn from other successful models and integration vanguards and don't waste precious resources coming up with new solutions to common challenges. (See Tool Highlight: Transfer Tools below.)

Reframing "the train wreck"

The train wreck probably does not need an introduction. You may be able to conjure a memory of a patient or recall a story from a colleague about a community birth transfer where everything seems to have gone wrong and a poor outcome ensued. These cases are terrifying to providers who may feel like they don't have the control to prevent these situations from occurring.

However, actual train wrecks—the kind that involve trains and railroad tracks—are rare disasters that the industry uses as learning opportunities to identify and fix systemic problems

to prevent future similar incidents. In the wake of an accident, people do not assume that train travel is inherently reckless or that the train conductor is always to blame.

The same mindset can be applied to transfers that have poor outcomes or where the process went awry. Careful review of the root causes and contributing factors almost always identifies opportunities to improve integration systems and processes that support high quality, respectful care and appropriate collaboration.

Accredited birth centers are required to conduct root cause analysis for all sentinel events, and the CABC reviews all cases nationally and regularly disseminates aggregate findings and issues recommendations to improve birth center safety.[27] Collaboration and communication challenges are among the most common root causes identified, underscoring the need to focus on smooth transfer and a culture of collaboration and teamwork.

When the concept of the "train wreck" invariably comes up in your birth center planning, use it as an opportunity to reframe sentinel events as system failures that require system responses. This is also an opportunity to reinforce that emergency transfers are rare events that require preparedness, but are not the typical outcome of birth center care. Most transfers from the birth center to the hospital are non-urgent with positive outcomes. A singular focus on emergent transfers when engaging hospital stakeholders can obscure the denominator of all birth center births and all transfers.

> "When doing case reviews, look at all transfers, not just the urgent or problematic ones. Most will be normal and calm. Remind people that most of these cases are low key. And remind them all of the birth center births that happened with no transfer, to see how routine it is to not have an issue or need for transport."
>
> —Physician leader in a hospital that partners with an independent birth center

[27] Stapleton, S., "An Analysis of Sentinel Events Reported to CABC 2017-2019." *Commission for the Accreditation of Birth Centers Newsletter* 5 (2) (March 2020): 1-2. *https://www.birthcenteraccreditation.org/wp-content/uploads/2020/03/CABC-Newsletter-Vol-5-Issue-2-Sentinel-Event-Analysis.pdf*.

Tool Highlight: Transfer Tools

Resource	Author / Sponsor	Notes
Smooth Transitions	Foundation for health care Quality	This state-wide initiative engages hospitals, birth centers and home birth providers across Washington, which is the most integrated state according to a nationwide study.[28] The collaborative generates best practice resources that have become a model for multiple states.
EMS Toolkit: Coordination and Collaboration with EMS for Safe, Timely Transfers	American Association of Birth Centers and Primary Maternity Care	This toolkit is designed to help facilitate safe and seamless emergency transport between facilities through active engagement and teamwork with EMS providers. It includes planning tools and educational resources for birth center staff as well as EMS partners.
Step Up Together: Drills & Skills	Primary Maternity Care	This collaborative learning program helps prepare and equip clinical leaders in birth centers and other community birth practices to conduct, document and debrief emergency drills. The program includes implementation kits for clinical scenarios including shoulder dystocia, neonatal resuscitation, postpartum hemorrhage, breech birth, severe hypertension and more.
Best Practice Guidelines for Transfer and Collaboration	Birth Place Lab	Includes consensus guidelines that have been endorsed by multiple organizations addressing professional collaboration between community midwives and hospital-based providers, as well as templates and tools for smooth transport.
HiveCE Transfer Tools	HiveCE	Includes online continuing education courses about transfer best practices for midwives, emergency services personnel, nurses and receiving hospital providers.

[28] Vedam, S., K. Stoll, M. MacDorman, et al., "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes." *PLoS ONE* 13 (2) (2018): e0192523. *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523*.

Drills and Simulations

Like all low-frequency, high-acuity events, emergency transfers require preparedness, muscle memory and clear and effective communication. After designing and clearly documenting your transfer processes, these routines should be "stress tested" to identify opportunities to improve and troubleshoot. Continuing regular drills can help keep skills fresh and contribute to teamwork.

Accredited birth centers are required to conduct quarterly drills for all clinical staff focusing on the most common obstetric emergencies, including shoulder dystocia, hemorrhage and neonatal resuscitation. At least annually or whenever transfer processes have changed, conduct a comprehensive drill that engages transport and hospital personnel in a scenario that begins in the birth center and ends in the operating room or neonatal intensive care unit.

> "As we get ready to open our birth center, we have been running drills as part of our orientation and it's been a good way to build a relationship with each other and our local EMS and Fire Department."
>
> —Nurse leader at hospital-owned birth center

Ensuring Positive Transfer Experiences

Efforts to ensure smooth transfer should also address the patient and family experience. Poor transfer experiences can contribute to birth trauma, dissatisfaction and distrust, and positive transfer experiences can have the opposite effects. Unfortunately, people who choose to give birth outside of the hospital often face judgment and bias, including from health care providers. This bias stems from the dominance of hospital-based care, and can intersect with other forms of bias people face accessing health care, including discrimination based on race, ethnicity, age, marital status and source of payment.

> "Even if you don't like the choice the patient made, you give them dignity. ACOG guidelines state you should maintain a non-judgmental demeanor towards patients when transferring in. All of your personal opinions need to be put aside to provide good care and a solid safety net, advocate for patients to make their own decisions, and treat everyone in the room as an expert with valid expertise."
>
> —Health system midwife in partnership model

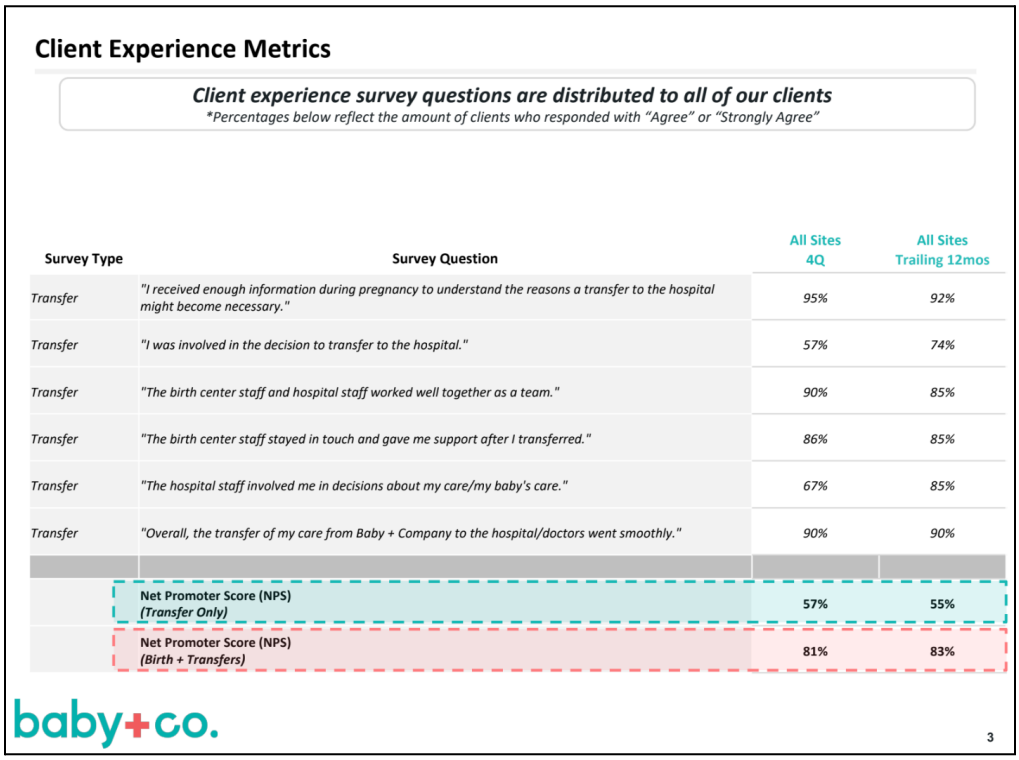
Health systems and birth centers should collaborate on smooth transfer by maintaining a focus on patient- and family-centered care and educating all providers about respectful care.
Tips for Improving transfer experiences:

- **Collaborate with the birth center to educate clients** about what to expect during transfer and hospitalization.
- **Offer a tour, class, handouts or other tools to familiarize birth center patients with hospital services.** Include practical tips like a hospital map showing where L&D is located, where to park, etc.

Spotlight: Systematically Analyzing Transfer Experiences for Improvement Opportunities

Baby+Co. operated a network of midwifery-led birth centers integrated with multiple health systems across four states. The company collaborated with EHR vendor Maternity Neighborhood to design and deploy patient experience surveys that were triggered automatically by intrapartum, postpartum, or newborn transfers.

The surveys included seven structured questions and one open-ended prompt. Data were benchmarked across the network and shared, along with free-text responses with each hospital partner at quarterly joint quality meetings. The data reinforced what was working well and helped identify ways to improve transfer processes to promote optimal outcomes and experiences.



Client Experience Metrics

Client experience survey questions are distributed to all of our clients

**Percentages below reflect the amount of clients who responded with "Agree" or "Strongly Agree"*

Survey Type	Survey Question	All Sites 4Q	All Sites Trailing 12mos
Transfer	*"I received enough information during pregnancy to understand the reasons a transfer to the hospital might become necessary."*	*95%*	*92%*
Transfer	*"I was involved in the decision to transfer to the hospital."*	*57%*	*74%*
Transfer	*"The birth center staff and hospital staff worked well together as a team."*	*90%*	*85%*
Transfer	*"The birth center staff stayed in touch and gave me support after I transferred."*	*86%*	*85%*
Transfer	*"The hospital staff involved me in decisions about my care/my baby's care."*	*67%*	*85%*
Transfer	*"Overall, the transfer of my care from Baby + Company to the hospital/doctors went smoothly."*	*90%*	*90%*
	Net Promoter Score (NPS) ***(Transfer Only)***	**57%**	**55%**
	Net Promoter Score (NPS) ***(Birth + Transfers)***	**81%**	**83%**

baby+co.

3

Joint quality management in hospital-owned birth centers

Among the unique benefits of hospital ownership of an independent birth center are the expanded opportunities to collaborate on quality and safety:

- **Interdisciplinary engagement in quality.** Hospital ownership increases opportunities to engage interdisciplinary stakeholders and service lines that touch birth center care, such as obstetrics, neonatology, pediatrics, anesthesia, nursing and transport. Most hospital-owned centers we interviewed held quarterly joint quality meetings and partnered on team-based training activities, such as drills and emergency skills training.
- **EHR integration.** Several hospital-owned birth centers have achieved fully integrated electronic charting across the two facilities. Each center relied on a version of Epic's Stork product that had been modified for birth center admissions and that enables streamlined workflows for patient transfers and handoffs as well as facility billing for the birthing parent and newborn.
- **Protected sentinel event review.** When the birth center and hospital are in the same health system, staff can more freely engage in root cause analysis of sentinel events. In partnership models, such joint review is not necessarily protected from legal discovery.
- **Pooled quality and experience outcomes.** Ownership of a birth center opens opportunities to include birth center patients in performance data for value-based

contracts. Birth centers tend to contribute favorably to outcomes of interest to value-based purchasers, such as preterm birth, cesarean birth, lactation, patient experience and total cost of care.

> "Our state requires an oversight committee so we tried to make sure there was a mix of representation on that, so we included representatives from our family medicine residency, our employee OB group, and the NICU to encourage collaboration."
>
> —Administrator at hospital-acquired birth center

Financial and Business Case Considerations

In this section:

- Optimizing payment for birth centers: Contracting and reimbursement considerations
- Structuring finances for consultation and collaboration
- Birth center budgeting: What hospital leaders planning to build or buy a birth center need to know
- Promising models to align payment with integration

Tools Highlighted:

Getting Payment Right: Unlocking High-Value Care Through Appropriate Birth Center Reimbursement

AABC Toolkit: Facility Billing for Birth Centers

Financial and Business Case Considerations

To achieve a sustainable practice, hospitals must dedicate time and resources to birth center contracting and budgeting. This chapter walks you through critical considerations for establishing and integrating birth center care in a financially viable way either through partnership or ownership.

As you explore the financial aspects of your birth center strategy,

- ☐ Prepare a detailed budget,
- ☐ Educate your hospital team about the unique elements of birth center care and
- ☐ Defer to the experts—birth center providers and staff or consultants, who likely have extensive experience navigating the payment system.

Birth centers typically struggle to achieve consistent profitability because contracting and reimbursement for pregnancy and birth care prioritizes hospitals and physicians. Our system's fee-for-service model rewards more intervention and shorter appointments, and many hospitals design their services and care approach accordingly. Birth center care, on the other hand, focuses on supporting relationship-based prenatal care, physiologic labor, birth and postpartum/newborn transition and, as a result, embraces longer appointments and less intervention. Value-based payment models can help address this discrepancy and make it easier for birth centers to thrive, however, payors have yet to implement these models in a way that has yielded change or included birth centers.

Hospitals can use their market power to boost payment and change payor positioning related to birth centers and midwives. By drawing more attention to the unreimbursed and poorly reimbursed aspects of the birth center model and advocating for fairer compensation, hospitals and health systems can increase payor reimbursement to all facilities and providers participating in the model, including independent birth centers.

Optimizing payment for birth centers: Contracting and reimbursement considerations

The Affordable Care Act clarified that payment for birth center facility services is distinct from and additional to payment for labor and birth professional services. However, this standard has not been widely or evenly adopted by non-government payors. Furthermore, there are no national standards for how to use billing and revenue codes designated for birth centers, and existing codes do not cover the full range of services offered in birth centers.

In the absence of national standards, birth centers must independently determine which codes are accepted by local health plans. Accepted codes often vary with each payor, forcing a single birth center to use different codes for the same services with each contracting payor. This widespread variation creates unnecessary administrative complexity for birth center billing as customized workflows are not well supported by outpatient practice management software.

AABC offers two comprehensive resources to help educate and equip those responsible for facility contracting and billing. Start by reading *Getting Payment Right* to understand the overall landscape of birth center payment and solutions to key structural barriers. Use AABC's Facility Billing Toolkit to identify recommended best practices for birth center contracting and use of facility fee codes.

Tool Highlight: *Getting Payment Right: Unlocking High-Value Care Through Appropriate Birth Center Reimbursement*

Description: This report and accompanying webinar and resources outline the birth center model of care, provide an in-depth analysis of the birth center payment system and present guidance to birth centers, payors and health systems to ensure equitable access to and financial viability of the birth center model.

How to use: Review the report and associated tools to inform your contracting strategy and to help you better understand the contextual and regulatory challenges to fair reimbursement for birth center care.

Developed by: American Association of Birth Centers and Primary Maternity Care

Tool Highlight: *AABC Toolkit: Facility Billing for Birth Centers*

Description: A resource for any stakeholder interested to learn more about birth center facility billing. Developed by veteran birth center staff from across the United States, it covers the nuts and bolts of setting up and beginning to bill facility fees.

How to use: Requires AABC membership. Designed as both a primer and operational guide to understand the goal of facility contracting and eventually submit claims using best practice guidelines.

Developed by: American Association of Birth Centers, Industry Relations Committee

Structuring finances for consultation and collaboration

Whether pursuing a partnership or ownership approach, you need to consider how *midwives* and *physicians* work together financially within your system. Birth centers and hospital providers need to understand how the relationship will impact their bottom line.

Birth center patients are best served when midwives have reliable physician colleagues who can provide consultative services or accept care for patients when clinically indicated. Many factors specific to your situation will influence what shape this relationship takes and what structure will make the most sense for the parties involved. For example, will the hospital employ physicians and midwives or will they be privately employed? Are or will the physicians and midwives be working for the same practice, or different practices? We recommend hiring a consultant to assist you in determining the best way to structure this relationship based on your particular characteristics.

Key concepts to explore:

1

Relative Value Units (RVUs). While RVUs are well known in physician settings, they are less likely to be used in a nurse midwifery practice. RVU models prioritize volume and acuity, two factors on which midwives will naturally score lower compared with their physician colleagues because the midwifery model relies on longer appointment times and midwives generally care for lower-acuity patients. Few industry benchmarks exist to help set RVU goals for midwives.

- The direct impact of partnering with or acquiring a birth center will be highly situational based on the available market and the setup of your RVU system. To learn more about RVUs and midwives, review this webinar produced by Grow Midwives.
- Some physicians may worry that a partnership model could mean that midwives and birth centers will capture some of their patient base, decreasing the overall RVUs of the physician practice. Consider how the referral volume from the birth center will serve to counterbalance the potential decrease in routine OB for the physicians. The birth center will provide specialty referrals to physicians during the prenatal and postpartum period, antenatal testing and intrapartum consults or transfers. Some of these services may serve to boost RVU for physicians while the midwives retain lower-acuity routine services.
- Consider protecting physician, midwife and nurse productivity bonuses during the first year of your program. This tactic could help limit tensions and territorialism that may arise as providers adjust to a new collaboration model.

2

Billing "incident to" services. "Incident to" services are defined as those services billed by one provider (a physician, for example) even though they may be provided by a different practitioner (e.g., a midwife or lactation consultant), whether located in a separate office suite or within an institution) or in a patient's home."[29] Requirements for "incident to" billing state that providers "must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services."[30] While "incident to" billing is common practice in some places, it can increase

[29] Centers for Medicare & Medicaid Services (CMS), 'Incident to' Services." *MLN Matters* SE0441 (2016). *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0441.pdf*.

[30] CMS, "Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual* (CMS: Baltimore MD, 2022). §60.1 (B). *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.

vicarious liability exposure for the physician. Additionally, physicians typically play a limited to non-existent role in day-to-day freestanding birth center care, reducing the practicality of having them on site for all clinical care. See the Medical Director bullet below for a better understanding of what role a physician could play. We recommend reviewing Grow Midwives' A Legal Analysis: The Changing Use of Billing "Incident To" in the provision of Midwifery Services before considering billing midwife services incident to a physician.

If you currently bill "incident to," we encourage you to rethink this approach. Often practices choose to bill this way to boost reimbursement since nurse-midwives are sometimes treated as mid-level providers and are paid less than physicians when providing the same services. Although the Affordable Care Act required parity in Medicare payments for nurse-midwives and physicians[31], not all payors, commercial or Medicaid, have followed suit. Instead of relying on "incident to" billing, we recommend hospitals use their position to lobby Medicaid and commercial payors for pay parity between midwives and physicians, consistent with the established Medicare standard. This action would help health systems that employ midwives *and* independent midwifery practices achieve financial sustainability.

3

Medical Directors. Birth centers sometimes choose or are required by state regulation to hire a medical director who functions as part of their clinical team. The director's scope of work will depend on the birth center's needs and other factors, ranging from rather light (providing consulting services to birth center providers on clinical cases) to much more involved (seeing patients at the birth center for specific appointment types or assisting with setting policies and procedures). A medical director can enhance alignment between facilities even in a partnership model. A hospital OB/GYN or MFM (Maternal-Fetal Medicine specialist), for example, could serve as the medical director to help to subsidize the cost of this role.

4

Referrals and transfers. In most cases, midwives and the birth centers bill for care up until the point of transfer, and physicians or hospitals bill for the services they provide upon receiving the transfer or a referral.

[31] ACNM, "Implementation of the Affordable Care Act" (2022). *https://www.midwife.org/implementation-of-the-affordable-care-act*.

- Referrals: Services are typically billed outside the global maternity professional fee. Common referrals include problem office visits to confirm or rule out a diagnosis, procedures such as external cephalic version or a level II ultrasound, labs, etc.

- Transfers: The point of transfer varies for facility services and professional services. For example, a patient could transfer from the birth center facility to the hospital, ending their outpatient stay and beginning their inpatient stay, but continue professional care from birth center midwives if they have professional hospital privileges.

  When the hospital or physician assumes care, they can typically begin to bill consistent with national billing and payor standards. The specific codes used depend on the relationship between providers and institutions. For example, if the midwives and physicians are employed by the same practice then a transfer of care from midwife to physician may still qualify under the global maternity professional fee because the same practice continues to render care.

Birth center budgeting: What hospital leaders planning to build or buy a birth center need to know

Over the course of our interviews with hospitals and birth centers around budgeting, some themes have emerged that strongly influence the sustainability of birth center integration efforts. We compiled these best practices as the Dos and Don'ts of Birth Center Budgeting for those hospitals that will be building or buying a practice.

Do's of Birth Centering Budgeting:

1. **Consider the true costs of staffing.**
   - Plan for longer appointment times and lower case loads per clinician, regardless of the appointment type. Consider the average patient volume of each call shift, and whether the midwives take call on site or from home, to determine the right shift length and staff necessary to cover your volume. If you plan to have additional clinic service lines such as a robust GYN practice, add additional clinician time in the clinic to cover the volume.
   - Establish a second call or back up call system if the midwives have privileges at the hospital and transfer patients, or are very busy. If your hospital has an established existing midwifery practice, consider establishing midwife-to-midwife transfers (when clinically appropriate) to enable continuity of

midwifery care. Consider the options with birth center staff and determine which framework suits the situation best.
- Accept that on-call time is compensated time where the provider or nurse is committed to the practice, even if the staff is able to take call from home and have shifts where they are never called in.
- Understand that midwife and nurse/birth assistant roles are very different in the birth center setting compared to the hospital setting. In the hospital, nurses attend a patient for much of their labor, calling the provider when necessary or when birth is near. In a birth center, these roles are reversed, with the midwife attending the patient for labor, and the birth assistant joining when birth is near.
- If purchasing a birth center, anticipate increasing salaries for all staff to align them with hospital benchmarks. Birth centers are often low-resource businesses that typically cannot afford market compensation. Upon transitioning to hospital ownership, salaries will increase to meet market and hospital standards.
- Consider the impact of nurse and/or provider unions and how birth center compensation and benefits may change if/when aligned with union requirements.

2. **Include electronic health record (EHR) integration costs.**
    - Plan to integrate the birth center to your EHR. Invest in IT (information technology) support for design and migration and robust staff training. Integrated EHRs are a clinical benefit for all staff working in or with the birth center as well as for patients. An integrated EHR will help the birth center feel included in your health care system, reduce redundancies in reporting and data entry and contribute to safety efforts by ensuring smooth exchange of records.

Spotlight: Operational Hurdles Persist After Acquisition

A birth center recently acquired by a hospital did not migrate to the hospital EHR because of the capital expense. This process is planned to occur in 12-18 months. Meanwhile the birth center operates on its legacy EHR, with limited to no hospital visibility into the system. Despite the birth center's willingness to allow access for hospital staff, no access has been extended because it is easier for hospital staff to rely on the birth center users for the information they need, rather than learn a new system. The birth center "feels like an island" and practice leaders at the birth center feel like "gatekeepers" out of necessity, not by choice.

3. **Be realistic about your space needs.**
    - Expect 10-12 births per month per birth room at a maximum. You can add 2-3 patients per room per month in your overall patient load to account for prenatal attrition—patients "risking out" of midwife-led birth center care for late pregnancy clinical conditions that necessitate a transfer to a higher level of care. (Note: This could still be midwife-led care if the midwives are to attend births in the hospital, but the delivery would no longer occur in the birth center.) In total, enroll about 15 birth center patients per birth room per month, with the expectation that your average deliveries per room will be lower due to attrition.

4. **Be specific with projections.**
    - Plan for all of the services the birth center will need and leverage economies of scale with existing hospital service contracts such as laundry, facility maintenance, supplies, etc.
    - Table 6 reflects sample annual expenses for an independent, freestanding birth center. Consider each item and how your institutional position will impact these costs. Where will you incur additional expenses because of hospital infrastructure, risk management and more restrictive regulations?

> "When the hospital looked at the birth center and how we ran, they saw we were doing it at a quarter of the cost of their labor and delivery unit. When they took it over, they didn't realize, and nor did we, that because they were part of the hospital system that had to follow additional regulations that we were not subject to, and it took away the efficiency of the model."
>
> —Former birth center owner

5. **Budget time for all hospital staff to learn about the birth center and what it offers.** (See "Build the Foundation" in Partnership or Ownership? Understanding Integration Approaches.)
    - Whether building, buying, or partnering, ensure that hospital staff from all relevant departments are aware of the birth center and what services are offered. Be sure to include schedulers, front desk attendants and financial services who will frequently engage with birth center patients.

- Arrange for various groups of staff to tour the birth center and review what the service line offers. An in-person experience will stick with your staff.

Table 6: Sample Annual Expenses for a Freestanding Birth Center*

EXPENSE	SAMPLE AMOUNT 100 births/year	SAMPLE AMOUNT 300 births/year	INCLUDES
Personnel - Midwives	$450,000	$700,000	Team of midwives to cover the 24/7 call schedule; provide associated prenatal, postpartum, and primary care; and participate in practice management, community engagement, and quality improvement initiatives
Personnel - Other Clincial	$150,000	$500,000	Birth assistants (Registered Nurse or specially trained/certified community birth assistant); office-based medical assistants and/or nurses
Personnel - Non-Clinical	$200,000	$500,000	Administrative director and support team, education and care coordination personnel
Business Activities and Contracted Services	$200,000	$300,000	Malpractice insurance, compliance programs, IT services, billing service and other management fees, answering service, janitorial and waste disposal services, Medical Director, staff training, and other costs of delivering care and complying with birth center standards
Facility Rent and Utilities	$100,000	$125,000	Facility that can accommodate 2-4 birth suites, exam rooms, classroom(s), a laboratory, supply areas, restrooms, and staff areas; must meet relevant state and local guidelines related to size and clearances, security, fire and hazardous waste safety, ventilation, plumbing, and electrical
Furniture, fixtures, and equipment	$20,000	$25,000	Amoritized cost of medical devices and clinical equipment as well as non-clinical furniture and fixtures
Technology	$10,000	$20,000	Computers, printer/fax/scanning, software including charting system, and wireless network
Office and Clinical Supplies	$25,000	$75,000	Medications, consumable supplies for births, test kits and other laboratory supplies, patient education materials, and general office supplies
Licenses and Accreditation	$5,000	$5,000	State licensure and CABC accreditation fees
Total Expenses	**$1,160,000 = $11,600/birth**	**$2,250,000 = $7,500/birth**	

*Note that these are hypothetical costs and may not reflect actual costs.
Pricing should, whenever possible, reflect actual costs and be adjusted for market differences.

Source: Getting Payment Right: How to Unlock High-Value Care Through Appropriate Birth Center Reimbursement, http://birthcenters.org/whitepaper-payment. Reprinted with permission.

6. **Budget time for all hospital staff to learn about the birth center and what it offers.** (See "Build the Foundation" in Partnership or Ownership? Understanding Integration Approaches.)
    - Whether building, buying, or partnering, ensure that hospital staff from all relevant departments are aware of the birth center and what services are

offered. Be sure to include schedulers, front desk attendants and financial services personnel who will frequently engage with birth center patients.
    - Arrange for various groups of staff to tour the birth center and review what the service line offers. An in-person experience will stick with your staff.

7. **Consider how the birth center may impact hospital facility and practice revenue, both positively and negatively.**
    - Birth centers offer a highly differentiated service and can draw people from outside of a hospital's current catchment area. Birth centers may also draw away low-risk patients with the lowest reimbursement (unmedicated vaginal birth) from the hospital, increasing capacity for the hospital to provide care for higher-risk pregnancies. Whether and how a birth center might impact hospital revenues and costs depends on these factors that vary across communities and payment contexts.
    - Some hospitals worry about the potential decline in hospital revenue from the patients who select birth center care over hospital care. In reality, birth center volume is low, and the impact to hospital revenue will not be significant. Any losses in revenue from shifting birth volume could be recouped through value-based contracts that reward quality.
    - If your hospital pays providers based on volume or volume incentives, consider changing compensation or setting a standard bonus that is not volume based for at least the first year of the integration effort to prevent competition among providers that could undermine team building.

Don'ts of Birth Center Budgeting:

1. **Don't overhaul grassroots marketing efforts that are working.**
    - Birth centers know their target market and are often successfully engaging with their core audience on a limited advertising budget. Don't disrupt what is already working and instead partner with the birth center to determine where hospital resources can add value. If the birth center has a strong social media presence and following, support and maintain its marketing efforts. To enhance visibility, assist with targeted outreach.

2. **Don't negotiate insufficient rates with payors.**
    - Wide variation exists in how birth centers are paid, especially for facility services. We will not cover the specifics in this guide, but instead direct you to the AABC white paper "Getting Payment Right," which provides the building blocks for understanding this topic.

- Birth center contracts are nuanced and unique. Educate yourself by contacting other birth centers in your state to understand local standards. Payor contractual stipulations often mean that birth centers cannot discuss their negotiated rates, but it should be possible to determine what codes are commonly in use and what difficulties exist.
- If buying an existing center, be sure that birth center contracting staff review any contract changes proposed by the health plans before signing so birth centers can weigh in on the impacts and quality of negotiated rates.
- Emerging facility billing trends among birth centers include additional facility billing for other common services such as observation and extended stay. Use the experience you have from an inpatient perspective and work with birth center staff to understand what services are not being fully billed currently.

3. **Don't fail to turn to your midwife and birth center colleagues for help and expertise.**
    - Birth center staff are not only experts in low-risk birth care, they are also very knowledgeable about the business realities of birth centers and are great resources for budgeting and contracting questions.
    - Birth center staff and experts can help with staffing questions. Ask them for input on the staffing plan to ensure it makes sense in a community birth setting.
    - Remember that birth centers are typically small businesses where staff members wear multiple hats, unlike hospitals where many unique roles have distinct individuals filling the job. A birth center nurse may be well versed in working the front desk and medical supply inventory, or the administrator might complete small facilities repairs and be responsible for marketing.

Promising models to align payment with integration

Value-based payment (VBP) is an emerging trend in maternity care. Most models implemented to date have focused on state-wide efforts through Medicaid with smaller scale efforts led by self-insured employers. Historically birth centers have struggled to participate in VBP programs due to their small size relative to other care providers and their independent status. However, birth centers are an ideal setting for VBP programs because they so often meet the triple aim of high satisfaction, excellent outcomes and lower costs.

> "We assumed the hospital would have power to negotiate for better contracts. What stumbled them up was that the contract writer didn't realize what a birth center was. We had fought hard for our original facility fees but the hospital contract writer didn't understand that."
>
> —Administrator of a birth center acquired by a hospital

Health systems that have birth centers in their integrated network, whether through a partnership agreement or through acquisition/building, will be best positioned to convene or participate in maternity VBP programs such as bundled payments for the maternity episode.[32] Including birth center and midwifery services in a bundle or other VBP arrangement can help ensure that patients receive care in the appropriate settings while also improving clinical outcomes and lowering costs.[33]

Being able to speak to historical outcomes in both the birth center and hospital settings will provide compelling support for your model of care when negotiating with payors. Collect robust outcomes data for both settings to understand your performance based on potential VBP performance measures such as NTSV cesarean rates, preterm birth rates, breastfeeding initiation, etc. Midwifery practices can collect their outcomes while contributing to national research on the midwifery model by participating in the AABC Perinatal Data Registry (PDR), an online registry for continuous collection of perinatal data.

Cost savings derived from implementing value-based care models should result from improved patient outcomes achieved via midwife-led birth center care, not by paying less for birth center services that are comparable to services delivered at the hospital. VBP arrangements should financially reward birth centers for consistently better outcomes, resulting in overall cost savings due to improved health. In a fee-for-service scenario, birth centers deserve to be paid the equivalent of what the hospital would make for a similar service (i.e., an uncomplicated vaginal birth without the use of epidural).
For a detailed review of VBP programs that include birth centers (Minnesota Birth Center and Baby+Co.), read "A Scoping Review of Alternative Payment Models in Maternity Care: Insights in Key Design Elements and Effects on Health and Spending."[34]

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[32] Green, K., and C. Pierce-Wrobe, *Expanding Access to Outcomes-Driven Maternity Care through Value-Based Payment* (Health Care Transformation Task Force: Washington DC, 2019). *https://hcttf.org/wp-content/uploads/2019/07/Expanding-Access-to-Outcomes-Driven-Maternity-Care-through-Value-Based-Payment.pdf*.
[33] Id.
[34] de Vries, E.F., Z.T.M. Scheefhals, M. de Bruin-Kooistra, et al., "A Scoping Review of Alternative Payment Models in Maternity Care: Insights in Key Design Elements and Effects on Health and Spending." *International Journal of Integrated Care* 21 (2) (2021): 6. Table 2. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8086739/*.

Conclusion

Conclusion

Birthing people have growing interest and demand in the freestanding birth center model, presenting hospitals and health systems with a unique market opportunity to embrace and uplift birth center care. This guide walks you through a few approaches to integrating birth center care into your service line—partnership, construction and acquisition—using tools and lessons learned from hospitals and birth centers on the ground. These resources will help you navigate structural and cultural challenges as they arise. Birth center integration can feel like a daunting task, and hiring an experienced team can help you keep the effort moving and navigate any potential barriers to success.

If you put patients and provider relationships at the center of a thoughtful planning effort, we believe that the process will be worthwhile. We wish you the very best on your journey.

Appendix: Glossary of Terms

Antepartum
During pregnancy

Birth center
See freestanding birth center.

Call
Provider availability to patients for telephone calls and inpatient services.

Collaboration
A process involving mutually beneficial active participation between autonomous individuals whose relationships are governed by negotiated shared norms and visions.

Co-management
The process whereby a midwife and physician jointly manage the care of a patient with medical, gynecologic, or obstetric complications or a newborn.

Community birth setting
Birth in a home or birth center

Community birth center
A birth center offering facilities for labor and birth in a homelike setting, typically integrating various health services and serving a particular population united by location or cultural connections.

Dyad transfer
Transfer of the birthing parent and newborn together.

Consultation
The process whereby a midwife who maintains primary management responsibility for the woman's care seeks the advice or opinion of a physician or another member of the health care team.

Credentialing
The process by which a hospital or health plan reviews and validates a provider's qualifications and career history including their education, training, licenses and specialty certificates. Once

a provider's credentialing is approved, they can apply for privileges to practice or be paid by a health plan.

Disparity
Observable differences, particularly in reference to funding allocation or health outcomes among different populations.

Eligibility
Suitability for birth center birth or midwifery care, based on guidelines and midwifery scope of practice.

Emergency Transfer
See Transfer.

Freestanding Birth Center
A health care facility for childbirth where care is provided in the midwifery and wellness model. The birth center is not located at a hospital.

Gynecological services
The provision of annual exams, health screenings and treatment involving women's reproductive care outside of the maternity cycle.

"Incident to" services
Under certain circumstances, services are billed by one provider (a physician, for example) even though they may be provided by a different practitioner (e.g., a midwife or lactation consultant).

Inequity
Disparities in resources and access owing to structural, social and economic conditions.

Inpatient services
Services that are provided in a hospital setting. For a midwife, this may include triage, labor management, delivery, postpartum and newborn care.

Intrapartum
During labor

Maternity care desert
Areas where maternity care choices are limited or inaccessible.

Medical management
The process whereby the midwife directs or refers the woman to a physician or another health care professional for management of a particular condition or aspect of care.

Midwife
For the purposes of this guide, a women's health practitioner with certification recognized by a state's accrediting body.

Midwifery model of care
A model of care based upon the foundation that pregnancy and birth are physiologic life events.

Obstetric services
A term for pregnancy and delivery services, also referred to as maternity care.

Outpatient services
Services that are provided in an outpatient setting such as an office or clinic. Outpatient services can include ultrasound and laboratory services.

Physician oversight/supervision
A requirement by either a state, hospital, or health plan that a physician has the responsibility to oversee or supervise a midwife. There is no federal requirement for physician oversight/supervision.

Practice
A group of providers and support staff that provide care to patients. The practice can provide care in both outpatient and inpatient settings.

Practice model
A way to describe the caseload and staffing structure of a practice. For example, if a practice has a defined set of patients that midwives are responsible for, this may be referred to as a midwifery caseload model. If midwives provide inpatient care as first call for every patient, regardless of who sees the patient for prenatal care, this may be referred to as a shared caseload, midwifery first call model. There is no consistent use of definitions for "practice models," and in this document we have attempted to provide some structure to the concept.

Practice setting
A way to describe the employment structure of a practice. For example, if midwives are employed by a hospital we refer to this as a hospital-based practice. If a midwife is employed by a federally qualified health center (FQHC) we refer to this as a community-based practice.

Root cause analysis
Review of a clinical case using a structured process that helps identify root causes, contributing factors and associated improvement opportunities.

Scope of practice
The types of care provided by a midwife in a practice setting. Midwifery encompasses a full range of primary health care services for women from adolescence to beyond menopause. These services include the independent provision of primary care, gynecologic and family planning services; preconception care; care during pregnancy, childbirth and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They can conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices. Midwifery care also includes health promotion, disease prevention and individualized wellness education and counseling. The scope of practice of a midwife may vary depending on her experience, physician relationships and organizational requirements.

Top of license
Refers to a midwife being able to provide care at the highest level that her certification, education, experience and state regulatory requirements allow. According to federal law, midwives are independent practitioners. Some states require physician oversight/supervision.

Transfer
Hand-off of care between a midwifery-led practice and a hospital or health system.

Vicarious liability
Generally, vicarious liability means that employers or entities can be held financially responsible for mistakes made by their employees and agents.

Written practice guidelines
Written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.

Appendix: List of Acronyms

AABC
American Association of Birth Centers, the professional association that sets standards for birth centers

ACNM
American College of Nurse-Midwives, the professional association for certified nurse-midwives (CNMs) and certified midwives (CMs)

ACOG
American College of Obstetricians, the professional association for obstetricians and gynecologists (OB/GYNs)

AMU
Alongside midwifery unit

BAA
Business Associate Agreement

BCE
Birth Center Equity, an organization dedicated to growing and sustaining BIPOC-led birth centers

BIPOC
Black and Indigenous People of Color

CABC
The Commission for the Accreditation of Birth Centers is the nonprofit organization that accredits birth centers.

CE
Continuing Education

CLIA
Clinical Laboratory Improvement Amendments

CNM
Certified Nurse Midwife

EHR
Electronic Health Record

EMS
Emergency medical services

FQHC
Federally qualified health center

FTE
Full time equivalent

GYN
Gynecology

HIPAA
Health Insurance Portability and Accountability Act

IT
Information technology

L&D
Labor and Delivery

LGBTQ+
Lesbian, gay, bisexual, transgender, queer

MFM
Maternal-Fetal medicine

NICU
Neonatal intensive care unit

NTSV
Nulliparous, term, singleton, vertex

OB/GYN
Doctor of Obstetrics and Gynecology

OSHA
Occupational Safety and Health Administration

PBGH
Purchaser Business Group on Health

PDR
Perinatal Data Registry

PMC
Primary Maternity Care

RVU
Relative Value Units

SWOT
Strengths, Weaknesses, Opportunities, and Threats

ULaB
Undisturbed Labor and Birth Index

VBP
Value-based payment

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