



MAKING THE CASE FOR MOTHER-FRIENDLY BIRTH PRACTICES

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What is the Mother-Friendly Childbirth Initiative (MFCI)?

The Mother-Friendly Childbirth Initiative (MFCI), drafted in 1996, was an evidence-based consensus document ahead of its time. In 2006, the CIMS Expert Work Group conducted a systematic review of the evidence in support of the *Ten Steps of Mother-Friendly Care* and the MFCI's philosophical principle that birth can safely take place in hospitals, birth centers and homes. The result of their work confirmed the validity of the MFCI and was published in the Winter 2007 Supplement of the *Journal of Perinatal Education: Advancing Normal Birth*.

Since then, research, professional guidelines, state-wide health care directives, hospital systems, health care quality improvement initiatives, and federal and state-level maternity care legislation have identified many aspects of the MFCI and the *Ten Steps of the Mother-Friendly Childbirth Initiative* as key factors to improving maternal-infant health outcomes. The MFCI later served as the basis of the global initiative, the *International Mother-Baby Childbirth Initiative* (IMBCI, created with technical advisory help from leading national and international organizations including the World Health Organization and UNICEF).

What Are the Five Philosophical Cornerstones of the MFCI?

The major philosophical cornerstones of the MFCI—Normalcy of the Birthing Process, Empowerment, Autonomy, Do No Harm, and Responsibility (accountability) have found their way in key position papers, quality improvement initiatives, legislative initiatives, and maternity care practice guidelines.

Are the Philosophical Cornerstones of the MFCI Supported by Professional Associations?

An unprecedented consensus document, *Quality Patient Care in Labor and Delivery: A Call to Action*, which reflects the philosophical cornerstones of the MFCI, was published in the December 2011 issue of the *Journal of Obstetric, Gynecologic, and Newborn Nursing* and endorsed by seven leading U.S. maternity care professional associations:

- American College of Obstetricians and Gynecologists
- Association of Women's Health, Obstetric and Neonatal Nurses
- American College of Nurse-Midwives
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Osteopathic Obstetricians & Gynecologists
- Society for Maternal-Fetal Medicine

The philosophical premise of this document reflects the values, recommendations and vision of the MFCI. The seven associations agree to the following:

- Pregnancy and birth are physiologic processes that usually proceed normally.

- Most women have normal conception, fetal growth, labor, and birth and require minimal or no intervention in the process.
- Women and their families hold different views about childbearing based on their knowledge, experiences, belief systems, culture, and social and family backgrounds.
- As representatives of professional societies whose members care for pregnant and laboring women, we agree that patient-centered and safe care of the mother and child enhances quality and is our primary priority. Optimal maternal health outcomes can best be achieved in an atmosphere of effective communication, shared decision-making, teamwork, and data-driven quality improvement initiatives.

The MFCI encourages woman- and family-centered care, effective and culturally sensitive communication, shared decision making, collaboration among health practitioners, and transparency in providing accurate and statistical information to the public about its practices and procedures for birth care including outcomes and rates of intervention. Step 6 of the MFCI recommends that practices be evidence-based and not used routinely.

The consensus statement is available from,

<http://onlinelibrary.wiley.com/doi/10.1111/j.1552-6909.2011.01317.x/abstract>

What Are the Health Benefits of the *Ten Steps of the Mother-Friendly Childbirth Initiative*?

Implementing the recommendations of the MFCI will help maternity care professionals to maximize the health benefits of physiological birth for mother and baby. Benefits include:

- Lower rates of maternal and neonatal morbidity and mortality;
- Higher breastfeeding rates;
- Increased health benefits for infants;
- Increased opportunity for maternal-infant attachment;
- Reduced rate of post-partum complications and re-hospitalization;
- Higher likelihood of positive mental health and early parenting.

What Is the Role of Nurses in Improving Maternity Care?

In its report *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine (IOM) concluded that nurses can play a vital role in helping to transform the health care system and can and should play a fundamental role in its transformation. The roles, responsibilities and education of nurses need to change to meet the increasing demand for safe, high-quality, and effective health care services.

To help transform maternity care nurses will be expected to:

- Adopt best practices;
- Deliver high-quality care;

- Attain requisite competencies that include leadership, health policy, system improvement, research and evidence-based practice, teamwork and collaboration;
- Be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States;
- Participate in, and sometimes lead in the health policy arena, decision-making and be engaged in health care reform-related implementation efforts.

The Mother-Friendly Childbirth Initiative can serve as an evidence-based guide to assist labor, delivery and neonatal nurses provide safe, high-quality and effective care.

IOM, *The Future of Nursing-Report Brief* (October 2010) is available from, <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>

Health Initiatives and Policies that Reflect the Recommendations of the MFCI

The maternity care experts, professional organizations, and consumer advocates who drafted the *Mother-Friendly Childbirth Initiative* outlined philosophical principles and specific evidence-based recommendations to improve health care quality, maternal and newborn outcomes, and women’s experiences of maternity care based on the evidence available in 1996. Today, their vision is reflected in several documents and initiatives aimed at making childbirth safer, less costly, and more satisfying to childbearing women and their families. An update of current scientific evidence that supports the MFCI was published as a Supplement to the Winter Issue of the *Journal of Perinatal Education* in 2007. The complete Supplement can be downloaded from www.motherfriendly.org .

The following is a selected list of health initiatives, guidelines, quality improvement measures and publications that support the principles and recommendations of the MFCI.

I. The MFCI is aligned with the Institute of Medicine’s Recommendations to Improve Healthcare.

More than a decade ago the Institute of Medicine published its wide-sweeping report on the state of healthcare in the U.S.

Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge —yet there is strong evidence that this frequently is not the case.
--Institute of Medicine

In *Crossing the Quality Chasm: A New Health System for the Twentieth Century*, the Institute concluded that the nation’s health care delivery system had fallen far short in its ability to translate evidence into practice and to apply new technology safely and appropriately.

The Institute of Medicine identified six specific aims for improvement. Healthcare needs to be:

- **Safe:** avoiding injuries to patients from the care that is intended

to help them;

- **Effective:** providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit;
- **Patient-centered:** providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions;
- **Timely:** reducing waits and sometimes-harmful delays for both those who receive and those who give care;
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy;
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The *Mother-Friendly Childbirth Initiative* can be used as a model of care by caregivers and birth facilities to achieve the Institute of Medicine's aims for improving maternity care.

Crossing the Quality Chasm: A New Health System for the Twentieth Century is available here: http://www.nap.edu/openbook.php?record_id=10027&page=1

II. The MFCI is aligned with the Healthy People 2020 Goals.

The **Healthy People 2020** national goals are to reduce health disparities and improve the health of Americans. Included in this health initiative are specific goals to improve Maternal, Infant, and Child Health. The *Mother-Friendly Childbirth Initiative* is aligned with these goals. By providing evidence-based care and working towards achieving the *Ten Steps of the Baby-Friendly Hospital Initiative*, caregivers and hospitals can do their part to meet these **Healthy People 2020** goals:

- Reduce maternal illness and complications due to pregnancy and complications during hospitalized labor and delivery;
- Reduce cesarean births among low-risk (full-term, singleton, vertex presentation) women and women giving birth for the first time;
- Increase the number of women who plan a VBAC;
- Reduce the rate of maternal mortality;
- Reduce late preterm or live births at 34 to 36 weeks of gestation;
- Reduce low birth weight (LBW) and very low birth weight (VLBW);
- Reduce preterm births; and
- Reduce fetal, neonatal, and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth).

The *Mother-Friendly Childbirth Initiative* includes several recommendations that can help to meet these goals: provide evidence-based care, increase access to midwifery care, and to birth companions, restrict inductions of labor and cesarean sections to medically indicated conditions, increase access to VBAC, support and facilitate maternal-infant attachment and breastfeeding, provide appropriate post-partum community resources.

A copy of **Healthy People 2020** is available from, <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26>

III. The MFCI is aligned with the Philosophical Principles and Recommendations of *Evidence-Based Maternity Care: What it is and What It Can Achieve* (Carol Sakala and Maureen P. Corry, 2008).

Evidence-Based Maternity Care: What It Is and What It Can Achieve is a collaborative maternity care quality improvement project that outlines the evidence that supports the health benefits of physiologic birth. It defines optimal maternity care as effective care with the least harm for childbearing women and newborns.

Research shows that when women receive evidence-based care that supports the physiological process of birth, they are less likely to rely on pain medications, need augmentation of labor, use of forceps/vacuum extraction, episiotomy, and cesarean section. This type of care is much less costly, provides outstanding value for those who pay for this care.
Evidence-Based Maternity Care: What It Is and What It Can Achieve.
Carol Sakala and Maureen P. Corry (2008).

Who are the organizations that support the findings of *Evidence-Based Care: What It Is and What It Can Achieve*?

The report, which highlights best evidence, is supported by the Milbank Memorial Fund, the Reforming States Group, and Childbirth Connection. The Milbank Memorial Fund is a foundation that works to improve health by helping decision makers in the public and private sectors acquire and use the best available evidence to inform health policy. Childbirth Connection, founded in 1918, is a national not-for-profit organization that works to improve the quality of maternity care through research, education, advocacy and policy. The Reforming States Group, organized in 1992, is a voluntary association of leaders in health policy from all fifty U.S. states, as well as Canada, England, Scotland and Australia.

Evidence-Based Care: What It Is and What It Can Achieve reinforces the importance of the five philosophical cornerstones of the MFCI: Normalcy of the Birthing Process, Empowerment, Autonomy, Do No Harm, and Responsibility.

Evidence-Based Care: What It Is and What It Can Achieve is available from, <http://childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf>

IV. The MFCI is Aligned with the California Maternal Quality Care Collaborative (CMQCC) Principals and Recommendations on Cesarean Section and VBAC.

Who is the California Maternal Quality Care Collaborative (CMQCC)?
The mission of the CMQCC is to end preventable morbidity, mortality and racial disparities in California's maternity care.

In December 2011, the Collaborative published a comprehensive White Paper on the state's cesarean section rates, *Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality*.

The report concluded the following:

- Higher cesarean rates have brought higher economic costs and greater health complications for mother and baby, with little demonstrable benefit for the large majority of cases.
- There is growing evidence that for the majority of women, having a cesarean (compared to giving birth vaginally) is associated with greater psychological distress and illness, including postpartum anxiety, depression, and post-traumatic stress disorder.
- Childbearing women lack information about childbirth options and risks, and need opportunities to be educated about them.
- A first step is for all stakeholders to support cultural change to recognize the value of normal vaginal birth for mothers and babies.
- We should examine labor management practices to reduce those that lead to the development of indications for cesareans.
- Hospitals should encourage VBAC through hospital policies and supportive care.
- There is a need for more precise clinical practice guidelines and greater accountability and incentives for following them.

The Mother-Friendly Childbirth Initiative supports the psychological and physical benefits of physiological birth, the imperative to first do no harm, provider accountability, the elimination of the routine use of interventions, lower cesareans and more VBACs, and advocacy for informed consent and informed refusal. The MFCI encourages birth facilities to maintain a 10%-15% cesarean rate and to move towards a 60% VBAC rate with a goal of 75% or more.

The CMQCC White Paper is available from, http://www.cmqcc.org/white_paper

V. The MFCI is aligned with the National Quality Forum Voluntary Consensus Standards for Perinatal Care.

What is the National Quality Forum?

The National Quality Forum (NQF) is a non-profit organization of a wide variety of healthcare stakeholders whose mission is to improve the quality of American healthcare. It has also called for voluntary consensus standards to improve maternity care. The

NQF's Perinatal and Reproductive Healthcare Steering Committee established national consensus standards for improving care provided during the last trimester of pregnancy through hospital discharge for both mothers and babies.

The NQF standards include:

- Reducing the number of low-birth-weight babies;

- Reducing elective deliveries before 39 weeks;
- Reducing cesareans for low-risk first time mothers;
- Reducing episiotomy, perineal laceration, injury and birth trauma for neonates;
- Increasing exclusive breastfeeding;
- Reducing nosocomial (originating in the hospital) blood stream infections in newborns; and
- Reducing in-hospital maternal deaths.

The MFCI recommends reducing elective inductions and cesareans so as to reduce the rate of complications for both mothers and babies, preterm births, infections in newborns and admissions to a NICU. The MFCI recommends non-pharmacologic options for pain relief and providing women the freedom to assume positions of their choice for labor and birth, since this has been shown to reduce the need of instrumental deliveries and complications of second stage.

Access to midwifery care and continuous labor support as recommended in the MFCI has been shown to reduce the likelihood of interventions and complications during childbirth and increase the rate of breastfeeding. Because repeat cesarean sections put mothers at higher risk for hemorrhage, placental complications, hysterectomy and death, the MFCI encourages access and support for VBAC.

Perinatal measures from the NQF are available from, <http://www.qualityforum.org/>

VI. The MFCI is Aligned with the National Priorities Partnership's National Priorities & Goals for Perinatal Care.

What is the National Priorities Partnership?

The National Priorities Partnership (NPP) is a partnership of more than 50 major organizations that collectively influence every part of the health care system and represents multiple stakeholders from the public and private sectors. The aim of the Partnership is to improve the current health care system by addressing four major challenges.

- Eliminating harm
- Eradicating disparities
- Reducing disease burden, and
- Removing waste in the system

The Partnership has identified priority areas that can have the most impact on maternity care. These are:

- Engaging patients and families in managing their health and making their own decisions about their care;
- Improving the health of the population by fostering health and wellness by focusing on prevention and reducing risks;
- Improving the safety and reliability of America’s healthcare system by practicing evidence-based medicine;
- Ensuring that patients receive well-coordinated care within and across all healthcare organizations, settings, and level of care;
- Eliminating excessive care practices not based on the evidence, including tests, drugs, procedures and hospital stays.

The *Mother-Friendly Childbirth Initiative* is an evidence-based mother-, baby-, and family-friendly model of maternity care that focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs. It reflects respect for women’s values, beliefs, and preferences and encourages informed consent and informed refusal. The MFCI also calls for collaborating and consulting throughout the perinatal period.

In January 2012 the NPP formed the Maternity Action Team to focus specifically on improving maternity care. The goals of the Action Team, which includes major stakeholders in maternity care, are to reduce elective deliveries prior to 39 weeks to 5% or less and reduce cesarean births among low-risk women to 15% or less.

The *Mother-Friendly Childbirth Initiative* recommends a total cesarean rate of 10% or less in community hospitals, 15% or less in tertiary (high risk) hospitals and an induction rate of 10% or less.

Find out more about the NPP priorities to improve health care from, <http://www.nationalprioritiespartnership.org/> and about the Maternity Action Team at http://www.qualityforum.org/Setting_Priorities/NPP/NPP_Action_Teams.aspx

VII. The MFCI is aligned with the Joint Commission National Perinatal Core Measures for Cesarean Section and Exclusive Breastfeeding

What is the Joint Commission?

The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. The Joint Commission wants hospitals to lower their early elective delivery rates (before 39 weeks) and their cesarean rates for nulliparous women with a term singleton baby in a vertex position. (NTSV), and to increase their exclusive breastfeeding rates.

Starting in January 2014, it will be mandatory for Joint Commission-accredited hospitals with more than 1,100 births a year to report these perinatal core measures.

The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section (CS) rates. Some hospitals now have CS rates over 50%. Hospitals with CS rates at 15-20% have infant outcomes that are just as good and better maternal outcomes. --The Joint Commission

The MFCI encourages physiological birth, restricted use of interventions that can lead to a cesarean, access to midwifery care and labor support shown to lower the odds of a cesarean, access to VBAC, and a maximum cesarean rate of 15% for hospitals that care for high risk mothers and babies. Step 10 of the MFCI recommends that birth facilities become Baby-Friendly.

The Joint Commission perinatal quality measures are available from, http://www.jointcommission.org/core_measure_sets.aspx

VIII. The MFCI is Aligned with the Recommendations of the March of Dimes and the Leapfrog Group to Reduce Elective Deliveries.

What is the March of Dimes?

The March of Dimes is a leading organization dedicated to reducing premature births and improving newborn outcomes.

Preterm births are a leading cause of infant morbidity and mortality. Research shows that increasing trends to schedule elective inductions of labor and cesarean sections has contributed to the number of babies born preterm. To help hospitals, care providers, and maternity care professionals to eliminate non-medically indicated deliveries, the March of Dimes, California Maternal Quality Care Collaborative (CMQCC), and the California Department of Health, Maternal Child and Adolescent Health Division collaborated on the publication of ***Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age; Quality Improvement Toolkit***.

What is the Leapfrog Group?

The Leapfrog Group is a leading national non-profit organization actively changing the way health care is purchased and delivered. It seeks to help employers with value-based purchasing of healthcare. The organization in collaboration with the March of Dimes launched a national campaign to reduce elective deliveries before 39 weeks.

Are Elective Deliveries Safe?

Research has shown that early elective delivery (between 37 and 39 weeks of gestation) without medical or obstetrical indication is associated with neonatal morbidities, with no benefit to the mother or infant. Induction of labor doubles the risk for cesarean section in first births, thereby exposing mothers to harms associated with a major abdominal surgery.

What Is an Acceptable Rate for Elective Deliveries?

A 2012 Leapfrog survey showed that elective delivery rates varied widely. For example, in California, individual hospital elective delivery rates ranged from 0.0% to 37.8%.

Since some hospitals were able to keep their elective deliveries before 39 weeks to 5% or less, effectively reducing costs without compromising maternal and newborn outcomes, Leapfrog set its own benchmark for elective deliveries to 5%. U.S. hospitals will need to be at or below this target to earn credit from Leapfrog on this measure. The National Quality Forum and the Joint Commission also endorse the 5% benchmark for elective deliveries.

In 1996 when the *Mother-Friendly Childbirth Initiative* was drafted, it called for an induction rate of 10% or less and a total cesarean rate of 10% or less in community hospitals and 15% or less in tertiary (high-risk) hospitals) as recommended by the World Health Organization (WHO).

A copy of the *Eliminating Non-Medically Indicated (Elective) Deliveries 39 Weeks Toolkit* is available from, http://www.marchofdimes.com/professionals/medicalresources_39weeks.html

The Leapfrog Group Fact Sheet, *Early Elective Deliveries* and U.S. hospital rates for early elective deliveries are available from, www.leapfroggroup.org/tooearlydeliveries .

IX. Recommendations in the *Ten Steps of the Mother-Friendly Childbirth Initiative (MFCI)* Have Been Included in the WHO/UNICEF's *Infant and young child feeding: A tool for assessing national practices, policies and programmes (2003)*.

The WHO and UNICEF concur that childbirth practices have a direct impact on breastfeeding success. In particular, support during labor, maternal positioning, use of IV fluids in labor, labor pain medications, surgical procedures, maternal emotional states, and contact with the baby after birth. Furthermore, the impact of procedures such as vacuum extraction, forceps, and cesarean section can affect the newborn's ability to suckle and breastfeed.

WHO and UNICEF recommend that to maximize the establishment of successful breastfeeding, women in labor, regardless of birth setting, should have access to the following practices recommended in the MFCI:

- Care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's culture, ethnicity and religion;
- Birth companions of her choice who provide emotional and physical support throughout labor and delivery;
- The freedom to walk, move about, and assume the positions of her choice during labor;
- Care by staff trained in non-drug methods of pain relief and who do not promote the use of analgesic or anesthetic drugs unless required by a medical condition;

Birth practices affect breastfeeding.

- Care that minimizes routine practices and procedures that are not supported by scientific evidence including withholding nourishment, early rupture of membranes, use of IVs, routine electronic fetal monitoring, episiotomy and instrumental delivery;
- Care that minimizes invasive procedures such as unnecessary acceleration or induction of labor and medically unnecessary cesarean sections.

The Mother-Friendly childbirth practices are included in Part Three of the document. A copy of the *WHO/UNICEF Infant and young child feeding: A tool for assessing national practices, policies and programmes (2003)* is available from, <http://www.who.int/nutrition/publications/infantfeeding/9241562544/en/index.htm>

Maternity Care Legislation Supports the Principles and Recommendations of the *Mother-Friendly Childbirth Initiative*

Background

In July of 1996, 31 individuals and 26 organizations representing over 90,000 members ratified the Mother-Friendly Childbirth Initiative (MFCI). The MFCI, an evidence-based, wellness model of maternity care was a comprehensive response to birth advocates' analysis of the serious gaps in maternity care services of the time. After more than a decade, birth advocates are finally seeing maternity care legislation that promises to address the health needs of mothers and infants.

Current health care law and forthcoming legislation is now addressing the very issues highlighted for change in the MFCI. They include:

I. The Patient Protection and Affordable Care Act (HR 3590), 111th Congress

<http://www.govtrack.us/congress/bill.xpd?bill=h111-3590&tab=summary>

Signed into law on March 23, 2010, the Patient Protection and Affordable Care Act includes major provisions to increase women's access to evidence-based care and maternity care providers of their choice. The bill recognizes the importance of focusing specifically on women's health needs and does away with several Medicaid and Medicare reimbursement inequalities against midwives and birth centers across the country.

The Affordable Care Act underscores the importance of:

- Evidence-based care
- Patient choice
- Accountability for providers' care practices
- Shared healthcare decision making
- Women's choice for midwifery care and birth centers
- Support for breastfeeding
- Continuity of care
- Value of services (reduce cost)

Section 4207 of the Patient Protection and Affordable Care Act

This amendment requires employers to provide reasonable break time and a private, non-bathroom place for nursing mothers to express breast milk during the workday, for one year after the child's birth.

II. MOMS for the 21st Century Act (HR 2141), 112th Congress

<http://www.opencongress.org/bill/112-h2141/text>

This bill was introduced by California Congresswoman Lucille Roybal-Allard on June 15, 2011 to promote optimal maternity outcomes by making evidence-based maternity care a national priority, and for other purposes. The Maximizing Optimal Maternity Services for the 21st Century Act places a national focus on evidence-based maternity care practices to help achieve the best possible maternity outcomes for mothers and babies. If passed, this bill would expand federal research on best maternity care practices and authorize a public awareness media campaign to educate the public about the best-proven maternity care practices.

Specific focus areas of the bill include:

- Protecting, promoting, and supporting the innate capacities of childbearing women and their newborns for childbirth, breastfeeding, and attachment;
- Using obstetric interventions only when such interventions are supported by strong, high-quality evidence, and minimizing overuse of maternity practices that have been shown to have benefit in limited situations and that can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous electronic fetal monitoring, labor induction, epidural analgesia, primary cesarean section, and routine repeat cesarean birth;
- Reliably providing beneficial practices with no or minimal evidence of harm that are underused, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor support, non-supine positions for birth, and external version to turn breech babies at term;
- A shared understanding of the results of the best available research comparing hospital, birth center, and planned home births, including information about each setting's safety, satisfaction, outcomes, and costs; and
- Informed decision-making by childbearing women.

III. Maternal Health Accountability Act of 2011 (H.R. 894)

<http://www.opencongress.org/bill/112-h894/show>

This legislation was introduced by Representative John Conyers (D-MI) on March 11, 2011. If passed, the bill would provide funds for states to establish Maternal Mortality Review Committees, to collect data on pregnancy-related and pregnancy-associated deaths, and require states to reduce or eliminate disparities in maternal health outcomes. Each maternal death would be investigated and all findings and recommendations would be disseminated.

IV. Partnering to Improve Maternity Care Quality Act of 2010 (HR 6437)

<http://www.govtrack.us/congress/bill.xpd?bill=h111-6437&tab=summary>

This bill, introduced by Representative Eliot Engel (D-NY) in November of 2010 is designed to promote optimal maternity outcomes by making evidence-based maternity care a national priority. If passed, it would ensure the development of national, evidence-based quality measures for maternity care in Medicaid and create and implement a national patient survey of women to assess their experience of maternal care. The bill would also authorize an Institute of Medicine report to identify a package of essential evidence-based services for childbearing women and newborns.

V. Access to Certified Professional Midwives Act of 2011 (H.R. 1054), 112th Congress
<http://www.govtrack.us/congress/bill.xpd?bill=h112-1054>

Introduced on March 10, 2011 by Representative Chellie Pingree (D-MN), the bill provides access and reimbursement to certified professional midwives (CPMs) for services provided to women enrolled in the Medicaid program. This bill adds the services provided by Certified Professional Midwives as a new category of mandated health service under the federal-state Medicaid program.

If passed, the bill would require all states that license, register, or legally authorize CPM practice to make CPM services available to all pregnant women who receive Medicaid. The bill would also add the services of a Certified Professional Midwife as a new category to the existing categories of providers (such as hospitals, nurse practitioners, certified nurse midwives and birth centers) eligible for Medicaid payment.

***The Mother-Friendly Childbirth Initiative* Outlines Several Gaps in Maternity Care that Still Need Improvement and Are Supported by Current Legislative Initiatives:**

- Higher perinatal morbidity and mortality and a higher maternal mortality rate than many other industrialized countries;
- Disparities in access to care and health outcomes;
- High rates of cesareans and inductions of labor;
- Lack of access to midwifery care;
- Routine use of non-evidence based birth practices which expose mothers and newborns to avoidable harms;
- Increased use of technology, which undermines women's confidence in their innate ability to give birth; and lack of support for breastfeeding.

Examples of National, State and Hospital Quality Improvement Initiatives That Reflect the Recommendations of the *Mother-Friendly Childbirth Initiative*

Across the U.S., hospitals, providers, quality improvement leaders, and healthcare payers are working to implement patient-centered, evidence-based maternity care practices for optimal maternal and newborn outcomes. These are selected examples:

I. Childbirth Connection, *Transforming Maternity Care : 2020 Vision for a High-Quality, High-Value Maternity Care System* and *Blueprint for Action*

<http://transform.childbirthconnection.org/vision>

<http://transform.childbirthconnection.org/blueprint>

In 2008, Childbirth Connection, a non-profit maternal care quality improvement organization, convened a Vision Team of experts in maternity care and health systems design to define the fundamental values, principles, and goals for a high-quality, high-value maternity care system. The work of this team resulted in an unprecedented, comprehensive, system-wide consensus document, *Transforming Maternity Care: 2020 Vision for a High-Quality, High-Value Maternity Care System* which outlines specific steps and actions needed to improve maternal and newborn health outcomes and reform the maternity care system. The experts concluded:

The goals for maternity care are best met by implementing a holistic, relationship-based model of care that is woman-centered, inclusive, and collaborative. Caregivers are included as dictated by the health needs, values, and preferences of each woman, taking into account her social and cultural context as she defines it, and given consideration for evidence of effectiveness, value, and efficiency.

Transforming Maternity Care: 2020 Vision for a High Quality, High-Value Maternity Care System.

The work of the Vision Team served as the basis for *Blueprint for Action*, a detailed list of actionable strategies for maternity care stakeholders to improve the quality and value of maternity care. The *Blueprint for Action* is focused on eleven areas for change. Four of these, are reflected in the *Mother-Friendly Childbirth Initiative*:

- Disparities in access and outcomes in maternity care
- Coordination of maternity care across time, settings, and disciplines
- Clinical controversies, and
- Decision-making and consumer choice

II. San Francisco General Hospital, California

<http://transform.childbirthconnection.org/2011/08/sts-cesarean/>

San Francisco General is a Baby-Friendly designated hospital. It chose to increase the number of mothers who successfully initiate breastfeeding by changing their operating room policies and establishing routine early skin-to-skin (STS) contact after a cesarean birth. The rate of STS within 90 minutes of a cesarean birth increased from 20% to 68% in the first three months. Babies who experienced STS in the operating room were better able to latch on to the breast and were less likely to receive supplemental formula before discharge.

III. Sutter Health, California

<http://www.cmqcc.org/people/1/story>

A network of physicians and hospitals initiated the First Pregnancy and Delivery Quality OB Improvement project that is focusing on reducing avoidable cesareans, elective inductions at term, early admission to the labor and delivery unit, episiotomies and subsequently 3rd and 4th degree perineal lacerations.

IV. Saddleback Memorial Medical Center, California

<http://www.cmqcc.org/people/12/story>

Saddleback Memorial Medical Center in Southern California Instituted policies to reduce elective induction of labor before 41 weeks gestation for first time mothers and to reduce the number of cesareans associated with elective inductions. Over time, the number of elective inductions fell from 25.5% to 0.6%, effectively improving health outcomes for mothers and newborns and substantially reducing costs.

V. California Maternal Quality Care Collaborative CMQCC; Reducing Cesareans

http://www.cmqcc.org/white_paper

According to the CMQCC, cesarean delivery rates in both California and the United States as a whole rose by 50 percent between 1998 and 2008, climbing from 22 percent to 33 percent of all births in just a decade. This trend is seen for every type of woman regardless of race/ethnicity, age, weight, or gestational age of the pregnancy. The rates are a result of two factors: the significant rise in first-birth cesareans done during labor and the significant decline in VBACs (vaginal births after a cesarean).

The risks to mothers and babies and the high costs associated with cesarean deliveries are significant, yet there is no data to show that these increasing cesarean rates overall have benefited women or newborns.

The CMQCC has published a white paper, *Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality*. The report outlined several recommendations to reduce cesarean rates, including:

- Hospitals should establish a balanced set of perinatal quality measures to drive QI initiatives and report outcomes to the public.
- Encourage VBACs.
- Increase public awareness about the risks of cesarean section with education, public service announcements, celebrity spokespersons, and shared decision tools.

VI. Michigan Health & Hospital Association Keystone Center- Obstetrics

<http://www.mhakeystonecenter.org/ob.htm>

Michigan Keystone Obstetrics supports the Mother-Friendly Childbirth Initiative. A comprehensive multi-disciplinary perinatal safety initiative that includes 67 hospitals in the state, the goal of the Keystone Project for Patient Safety & Quality's Obstetrics Collaborative is to eliminate preventable harms to mothers and newborns during childbirth.

Specifically:

- To reduce neonatal morbidities such as sepsis, respiratory complications, admissions to NICU, and re-hospitalization associated with induction of labor and cesarean sections.
- To reduce maternal complications from induction of labor, elective deliveries, episiotomy, instrumental deliveries, and epidurals.
- Educate clinicians on current evidence and professional standards.
- Provide transparency regarding the quality of care provided by hospitals.
- The initiative includes a strong patient empowerment component, comprehensive education on informed consent/refusal, and transparency of hospital procedures and complication rates.

By implementing Best Practice guidelines, educating patients, providing transparency, and changing attitudes to care, the project has resulted in significant improvements in preventing adverse obstetrical outcomes.

VII. West Virginia Perinatal Partnership: First Baby Clinical Initiative

<http://www.wvperinatal.org/>

The West Virginia Healthcare Authority, in partnership with the West Virginia Perinatal Partnership, the March of Dimes, and 14 West Virginia Birthing Hospitals is focusing on low-risk first-time mothers. Data gathered by the collaborative showed that first-time mothers have *twice the rate of epidurals, three to four times more labor complications than women who have given birth before, and almost twice the number of babies admitted to NICU at nearly three times the cost.* In 2009 50.9% of first-time mothers had no medical indication for induction of labor. The collaborative is focused on:

- Reducing complications resulting from unnecessary interventions including induction of labor and cesarean sections;
- Reducing early admission before active labor;
- Providing continuous labor support, and alternative methods of pain relief such as comfort measures and positioning for labor and birth; and
- Patient advocacy and educating expectant mothers throughout pregnancy about the benefits and risks of interventions (informed consent/refusal) and providing safe alternatives.

VIII. New Hampshire, Patient Voices Project

<http://transform.childbirthconnection.org/index.php?s=New+Hampshire+Patient+Voices>

The mission of the New Hampshire Patient Voices project is education and advocacy for safe, quality, compassionate healthcare that puts patients & their families at the center of care in policy and practice.

New Hampshire Patient Voices (www.patientvoices.org) partnered with the federal Agency for Healthcare Research & Quality to provide information on:

- Evidence-based educational materials for both consumers and healthcare providers.
- Links to hospital rating websites, patient care outcome data, and health care costs.
- Patient safety, updates on healthcare reform, and the latest research on healthcare quality, costs & utilization.

IX. Hospital Corporation of America (HCA)

<http://transform.childbirthconnection.org/2011/03/hcaliability/>

HCA, a Nashville-based 159 hospital system aimed to reduce perinatal morbidity and mortality, unwarranted cesarean sections, reduce malpractice loss and assure safe, highly reliable individual practice.

HCA standardized evidence-based practices and protocols related to clinical situations associated with high risk of injury or harm.

The focus areas include:

- Limiting use of oxytocin and misoprostol (Cytotec).
- Reducing operative vaginal delivery.
- Increasing staff availability for VBACs.

HCA saw a dramatic reduction in inductions and cesareans as a result of implementing oxytocin use protocols. Fewer cesareans were related to fewer abnormal heart tracings in labor involving artificial oxytocin and malpractice claims fell from 12/10,000 to 4/10,000 in 2009.

X. Intermountain Healthcare, Utah and Idaho

<http://transform.childbirthconnection.org/2011/07/intermountaininduction/>

Intermountain Health Care, a two-state, multi-hospital system adopted a no-early delivery policy (no elective deliveries before 39 completed weeks of gestation). Across 23 hospitals, outcomes were similar across providers but the number of elective deliveries and resources used varied significantly. After implementing the new guidelines, the number of elective inductions that lacked medical justification was reduced from 28 percent to less than 2 percent within a two-year period. Intermountain Healthcare saw fewer admissions to NICUs and fewer cesareans. The modified elective induction protocols reduced health care costs in Utah by \$50 million a year.

XI. The Vermont/New Hampshire VBAC Project

<http://www.nnepqin.org/Guidelines.asp#tabs-6>

In response to the lack of access to VBAC for women residing in large areas of Vermont and New Hampshire, the obstetric departments at Dartmouth Hitchcock Medical Center and Fletcher Allen Health Care teamed together in 2002 to create the VT/NH VBAC Project, an initiative of the Northern New England Perinatal Quality Improvement Network. The goal of the project was to increase the availability of safe care for VBAC in the region.

The goal was accomplished through the collaborative creation of three documents:

1. VBAC Guidelines (for hospitals)

2. Consent for Birth After Cesarean Section (for hospitals)
3. Birth Choices After a Cesarean Section (for consumers)

Since the publication of the guidelines, all of the hospitals in Vermont resumed their VBAC services and more than $\frac{3}{4}$ of the hospitals in New Hampshire now offer medical care for VBAC. The *Mother-Friendly Childbirth Initiative* supports VBAC and encourages hospitals to have a VBAC rate of 60% or more with a goal of 75% or more.

The Mother-Friendly Childbirth Initiative (MFCI), drafted in 1996, was an evidence-based consensus document ahead of its time. The maternity care professionals, researchers, and birth activists who drafted and ratified the document felt strongly that the way we cared for mothers and babies during pregnancy, childbirth, and the postpartum period urgently needed to be changed to improve outcomes. Fifteen years later, the *MFCI* proved to be a significant and effective model of maternity care respected by the highest office in the United States responsible for maternal and child health.

In a video address to the attendees of the 2013 CIMS Forum in Kansas City, Missouri, Michael C. Lu, MD, MS, MPH, Director of the Maternal Child Health Bureau of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services acknowledged that the *Mother-Friendly Childbirth Initiative* is an important tool that contributes to quality improvement in maternity care. In reference to CIMS, he said, “You’ve been the champions of quality and safety for maternity services in our nation.” Dr. Lu validated the philosophical principles of the MFCI. He stated, “*No woman should be subjected to unnecessary interventions and...every woman should be cared for in a system that respects her autonomy and upholds the principles of Empowerment, Do No Harm, and Responsibility and be given the choice of Mother-Friendly maternity services that you all champion.*”

There is agreement among progressive maternity care stakeholders that there is a need to implement evidence-based care, respect patient informed choice, provide transparency for birth practices, and reduce costs. The philosophical cornerstones of the *Mother-Friendly Childbirth Initiative*--Normalcy of the Birthing Process, Empowerment, Autonomy, Do No Harm, Responsibility and the evidence-based recommendations of the *Ten Steps for Mother-Friendly Hospitals, Birth Centers and Home Birth Services* can be used as a practice and policy tool to meet those needs and make childbirth safer, less costly, and more satisfying to childbearing women and their families.

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