



Transforming Maternity Care Blueprint for Action Clinical Controversies: Home Birth, VBAC, Vaginal Breech and Twin Birth, Elective Induction, and Cesarean Section without Indication

This document presents the content of the Transforming Maternity Care Blueprint for Action that addresses one of eleven critical focus areas. The complete Blueprint for Action can be accessed at <http://transform.childbirthconnection.org/blueprint>

Problems

Overreliance on maternity interventions and limited access to primary maternity care providers and settings provide the context for clinical controversies

Controversial clinical scenarios in maternity care include VBAC, vaginal breech and vaginal twin birth, cesarean section without indication, elective induction of labor, and home birth. Conflict about these forms of care occurs in the context of the current maternity care delivery system, which generally provides an intervention-intensive, specialty-oriented style of care. The system fosters liberal use of elective procedures and perverse financial incentives that favor overuse of services, including an overreliance on cesarean section versus skill-based and time-intensive approaches to facilitating labor and birth. Care is poorly coordinated and does not reliably ensure appropriate practice based on an individual woman's clinical circumstances and personal preferences.

Primary maternity care with a focus on support and prevention is optimal for the majority of women and newborns who are essentially healthy and at low risk for complications. Yet, most U.S. births are attended by specialists trained in high-risk pregnancy and disease management, a large number of whom have little training or experience in protecting, promoting and supporting physiologic childbirth—the most appropriate form of care for most of the population. Other providers, specifically midwives and family physicians, often have a different focus and emphasis in their training and experience in maternity care, such that their skills may be better suited for providing this style of care. However, these caregivers attend relatively few births in the United States. Similarly, the freestanding birth center more consistently provides such care to healthy, low-risk women than acute care hospitals, yet just a fraction of women have access to that care setting.

Inconsistent adherence to evidence, lack of consensus, and wide variability in the care of women with controversial clinical scenarios

Childbearing women with controversial clinical situations face mixed professional messages and disagreement about appropriate care and care options. Gaps between evidence and practice, uncertainty about effects of inadequately assessed practices, and diminished access to many forms of care pit many women and their preferences against the maternity care available in their communities. This conflict is magnified during health care transitions, when women's care may be managed very differently, often with inadequate coordination of care, by their various providers and settings.

Reduced access to essential practices and loss of provider skills that foster safe, physiologic childbirth

Women increasingly lack access to essential practices that foster vaginal birth and reduce the likelihood of cesarean section. Best current evidence supports providing carefully screened women access to practices such as planned VBAC, vaginal breech birth (Goffinet et al., 2006; Hannah et al., 2004; Hogle et al., 2003; Kotaska et al., 2009; Whyte et al., 2004), and vaginal twin birth; external version to turn fetuses to a head-first position; nonpharmacologic methods of labor pain relief and management; intermittent auscultation for fetal monitoring; and skillful judicious use of vacuum extraction and forceps. However, decreased use of these practices is leading to loss of skills and unsupportive environments.

Liability concerns

Liability concerns impact the care of women with controversial clinical scenarios. Perceived pressure pushes some clinicians and systems of care to make decisions with the primary aim of avoiding liability rather than supporting a healthy physiologic childbirth and honoring women's informed choices.

System Goals

- Primary maternity care is the standard of care for the majority of women and newborns who are at low risk for complications.
- Focused attention is given to resolving clinical controversies, which adversely affect childbearing women, caregivers, and the maternity care system.
- Care for childbearing women and newborns is provided within an integrated system that ensures respect and support for women's informed choices while responding appropriately to unexpected needs.

Major Recommendations and Action Steps

1. Align practice patterns and views of both maternity caregivers and consumers with best current evidence about controversial clinical scenarios and evidence-based maternity care generally.

- Review evidence and develop national clinical guidelines for VBAC, labor induction, vaginal breech and twin birth, elective primary cesarean, and out-of-hospital birth using transparent multi-disciplinary and multi-stakeholder processes with opportunities for public comment. Adopt resulting guidelines as the national standard of care. Develop parallel education and decision support resources for consumers and health professionals. Look to the U.K. National Institute for Health and Clinical Excellence as a model for this process.
- Revise educational requirements for maternity caregivers, adding curricula related to critical appraisal of scientific literature. Integrate the teaching of evidence uptake and evidence-based practice into the clinical training setting.
- Fund, conduct, and publish results of prospective comparative effectiveness research on the relative safety of birth across all settings through multidisciplinary collaboration and careful selection of comparison groups. Measure physical and psychosocial outcomes in the weeks and months after birth, implications for populations experiencing disparities, and experience of care.
- Convene a multidisciplinary consensus conference on vaginal breech birth with support from AHRQ and NIH, including international experience with vaginal breech birth. Convene a home birth consensus conference, which is already in the planning stage.

- Identify the critical gaps in the evidence needed for decision making on planned VBAC versus repeat cesarean, then fund and conduct targeted research with time frames that can compare short-term and longer-term outcomes and costs.
- Ensure ongoing collection of national data on the incidence of maternal demand cesarean through Pregnancy Risk Assessment Monitoring System, National Survey of Family Growth, and other surveys in light of conflicting views of this phenomenon.

2. At the clinical microsystem and health care organization levels, implement policies and practices that foster safe physiologic childbirth and decrease excessive use of elective procedures and interventions.

- Implement regular, multidisciplinary, peer clinical practice review of selected procedures and interventions on a case-by-case basis, such as indications for repeat cesarean and elective induction and nonmedical primary cesarean, to promote accountability and align evidence and practice by evaluating decision making.
- Implement multidisciplinary team training programs that include drills, simulation, interdisciplinary problem solving, and communication training to safely offer controversial practices that are supported by high-quality evidence, including planned VBAC, vaginal breech, and vaginal twin birth; vacuum extraction and forceps; and intermittent auscultation. Include physician and non-physician maternity caregivers, and anesthesia, pediatrics, and risk management professionals.
- Institute benchmarking programs to identify and move toward safe, achievable target rates of VBAC, vaginal twin and vaginal breech births, labor induction, and cesarean in low-risk, first-time mothers. Educate health professionals and child-bearing women, identify best practices for achieving these goals, and publicize innovation and success. Learn from successful programs, such as the NNEPQIN.
- Develop and implement training programs for maternity nurses and primary maternity caregivers to learn skills to provide comfort and promote labor progress through effective low-technology and nonpharmacologic measures.
- Assess the impact of “laborists” (health professionals who provide hospital-based maternity care only) on access to VBAC, vaginal breech and vaginal twin birth; rates of elective induction and nonmedical cesarean section; and experience of childbearing women and caregivers.
- Improve the capacity of hospitals and health systems to meet the needs of women in their communities who face controversial clinical scenarios by learning their concerns through focus groups or meetings with representatives. Engage communication specialists to help develop shared language, decision tools, and processes to improve communication around care transitions.
- Improve the capacity of community health systems to meet the needs of women who make an informed choice of planned home birth. Carry out community focus groups that include providers, women and their families, and facility staff to discuss ways to improve the safety of the home birth care continuum.
- Improve cooperation between hospital systems and home birth providers. Pilot the formation of cooperative maternity care teams to ensure effective coordination across settings and providers and collaborative management of out-of-hospital birth when indicated for optimum care and safety. Include emergency transport providers in the planning process to facilitate transitions and assure patient information transfer and support.

3. At the macro environmental level, institute legislative and policy initiatives, payment incentives, and liability protections to foster access to a full range of care options for labor and birth supported by evidence.

- Develop the capacity of consumers and advocates to engage in policy forums and support reforms that foster provision of appropriate care. Model initiatives on the National Breast Cancer Coalition's Project LEAD advocacy training programs.
- Develop and implement national standardized performance measures for controversial practices. Use these measures to encourage clinicians and facilities to retain skills and provide access to forms of care that are supported by evidence but are underused and inconsistently supported by health professionals and facilities.
- Support guaranteed adequate payment for primary maternity care at a rate of not less than 100% of fees for specialists reimbursed for providing similar services.
- Support guaranteed adequate payment for birth centers at a rate of not less than 100% of reimbursement levels for equivalent codes in hospitals.
- Amend the Social Security Act/Medicaid and Federal Employees Health Benefit Plan to include reimbursement of birth centers and midwives with nationally recognized credentials. Include birth centers in the federally-qualified community health center law.
- Provide state policy makers with the best available evidence about nationally credentialed midwives and freestanding birth centers to support regulation and appropriate reimbursement of these forms of care.
- Increase salaried positions for maternity caregivers to remove some incentives for overuse of procedures that are not medically indicated.
- Develop ethical payment incentives for consumers (e.g., reduced co-pay or co-insurance) that discourage or prevent elective induction of labor and cesarean on demand.
- Develop CPT codes to allow billing for supportive, low-technological management strategies for labor and birth, such as hydrotherapy and doula care, to reduce financial incentives for intervention in physiologic childbirth.
- Assess the impact of liability reforms on access to services for controversial clinical scenarios, including:
 - Premium discounts in exchange for implementing safety training to improve outcomes of controversial services.
 - Equal access to liability insurance for all midwives with nationally recognized credentials.
 - Regulatory and other options for prohibiting or discouraging insurers from limiting practice supported by best evidence.
 - Enterprise liability programs that relocate responsibility from individuals to systems.
 - Professional liability self-insurance programs.
 - Allowing adherence to evidence based practices as affirmative defense in the event of an adverse outcome.

Lead Responsibilities

Transparent multi-stakeholder processes are needed to address clinical controversies. Relevant stakeholders include the full range of clinicians who provide maternity care and their professional organizations, epidemiologists and researchers, hospitals and health systems, administrators, consumers and advocates, and federal and state agencies.

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