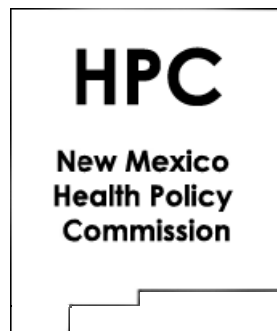


NEW MEXICO HEALTH POLICY COMMISSION



HOUSE JOINT MEMORIAL 7 *“CONTINUE OBSTETRIC HEALTH CARE TASK FORCE”*

A Report to the Legislative Health and
Human Services Committee

November 2009

THE NEW MEXICO HEALTH POLICY COMMISSION

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EXECUTIVE SUMMARY

The cost of malpractice insurance for medical providers continues to escalate in New Mexico and across the nation. This cost escalation threatens access to childbirth services for some New Mexico residents as costs of insurance threaten the financial viability of obstetrical providers, especially nurse midwives. As a result, the New Mexico State Legislature appropriated \$30,000 in 2006 and \$20,000 in 2007 to the New Mexico Health Policy Commission (HPC) to study alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of professional liability insurance for childbirth health care professionals and institutions.

In 2008, the New Mexico State Legislature passed Senate Memorial 1 (SM1) and House Memorial 9 (HM9), requesting the continuation of the task force investigating obstetric health care practitioner liability insurance.

Again in 2009, the New Mexico State Legislature passed House Joint Memorial 7 (HJM7) requesting the HPC to continue the task force on obstetric health care practitioner liability insurance and to expand the scope of the task force to include evidence-based maternity care, including a literature review on an October 2008 study entitled, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*.

From 2006 to 2008, recommendations have been developed, expanded, and presented by the task force in two previous memorial reports. Therefore, the HPC determined that this study would be conducted in the form of a white paper presenting task force findings and recommendations from previous years, an update on what has occurred since the task force last convened and additional information regarding evidence-based maternity care as requested in the 2009 HJM7.

The following are long and short-term recommendations made by the task force and presented, in greater detail, in the 2008 SM1/HM9 memorial report:

Long-Term Recommendations:

1. Define the design and implementation plan for an obstetric administrative compensation system to be completed within one year.
2. Investigate the relevance and feasibility of New Mexico's participation in the federally certified Patient Safety Organizations (PSOs).
3. Reduce legal barriers to clinical and facility level patient safety initiatives in New Mexico.
4. State policy on universal health care, as it is developed, should incorporate and prioritize access to physician and midwife patient care teams within New Mexico communities and include optimal patient safety safeguards and equitable compensation.

Short-Term Recommendations to Maintain Interim Obstetric Services Supply:

1. Continue and expand the Birthing Workforce Retention Fund (2008 HB 167) from \$44,000 in fiscal year 2009 to \$90,000 in fiscal year 2010.
2. Increase Medicaid reimbursement rates for New Mexico licensed providers of obstetric care, indexed to liability insurance rate increases and rural practice volume considerations.

For more detailed information regarding task force findings and recommendations, the 2007 and 2008 memorial reports may be accessed at www.hpc.state.nm.us.

Subsequent to the presentation of the above mentioned recommendations to the New Mexico Health and Human Services Interim Committee, a working group was formed from task force members. According to the working group, the increasingly challenging economic picture in the state, in addition to political opposition, ended their attempts to obtain funding for a demonstration design for improved risk management and patient compensation systems by the New Mexico State Legislature.

The working group has since accepted an offer of technical assistance from the Common Good Foundation. In addition, the group gained an institutional presence within the University of New Mexico School of Medicine's Center for Development and Disability as it began its next organizational phase. In August of 2009, an application for 501(c)3 status was filed with the IRS to recognize the "New Mexicans for Childbearing Safety and Patient Access to Care" as a non-profit organization.

Evidence Based Maternity Care¹

HJM7 requests that the HPC conduct a literature review on an October 2008 study entitled, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*.

The report indicates that effective maternity care with least harm is optimal for childbearing women and newborns. According to the report, evidence-based maternity care uses the best available research on the safety and effectiveness of practices to help guide maternity care decisions and to facilitate optimal outcomes in mothers and newborns.

The report indicates that practices with established or possible adverse effects should be avoided when the best available evidence does not identify any clear anticipated benefits to justify their use. In addition, an evidence-based framework questions the use of interventions that have little expected benefits and are outweighed by the risk of established harm.

¹ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

According to the report, many maternity practices that were originally developed to address specific problems are now commonly and even routinely used in healthy women. Such practices include labor induction, epidural analgesia, and cesarean section. These interventions are often used without consideration of alternatives; involve numerous co-interventions to monitor, prevent, or treat side effects; are associated with risk of maternal and newborn harm; and greatly increase costs.

The report presents alternative practices that are found to have little or no known adverse effects and indicates that such practices are underutilized. Such practices include prenatal vitamins, smoking cessation interventions, measures for preventing preterm birth, hands-to-belly maneuvers to turn fetuses to a head-first position before birth, continuous labor support, numerous measures that increase comfort and facilitate labor progress, nonsupine positions for giving birth, delayed cord clamping, and early mother-baby skin-to-skin contact. The report states that providing these forms of care would lead to improved outcomes for many mothers and babies.

According to the report, efforts to increase access to evidence-based maternity care should address barriers to quality improvement. Such barriers include:

- Lack of a set of robust maternity performance measures with buy-in of key stakeholders to use them for measuring, reporting, rewarding, and improving performance;
- Perverse incentives of payment systems;
- Adverse effects of the malpractice system;
- Primary reliance on specialists for providing maternity care to a predominantly healthy, low-risk population;
- Limited reliance on best evidence in leading guidelines for maternity care;
- Loss of core childbearing knowledge and skills among health professionals;
- Limited attention to harms and iatrogenesis;
- Challenge of translating research into practice;
- Adverse effects of pressure from industry;
- Inadequate informed consent processes and women's lack of preparation for making informed decisions; and
- Limitations of views put forth in media and popular discourse.

Further, the report provides recommendations in order to foster the increased provision of evidence-based maternity care. These recommendations include:

- Increase awareness about concerns with the present maternity care system and knowledge of evidence-based maternity care by educating and advising the range of stakeholders.
- Support research to further evidence-based maternity care.
- Reform the current reimbursement system to promote evidence-based maternity care and involve federal and state payers and private insurers.
- Require performance measurement, reporting, and improvement.

INTRODUCTION

The cost and availability of professional liability insurance policies for physicians, nurse midwives and institutions are critical factors in recruiting and retaining obstetrical health care professionals. However, the cost of malpractice insurance for medical providers continues to escalate in New Mexico and across the nation. This cost escalation threatens access to childbirth services for some New Mexico residents as costs of insurance threaten the financial viability of obstetrical providers, especially nurse midwives.

While this problem exists throughout the state, it has particularly impacted rural obstetrical providers leaving fewer care options available to many residents of rural New Mexico. The state is already experiencing a health care professional workforce shortage, and this problem is contributing to a more severe shortage.

In addition, New Mexico's continued ranking of last in the nation when measuring access to prenatal care in the first trimester and the absence of any intervention may leave New Mexican's with poorer access in the future. These trends could easily develop into an access crisis at a time when policy makers are attempting to remove other access barriers via universal health insurance coverage.

Although data indicate a worsening financial position for many obstetrical providers in the state primarily due to increasing professional liability premiums, data also show that New Mexico's birth morbidity and mortality rates are below that of the nation and that the outcomes of care delivery are largely positive compared with the nation.

This may be related to the fact that New Mexico also has the highest rate of midwife use in the nation with midwives providing services in the more rural parts of the state. Professional liability insurance is available to certified nurse midwives (CNMs) in New Mexico, but primarily from one company, whose rates are unregulated, and at a cost that is rapidly increasing. Note though that, professional liability insurance is not available to licensed midwives (LMs) who provide care for the majority of births that occur in New Mexico homes.

BACKGROUND

The New Mexico State Legislature appropriated \$30,000 in 2006 and \$20,000 in 2007 to the HPC to study alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of professional liability insurance for childbirth health care professionals and institutions.

As a result of the 2006 appropriation, the HPC formed a task force, which included representatives from the HPC, Insurance Division of the Public Regulation Commission, Department of Health, University of New Mexico (UNM) School of Nursing, UNM School of Medicine, and UNM Institute of Public Law. Representation included certified nurse midwives (CNMs), obstetricians, attorneys, physicians, and a lobbyist. The goals of the task force were to:

- Develop policy options regarding obstetrical liability to minimize birth injury;
- Provide a compensation strategy and system to individuals injured during childbirth; and
- Reduce the escalating cost of professional liability insurance for New Mexico's obstetrical professionals.

The task force examined existing models of insurance and patient safety, particularly with CNMs who are increasingly unable to purchase professional liability insurance at affordable rates. The ultimate objective was to propose legislative remedies to this developing problem in New Mexico.

The initial activities of the task force consisted of compiling New Mexico specific data about the number of births, the number of obstetrical providers, the extent of injury suffered during childbirth, and the professional liability coverage situation of midwives and obstetricians.

An extensive literature review was performed and a "mini-library" was developed that could be electronically accessed by all members of the task force.

In addition, the task force conducted a survey of New Mexico licensed CNMs to obtain information regarding their practice organization's handling of professional liability insurance and individual issues associated with the cost and availability of professional liability insurance.

The task force initiated contracts with the UNM Institute of Public Law for legal review of anti-donation clause issues associated with any state financial support that might be required on an initial and/or ongoing basis to develop a re-insurance proposal and an alternative compensation system. The task force also worked with the UNM Center for Development and Disability to update midwife insurance information availability.

In 2008, the New Mexico State Legislature passed Senate Memorial 1 (SM1) and House Memorial 9 (HM9) requesting the continuation of the task force investigating obstetric health care practitioner liability insurance. Twenty-two individuals participated in the task force. These individuals included CNMs, physicians, nurses, administrators, insurance specialists, lawyers, educators, and others.

A primary activity of the 2008 task force was to facilitate discussion on the costs of tort-based liability and safeguarding patient safety. This activity was accomplished by:

- Expanding the original task force;
- Holding an invitational symposium that brought together representative providers of New Mexican obstetric care;
- Facilitating an obstetrician-gynecologist (OB/GYN) physician conference call.
- Hosting a town hall meeting; and
- Conducting a physician survey to 142 OB/GYN physicians;

With the \$20,000 appropriation to the HPC in 2007, the task force organized and hosted the *Solutions for Survival Symposium* on May 16, 2008. The symposium enabled 44 private and institutional obstetrical providers and professionals to discuss shared challenges in providing obstetric services and liability coverage in New Mexico.

The keynote symposium speaker, Michelle Mello, J.D., Ph.D., of the Harvard School of Public Health, presented her research pertaining to the administrative compensation system. She further discussed the effect of the current tort-based patient injury compensation system.

On June 25, 2008, members of the task force and the New Mexico Medical Society conducted a conference call with private practice OB/GYN physicians. The purpose was to discuss and provide information relating to the challenges providers face as medical professional liability premiums continue to increase. In addition, the participants of the conference call had an opportunity to assess the recommendations of the task force.

On June 30, 2008, the *Childbirth Access and Professional Liability in New Mexico* town hall meeting was held. The town hall meeting provided for conversation specific to professional liability, administrative compensation systems, patient safety, and the birthing needs in rural and urban areas of New Mexico.

As an additional means of obtaining information, the task force surveyed OB/GYN physicians to obtain information related to each physician's practice and to determine the impact, if any, of the cost of professional liability insurance on their practice.

FINDINGS

From 2006 through 2008, the task force studied alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of professional liability insurance for childbirth health care professionals and institutions in New Mexico. Some of these findings are presented below.

The task force found the following regarding the tort-based malpractice approach and obstetrics in the state:

- The vast majority of medical injuries in the country as well as the vast majority of medical malpractice claims in New Mexico are not compensated or remedied through the tort system.
- The current tort system is slow, expensive, and tends to pursue those medical malpractice cases with a high potential for a large dollar verdict.
- Poor birth outcomes are rare, but have potential for the highest dollar verdicts, which cause increases in obstetrical malpractice insurance rates.
- Malpractice claim proceeds are the only current means to compensate birth injury.
- The negligence-based malpractice approach encourages wasteful “defensive” care practices and discourages proactive reporting of shortcomings that could contribute to service improvement.
- Florida and Virginia have had successful administrative “no-fault” systems for a small subset of childbirth outcomes. The systems encompass a very narrowly defined set of severe birth injuries and have had voluntary participation by providers. They have been difficult to evaluate because of the very narrow “carve out” and the potential for “cross-over” between administrative and tort remedies.

The task force found the following regarding the cost and availability of professional liability insurance for providers of obstetrical services in New Mexico:

- Problems with the cost and availability of medical malpractice insurance are experienced primarily by CNMs who provide obstetrical services and are not employees of large systems.
- The cost of CNM malpractice insurance to obstetrician practices that employ CNMs has increased substantially and may threaten the ability of practices to maintain CNMs as employees.
- Professional liability insurance is unavailable to licensed midwives who provide care for most of New Mexico’s home births. Those providers who perform home births do so at their own legal and financial risk.
- For licensed midwives (LMs) who work in birthing centers and CNMs in private practice or in small clinics, professional liability insurance is available from only one company, whose rates are unregulated, and at a cost that is rapidly increasing and threatens the ability of LMs and CNMs to stay in business.

- Professional liability insurance remains available in New Mexico, at a substantial though relatively stable cost, for most independent OB/GYNs and family doctors who perform deliveries.

The 2007 task force survey of New Mexico licensed CNMs indicated that the majority of CNMs were employees of physicians or corporation-owned practices, health systems or the state. For these individuals coverage was paid by a third party. However, 38 percent of survey respondents purchased individual policies. Findings indicated a crisis level impact on CNMs in private practice that purchased individual liability insurance policies. In addition, the survey indicated a challenge for physician practices from their own steady premium increases and the increases in premiums for their CNM employees. The data also showed a trend toward obstetrical providers becoming employees of hospitals, medical practices or the public sector, which was due in part to the increasing cost of professional liability insurance.

Community-based interviews and conversations with CNMs conducted by the task force confirmed that a very large and increasing portion of the obstetric workforce have become employees of corporate or public entities. Costs of individual liability policy premiums appeared to be a driving force in this trend.

The 2008 task force survey of New Mexico licensed OB/GYNS indicated:

- Decreasing obstetrical practices;
- Restricting care to certain high risk groups;
- Discontinuing the care option for vaginal birth following cesarean;
- Increasing cesarean births; and
- Practitioners leaving practice.

In addition, the 2008 *Solutions for Survival Symposium* participants concluded that:

- There is a shortage of obstetric providers in New Mexico, which is partially related to the cost of professional liability insurance and the threat of lawsuit;
- New Mexico obstetric providers are in an integrated system on a scale not experienced by the rest of the nation (CNMs deliver approximately 1/3 of the babies);
- Costs for New Mexico providers and hospitals have risen dramatically in recent years;
- Revenues and/or reimbursements are not adequate to address the higher costs; and
- Patient safety suffers as a result of the decline in the provider base.

Overall, the task force findings were that the lawsuit-based tort system that is focused on finding an individual who is negligent is often inadequate in identifying and correcting system-based problems. In addition, the tort-based system requires an expensive insurance-based protection for New Mexico licensed obstetric providers that encourages defensive practice, and does nothing to either deter negligent practice or

improve the patient safety environment. Additionally, the increasing practice of providers becoming hospital employees has intensified pressure on New Mexico hospitals, which comprise the essential safety net for the states' childbearing families.

The ultimate findings of the task force resulted in recommendations to the New Mexico State Legislature that a demonstration project be funded to design an administrative system for obstetric patient injury compensation, patient safety systems, and attention to effective discipline of licensed obstetrics if it were needed.

For more detailed information on these findings as well as additional findings, the 2007 and 2008 memorial reports may be accessed at www.hpc.state.nm.us.

RECOMMENDATIONS

The task force determined that the need to maintain access to obstetric providers in the state while system change design and implementation plans are developed will require both short-term and long-term recommendations. These recommendations, along with their rationales, are summarized below.

Long Term Recommendations:

1. Define the design and implementation plan for an obstetric administrative compensation system to be completed within one year. **(Legislation)**
 - The HPC or any relevant state agency will collaborate with the Insurance Division of the Public Regulation Commission, the Human Services Department, the Department of Health, and other appropriate agencies in the specifics of design and implementation of the new obstetric administrative system.
 - As the administrative system is designed, necessary data requirements for system implementation and evaluation not currently available through existing reporting systems will be identified by the HPC and regulatory or legislative remedies will be pursued.
 - An appropriation of \$75,000 is necessary for legal and policy consultations in the development of the implementation of an administrative obstetric compensation system.

The task force concludes that the costs of professional liability premiums and settlements for individual health professionals and institutions maintaining birthing units directly impacts patient safety. These factors contribute substantially to the inability to recruit and retain providers in smaller communities resulting in decreasing access. Defensive medicine that includes both increased operative deliveries and restricting delivery practice is linked to fears of liability claims and costs.

The proposed benefits of a structural change away from tort-based compensation and discipline outweigh the costs of maintaining the ongoing and current system. Benefits of an administrative compensation system include more predictable and leveling total costs of patient compensation, more compensation dollars going to patients, increased quality and decreased cost of care by eliminating defensive medicine-based practice pressures. Benefits for systems-based patient safety improvement efforts include replacing the shroud of silence and threat surrounding injury and error with learning organization approaches that use analytic and multidisciplinary practices to improve care safety and quality. Shifting the practice environment in these ways would reduce some barriers to rural practice and become a recruitment and retention strategy.

In summary, total costs for injury compensation would stabilize and ultimately decrease by shifting the system away from negligence-based criteria required to demonstrate malpractice toward a criteria of error “avoidability” in an administrative rather than tort model.

While the task force majority opinion is to recommend proceeding rapidly with design and implementation, further analytic program development is needed to develop specifics of an administrative compensation system design and implementation plan that will fit New Mexico’s health care environment. The HPC has accumulated expertise on the issue and is recommended to be the lead state agency to bring together necessary collaborators.

2. Investigate the relevance and feasibility of New Mexico’s participation in the federally certified Patient Safety Organizations (PSOs). **(Memorial)**
 - Assess existing PSO models and information about potential partnerships to provide a financial base for a New Mexico PSO.
 - In the event that a “health care administration” is established in New Mexico with oversight responsibility for state health entities, the task force recommends that reporting arrangements between the PSO and the “health care administration” be specified in recommendations about the selected model.
 - If the investigation reveals that pursuing a federally certified PSO is feasible and desirable, the task force recommends that the HPC pursue the full range of public and private funding for that purpose.

The benefits to New Mexico institutions, professionals and patients of having a federally qualified PSO are substantial and extend beyond childbearing. A PSO would provide anonymous and confidential analysis of errors and safety-related events and yield system level improvement-oriented feedback. While initial interest is strong, the cost of starting and building the capacity within the state is seen as prohibitive for any single entity. As a consequence the task force recommends assessment and recommendation

of feasible partnership models within and across states and across the public and private sectors.

3. Reduce legal barriers to clinical and facility level patient safety initiatives in New Mexico. **(Memorial)**

- Research structures in other states (including their PSOs) in order to create a central repository of closed obstetrical cases for learning purposes in New Mexico.
- Review existing New Mexico state laws, regulations, statutes, and precedents relating to protections of licensed providers and health care institutions from discoverability during structured peer review conducted for the purpose of patient safety system-based improvement and the obstacles to that protection.
- Consider appropriate legislative action to enhance provider and facility protection engaged in review of events or practices to improve health care practice and systems.
- Explore development and protections included in “Just Culture” type initiatives to further systems level improvements in the interest of patient safety in obstetrical systems in the state.

Over the past decade, analysis of error reduction and patient safety strategy has focused on creating conditions within health care organizations wherein errors and patient safety threats become objects of study, learning and quality improvement. Efforts of professional and organizational discussions and analyses are thwarted by the fact that these discussions are recoverable evidence subject to subpoena when a malpractice claim is being investigated. To the end of facilitating organizational and professional learning, these recommendations are designed to identify legal barriers to optimal institutional safety procedures and possible legislative remedies and facilitate a move toward creating a New Mexico closed claims repository for state-based learning. This research would serve dually as legal background for the implementation component of recommendation one.

4. State policy on universal health care as it is developed should incorporate and prioritize access to physician and midwife patient care teams within New Mexico communities and include optimal patient safety safeguards and equitable compensation.

The concerns of access and safety for childbearing New Mexicans and the need to stabilize and control the impacts of negative cost escalation on New Mexico institutions and health professions of insurance and compensation should be considered in concert with current state discussion of universal health care. Tort compensation by demonstrating malpractice is currently the only means of receiving needed health care for many injured citizens. Shifting to universal health care changes the motivators within the system and these policy changes should be considered concurrently.

New Mexico has model practice laws for both CNMs and LMs and has achieved multidisciplinary models that serve New Mexico communities and professionals well. The task force urges preserving and building upon the strengths of the multidisciplinary New Mexico obstetric services in moving toward future health care design.

Short-term Recommendations to Maintain Interim Obstetric Services Supply:

1. Continue and expand the Birthing Workforce Retention Fund (2008 HB 167) from \$44,000 in fiscal year 2009 to \$90,000 in fiscal year 2010. **(Legislation)**

Obstetrical provider supply continues to be inadequate and the state's communities cannot afford to lose further obstetrical health care professionals. One reason for practice closures is financial insolvency due in part to high rates of professional liability insurance premium increases. House Bill 167, passed in the 2008 legislature, created a fund to be used for relief for critical access obstetrical health professionals whose individual professional liability premium increase threatens their practice viability. Providing more funds as a stop gap measure during system redesign and implementation planning is critical.

2. Increase Medicaid reimbursement rates for New Mexico licensed providers of obstetric care, indexed to liability insurance rate increases and rural practice volume considerations. Minimally, the rate for obstetrical services should maintain current reimbursement formulas. **(Legislation)**

Reimbursement under New Mexico Medicaid for obstetrical services does not fully cover costs of providing obstetrical care. While Medicaid reimbursement increases were made in the 2008 legislature, the rate of increase has not kept pace with the cost increases in obstetrics. Additionally, rural practices of obstetrics and midwifery have special economies of scale issues that confront the rural obstetric provider. Volume of services per provider may be lower, yet costs of premiums (and other business costs) are not adjusted comparably.

NEW MEXICANS FOR CHILDBEARING SAFETY AND PATIENT ACCESS TO CARE

Subsequent to the 2008 SM1/HM9 memorial study, a working group was formed from the memorial task force. This working group does not include representation from the HPC. According to the working group, the increasingly challenging economic picture in the state, in addition to political opposition, ended their attempts to obtain funding for a demonstration design for improved risk management and patient compensation systems by the New Mexico State Legislature.

The working group has since accepted an offer of technical assistance from the Common Good Foundation. In addition, the group has gained an institutional presence within the University of New Mexico School of Medicine's Center for Development and Disability as it began its next organizational phase.

In August of 2009, an application for 501(c)3 status was filed with the IRS to recognize the "New Mexicans for Childbearing Safety and Patient Access to Care" as a non-profit organization. The ultimate goal of this organization is to encourage an optimal system for combining patient safety reforms with a more just and sustainable system of obstetric provider risk management.

While the IRS application is pending, the organization is currently registered with the New Mexico Attorney General's Office as well as the Public Regulation Commission as a charitable organization within the state.

When the process of recognition is complete, the New Mexicans for Childbearing Safety and Patient Access to Care plan to seek appropriate funding to move forward in their work. In addition, a partnership with the University of New Mexico, Bureau of Business and Economic Research has produced a plan to fund an update on the data within the state on the organization's issues.

The New Mexicans for Childbearing Safety and Patient Access to Care note that there has been discussion from President Obama regarding non-lawsuit based approaches to improve health care. The organization believes that the timing is right for New Mexico to be a leader in this endeavor.

EVIDENCE-BASED MATERNITY CARE²

The October 2008 report entitled, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* concludes that maternity care can be significantly improved by using evidence-based practices. According to the report, evidence-based maternity care uses the best available research on the safety and effectiveness of practices to help guide maternity care decisions and facilitate optimal outcomes in mothers and newborns. Evidence-based maternity care gives priority to care practices that are effective and least invasive, with limited or no known harms whenever possible.

The report indicates that practices with established or possible adverse effects should be avoided when the best available evidence does not identify any clear anticipated benefits to justify their use. In addition, an evidence-based framework questions the use of interventions having marginal expected benefits that are outweighed by the risk of established harm.

In addition, the report presents basic principles for determining what constitutes best available evidence. The following principles are discussed in further detail in the report.

- Question common assumptions. Maternity care practices based on the opinions of experts, the general public or on tradition are unreliable guides for decision making. Often, they do not reflect the best current research and could lead to inadequate care, poor outcomes, and wasted resources.
- Know that many studies of interventions are unreliable guides for decision making. Careful evaluation of the quality of research using “critical appraisal” skills is essential. Many studies are flawed or limited in scope and do not provide valid answers to key questions.
- Look for the “gold standard.” When available, well-designed and well-conducted systematic reviews of research should inform maternity care decisions. If systematic reviews are not available, well-designed and well-conducted studies with randomized controlled trial designs can provide the most valid answers to many questions.
- Make informed decisions that consider evidence about safety and effectiveness and the values and circumstances of individual childbearing women. When making maternity care decisions, it is crucial to consider the best available evidence as well as values, preferences, and individual circumstances of childbearing women who have been supported to understand such evidence. It is also important to consider the options within specific care settings, such as the skills of caregivers and available forms of care.

² Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

- Beware of misleading claims. There is growing recognition of the value of evidence-based care; however, it is important to be cautious of information describing “evidence-based” products and services that may not in fact reflect such principles.

Overused Interventions³

According to the report, many maternity practices that originally developed to address specific problems are now commonly and even routinely used in healthy women. Overuse of such practices exposes mothers and babies to risk of harm and has little or no medical benefit. These practices include induction, epidural analgesia, and cesarean section, which have all increased considerably in use over the past decade in the United States.

Labor Induction⁴

Labor Induction is the use of drugs and/or techniques to cause labor to start rather than waiting for labor to begin on its own. Studies indicate that medically induced labor increased by 135 percent from 9.5 percent of all women giving birth in 1990 to 22.3 percent in 2005.

According to the report, the national *Listening to Mothers II* survey indicates the most common reasons for labor induction. They reported a caregiver’s concern that the baby was overdue (25 percent), a maternal health problem that called for quick delivery (19 percent), mother’s desire to end the pregnancy (19 percent), and a caregiver’s concern about the size of the baby (17 percent). Many women reported use of this intervention with no expectation of a medical benefit.

However, the report indicates that when mothers and babies are exposed to induction agents and techniques and shorter gestation without evidence that health benefits outweigh the risks, there are potential effects, including the following:

- Synthetic oxytocin, which is widely used to induce labor, interferes with the functioning of a woman’s own oxytocin receptors. This may adversely affect other important functions of a mother’s natural oxytocin release, such as reducing postpartum hemorrhage and contributing to attachment and the establishment of breastfeeding.
- Prenatal methods for estimating gestational age are imprecise and have a margin of error of up to two weeks; therefore, elective labor induction may lead to delivery at an earlier gestational age than intended.

³ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

⁴ Ibid.

- An evolving understanding of normal fetal brain development has shown major changes continuing through forty-one weeks of gestation, and there is uncertainty about how extrauterine brain development compares to intrauterine development during similar time periods from conception.
- Induction appears to increase the likelihood of cesarean in first-time mothers when the cervix is not ready for labor and at earlier gestational ages.

The report states that induction for convenience or for a medical indication that is not supported by clear evidence may be expected to offer minimal benefit at best. According to the report, studies indicate that induction of labor may also increase the likelihood of the following:

- Fetal monitoring;
- Epidural analgesia;
- Cesarean section in first-time mothers;
- Cesarean section when the cervix is not ready for labor;
- Assisted delivery (vacuum extraction or forceps);
- Postpartum hemorrhage and transfusion;
- Longer intrapartum period and longer postpartum stay; and
- Costs (with increases in multiple cost centers).

In addition, the report indicates that economic analyses have found that induction increases costs associated with childbirth. The costs are especially high for first-time mothers as opposed to experienced mothers when carried out at earlier gestational ages and when a woman's cervix does not show signs of readiness for labor. According to the report, one analysis showed that induction added an average of 11 percent to the cost of childbirth among low-risk women.

According to the report, 22 percent of *Listening to Mothers II* survey participants indicated that they themselves tried to naturally start their labor. The most commonly reported methods used for trying to bring on labor were:

- Walking/exercise,
- Sexual intercourse, and
- Nipple stimulation.

The most common reasons for attempting to bring on labor were:

- Fully elective - the desire to end the pregnancy;
- Desire to avoid a medical induction;
- Interest in controlling the timing; and
- Provider's concerns about a large baby.

The report indicates that 21 percent of these mothers attempting to bring on labor reported success in inducing labor.

Epidural Analgesia⁵

Epidural analgesia is a regional form of pain medication administered into the epidural space of the spinal cord. This is the most effective form of pain relief commonly available for use during labor. The rate of epidural use during labor has increased in recent years. According to the report, 76 percent of participants in the national *Listening to Mothers II* survey experienced epidural analgesia or the spinal variant in 2005.

However, the report indicates that labor epidurals alter the physiology of labor and increase the risk of numerous adverse effects including immobility, voiding difficulty, sedation, fever, hypotension, itching, longer length of the pushing phase of labor, and serious perineal tears. Fetal and newborn risks include rapid fetal heart rate, hyperbilirubinemia, increased workup for sepsis and administration of antibiotics (due to fever in mothers), and poorer performance on newborn assessment scales.

Co-interventions which may pose additional side effects are used to monitor, prevent, and treat the unintended consequences of the epidural. Continuous electronic fetal monitoring, intravenous infusions, and frequent blood pressure monitoring are standard precautions with epidural analgesia that would otherwise be unnecessary in healthy women. Women with an epidural are also more likely to experience bladder catheterization, synthetic oxytocin, medication for hypotension, vacuum extraction or forceps, and episiotomy.

In addition, epidurals substantially increase costs of childbirth due to the costs of purchasing, operating, maintaining, and providing this package of interventions. According to the report, one analysis indicated as much as a 32 percent increase in the cost of care among low-risk first-time mothers and a 36 percent increase in cost among low-risk experienced mothers.

The report indicates that *Listening to Mothers II* survey participants gave favorable ratings to several drug free pain relief methods. However, some were underutilized due to lack of access, high-quality information and other reasons:

- Tubs - 91 percent of the six percent that reported use of tubs indicated that they were very or somewhat helpful;
- Use of hot or cold objects – 81 percent of the six percent that reported use of hot or cold objects indicated that they were very or somewhat helpful;

⁵ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

- Showers - 78 percent of the four percent that reported use of showers indicated that they were very or somewhat helpful; and
- Birthing balls – 67 percent of the seven percent that reported use of birthing balls indicated that they were very or somewhat helpful.

Cesarean Section⁶

According to the report, delivery by cesarean section is a beneficial and even life-saving procedure for both mothers and babies in certain circumstances. Absolute indications for cesarean section include prolapsed umbilical cord (cord precedes the baby's head through birth passage), placenta previa (placenta has grown over the opening of the cervix), placental abruption (placenta has separated from uterus before birth of baby), and persistent transverse lie (fetus is fixed in a horizontal position).

However, the report notes that although rates of cesarean section are increasing in the United States, absolute indications for cesarean section apply only to a small proportion of births. According to the report, studies indicate that the rate of cesarean sections has increased from 20.7 percent in 1996 to 31.1 percent in 2006, and, in 2008, one in three mothers were estimated to have given birth by cesarean in the United States.

The report indicates that unnecessary planned prelabor cesareans or cesareans initiated during labor may have potential effects, including the following:

- When babies do not experience labor, they do not benefit from the physiologic changes that precede the spontaneous onset of labor to help clear fluid from their lungs, and from further clearance during the process of labor, which appear to protect against serious breathing problems in newborns with the sudden transition to extrauterine life.
- Following the sterile intrauterine environment, passage through the vagina increases the likelihood of newborn intestines being colonized with beneficial bacteria and reduces colonization with harmful bacteria, in comparison with cesarean delivery.
- Because methods of estimating fetal gestational age are imprecise, planned cesareans may lead to iatrogenic prematurity.
- Delivery by elective cesarean is consistently associated with increased risk of respiratory morbidity in near-term newborns and full-term newborns.

⁶ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

In addition, the report notes that the following short-term harms are more likely to occur with cesarean section:

- Maternal death,
- Emergency hysterectomy,
- Blood clots and stroke,
- Surgical injury,
- Longer hospitalization and more likely rehospitalization,
- Infection,
- Poor birth experience,
- Less early contact with babies,
- Intense and prolonged postpartum pain,
- Poor overall mental health and self-esteem, and
- Poor overall functioning.

According to the report, cesarean born babies were more likely than vaginally born babies to experience:

- Respiratory problems,
- Surgical injuries,
- Failure to establish breastfeeding, and
- Asthma in childhood and adulthood.

The report also identifies many adverse effects impacting a woman's future reproductive life and mothers and babies in future pregnancies, including a greater likelihood of the following:

- Involuntary infertility,
- Reduced fertility due to decreased desire to have more children,
- Cesarean scar ectopic pregnancy,
- Placenta previa,
- Placenta accrete,
- Placental abruption,
- Uterine rupture,
- Hemorrhage,
- Low birthweight,
- Preterm birth,
- Stillbirth, and
- Maternal death.

According to the report, studies indicate that the likelihood of many of these conditions was found to increase as the number of previous cesareans increased.

In addition, the report indicates that the average hospital charge for an uncomplicated cesarean is almost twice as high as the average hospital charge for an uncomplicated

vaginal birth. The average charge for an uncomplicated cesarean is about seven times the average charge for a physiologic vaginal birth, as carried out in out-of-hospital birth centers across the country.

The report provides the following strategies found to reduce the likelihood of cesarean section:

- In clinical settings, multifaceted interventions, including audit and feedback.
- For pregnant women, providing access to and seeking settings and caregivers with conservative practice styles and low overall rates of cesarean section.
- For women in labor, working with caregivers to delay going to the hospital until labor is well established.
- For women in labor, having a companion (such as a doula, friend, or family member) who is not a member of the hospital staff and is present during labor exclusively to provide continuous support.
- For maternity care providers, applying skills to facilitate vaginal birth, including a broad range of strategies that foster progress and comfort during labor, manually turning babies that are not in a head-first position, skillful vaginal breech birth, skillful vaginal twin birth, and vaginal birth after cesarean.
- In facilities, avoiding, whenever possible, interventions that can increase the likelihood of cesarean section including continuous electronic fetal monitoring, labor induction (especially in first-time mothers with an “unfavorable” cervix), and early epidural.
- In facilities, limiting cesarean section to clearly established indications and addressing inappropriate use of unsupported indications, such as “large baby”, twin birth, preterm birth, and babies that are small for gestational age.

Underused Interventions⁷

According to the report, there are effective, noninvasive forms of care with little or no known adverse effects, and providing such care to childbearing women and newborns may lead to considerable improvement in outcomes. The report presents the following and other forms of care as underused interventions.

- Prenatal Multivitamins for Preventing Congenital Anomalies - Studies indicate that use of multivitamin supplements have proven protective against neural tube defects, cardiovascular defects, and limb defects.

⁷ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

- Smoking Cessation Interventions for Pregnant Women - Smoking cessation programs for pregnant women have been shown to reduce smoking and prematurity and to increase birth weight.
- Ginger for Nausea and Vomiting in Pregnancy - Evidence finds ginger to be helpful for nausea and vomiting in pregnancy, and no side effects have been identified to date.
- External Version to Turn Breech Babies at End of Pregnancy – Studies indicate that using hands-to-belly maneuvers to try to turn babies to a head-first position (external version) at the end of pregnancy succeeds in doing so in many instances and reduces the likelihood of cesarean section. Studies on the safety of this procedure indicate a low likelihood of adverse effects.
- Practices to Foster Women's Satisfaction with Their Childbirth Experience - Studies indicate that four conditions are most consistently associated with women's satisfaction with the childbirth experience: amount of support from caregivers, involvement in decision making, quality of mother-caregiver relationship, and having high expectations for the childbirth experience or experiences that exceeded those expectations.
- Continuous Labor Support - The continual presence of a labor companion who provides emotional support, comfort, and information has been found to offer important benefits to laboring women, in comparison with usual care. Benefits include reduced likelihood of the following interventions/conditions: pain medications, cesarean section, assisted delivery with vacuum extraction or forceps, and dissatisfaction with the childbirth experience. Such support also increased the likelihood of spontaneous vaginal birth.
- Measures to Relieve Pain, Bring Comfort, and/or Promote Progress during Labor - Studies have concluded that many women find several noninvasive methods of pain relief helpful during labor, including immersion in water, hypnosis, acupuncture, and intradermal sterile water injections for low back pain. Studies found that these measures increase comfort for many women, are associated with decreased use of medications, and appear to have excellent safety profiles.
- Delayed and Spontaneous Pushing – According to the report, hospital staff frequently coach women to push their babies out and direct them in forceful, sustained pushing as soon as a cervical dilation of ten centimeters is documented. Women with epidural analgesia who delay pushing have the opportunity for spontaneous descent of the baby, spontaneous rotation of the baby's head through the pelvic passage, and onset of the involuntary pushing reflex; additionally, the women are more likely to have a spontaneous vaginal birth with neither assisted delivery (vacuum extraction or forceps) nor cesarean section. In women without epidural analgesia, staff-directed pushing does not

appear to result in presumed benefits (such as shorter labor and improved fetal status) and instead appears to increase the likelihood of late fetal heart decelerations and the frequency and severity of perineal trauma in mothers.

- Nonsupine Positions for Giving Birth – Studies indicate that of women without epidurals, upright and side-lying positions are associated with less severe pain for mothers, less use of episiotomy, less use of vacuum extraction or forceps, fewer heartbeat abnormalities in babies, and a shorter pushing phase of labor. Further studies are needed to clarify the value of upright positions in women with epidurals.
- Delayed Cord Clamping in Full-Term and Preterm Newborns - According to the report, immediate cord clamping is standard procedure in U.S. hospitals. However, in term newborns, delaying cord clamping for a minimum of two minutes was associated with improved hematologic status, iron status, and iron stores, as well as reduced anemia, with benefits measured from two to six months after birth.

Factors Contributing to the Usual Patterns of Maternity Care⁸

According to the report, studies regarding the effectiveness of strategies for improving the quality of maternity care found consistent evidence that interventions identifying and addressing barriers to improvement are effective in improving care. The following are some of the leading factors contributing to the usual patterns of maternity care, which are presented in further detail in the report.

- Lack of a National Standardized Set of Maternity Performance Measures - Various entities have independently developed quality measures to assess the performance of health professionals, facilities, or health plans that provide maternity care. A national standardized set of perinatal measures has not been developed to assess and report performance. However, the National Quality Forum (NQF) is currently working with measure developers, prospective measure users, and other stakeholders to develop a standardized set of NQF-endorsed perinatal measures and to identify gaps in available perinatal measures.
- A Payment System That Incurs Perverse Incentives - The present system of payment for maternity care provides incentives for inappropriate care of healthy childbearing women. For example, maternity providers are paid a fixed fee for services. Payment is based on the portion of prenatal, labor and birth, and postpartum services the caregiver provides and the type of birth the patient had. Some fee schedules pay the same amount for vaginal and cesarean births, while many pay more for cesarean. In addition, a planned cesarean offers the

⁸ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

advantages of predictable scheduling and a short time commitment. This includes the ability to provide other reimbursable hospital and office services and gaining time for personal lives. Further, tightened reimbursement from payers and costly malpractice insurance premiums appear to cause providers to respond more directly to unintended payment system incentives than they did in the past.

- Malpractice Concerns – First, the liability system continues to uphold current standards of care and use of professional experts without regard to lessons from the best scientific research. Second, leading allegations in obstetric claims involve infant neurologic injury or stillbirth/neonatal death. Fear of high-cost awards to compensate families of children with disabilities appears to generate undesirable defensive behavior. Third, population-based studies that led to recognition of the high level of medical error in the United States clarified that maternity care involves a notable amount of negligent injury of newborns and especially of mothers. Fourth, implementing a culture of safety and quality and more cooperative methods for responding to concerns about error and injury may go a long way toward giving health care professionals and families who receive care increased confidence about the care that is delivered and may help limit adverse effects of the liability system. Fifth, care by midwives and in birth centers is often well-suited to childbearing women and can provide value to purchasers. Finally, maternity providers who have the relatively new certified professional midwife credential may have difficulty finding access to liability insurance products.
- Specialist Orientation Care Typical for Healthy, Low-Risk Mothers and Babies - Although most pregnant women in the United States are healthy and at low risk for complications, pathology-oriented and surgery-oriented obstetric specialists are the lead caregivers for women during both pregnancy and labor.
- Current Maternity Practice Guidelines Excessively Reliant on Opinion - A recent analysis of American College of Obstetricians and Gynecologists (ACOG) obstetrical practice bulletins published from June 1998 through December 2004 reported that a small proportion of the recommendations in the bulletins met high standards of evidence. Just 23 percent of obstetrics recommendations were Level A (“based on good and consistent scientific evidence”), whereas 35 percent were Level B (“based on limited or inconsistent scientific evidence”) and fully 42 percent were Level C (“based primarily on consensus and expert opinion”). Despite the weak foundation of guidelines from ACOG, the recommendations influence professional practice. To reduce risk of legal liability, providers may experience pressure to practice according to recommendations without good scientific support.
- Lack/Loss of Professional Core Knowledge/Skills for Optimal Childbirth - Support for physiologic labor is the safest care for healthy women experiencing normal labor. This is also the most economical care for purchasers of maternity services.

Most midwifery education programs offer an opportunity to observe physiologic childbirth and to learn about and become competent in supporting innate capacities of women and their fetuses/newborns. However, given current standards of practice, many physicians may have limited opportunities to observe and support physiologic childbirth during their education and beyond. Instead, first-line care often involves use of interventions such as synthetic oxytocin, epidural analgesia, and cesarean section.

- Knowledge Transfer and Application Challenging - It is difficult to stay abreast of and interpret the growing body of research on pregnancy and childbirth. There are far more Cochrane reviews for this clinical area than any other in addition to a large number of pregnancy and childbirth systematic reviews from other sources.
- Pressure from Industry - Drugs, devices, and other products with commercial value are more likely to be evaluated, adopted into practice, and promoted than simpler measures with little or no commercial value.
- Informed Consent Processes Often Inadequate - Studies of decision making in maternity settings consistently raise concerns about the adequacy of informed consent processes. In recent national surveys, virtually all women expressed the desire to know all or most of the complications of labor induction, epidural, and cesarean before deciding to undergo such procedures; however, mothers displayed poor knowledge of their actual side effects, whether they had experienced the specific intervention or not.
- Media Depiction of the Childbirth Experience Often Limited - It is difficult for journalists, the general public, and childbearing women themselves to understand the nature, extent, and causes of the evidence-practice gaps in maternity care. However, there is little other frame of reference for all stakeholder groups than the usual pattern of care.
- Increased Harm/Expense and More Entrenched Problems to Result If Policy Intervention Delayed - First, loss of skills and knowledge among maternity professionals is a serious concern. Younger professionals have fewer core skills for supporting childbearing women than those nearing retirement. Second, as standards of maternity care and the culture of maternity care shift, fewer professionals, administrators, policymakers, journalists, and women themselves have a frame of reference for what is appropriate care, and it is becoming difficult for all stakeholder groups to know what care is possible and optimal and to provide and seek such care. Finally, altering the present course can result in unintended downstream consequences. The rising rate of first-time cesareans and the increasing trend for repeat cesareans have health risk implications that will play out over a long period of time. With growing use of labor induction and cesarean section, hospital maternity units are reconfiguring to accommodate more surgeries, more labor and birth services scheduled during weekday hours,

and more postpartum beds due to longer postsurgical lengths of stay. Supplier-induced demand is likely to occur after hospitals make these costly capital investments and become dependent upon the increased revenue from cesarean as opposed to vaginal birth.

Recommendations⁹

The report provides the following recommendations in order to foster the increased provision of evidence-based maternity care:

1. Increasing the knowledge and use of evidence-based maternity care by educating and advising a wide range of stakeholders. These stakeholders include state and federal policymakers in legislative and executive branches, health professionals and health profession educators, hospital and health plan administrators, insurers, employers, researchers, childbearing women and their families, consumer advocates, and journalists.
2. Supporting research to further evidence-based maternity care.
3. Reforming the current reimbursement system to promote evidence-based maternity care and extending payment reform to all payers, including private insurers.
4. Requiring performance measurement, reporting, and improvement.

These recommendations are discussed in further detail in the report (See Appendix B).

⁹ Childbirth Connection. (October 2008). *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. Retrieved 10/5/09 from <http://www.childbirthconnection.org/article.asp?ck=10575>

Appendix A

Appendix B
