SB

22

SFIN

FILE

REPORTED OUT
MAY 3 2005
SENATE FINANCE COMMITEE

SENATE FINANCE COMMITTEE REPORT

DATE: 2/4/05

FURTHER:

DATE TURNED IN TO OFFICE: 5/3/05

Finance Committee considered SENATE BILL NO. 22

SB 22 MEDICAID COVERAGE FOR BIRTHING CENTERS

"An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

and recommends:

[✓] be **replaced** with _____ **CS** SB 22 (FIN)

[ ] adopt **previous** _____ **CS** CS forthcoming _____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[✓] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#
HSS	4/28/05			✓	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
	✓			
			✓	
	✓			
			✓	
COCHAIR: Gary Wilken	✓			
COCHAIR: Lyda Green	✓			

REPORTED OUT

MAY 3 2005

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB022-DHSS-HCS-REVISED-04-28-05
( ) Publish Date:

Revision Date/Time (Note if correction): Rev 4/27/05 12:30p
Dept. Affected: Health & Social Services

Title: ADDING BIRTH CENTERS TO FACILITIES PAID BY MEDICAID
RDU: Health Care Services
Component: Medicaid Services

Sponsor: DAVIS
Requester:
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

There is a great deal of uncertainty in calculating the cost differential between birth center and hospital births. There are potential savings and costs, but with the large number of variables involved, we cannot determine the net amount. Therefore, the fiscal note is for zero dollars. The number of Medicaid eligible women who might choose a birthing center instead of a hospital is unknown. In Alaska, about 2% of all births occur in a birthing center compared to less than 1% nationally. The rate of Medicaid deliveries in birthing centers would probably be lower than the statewide rate since birthing centers do not provide adequate care for high-risk pregnancies. Medicaid babies are generally the most at-risk because of their circumstances. An independent study found that the facility cost for a birthing center delivery is about 22% less than a hospital. The cost savings for 100 births is approximately $40,000.00.

(Continued on page 2)

Prepared by: Janet Clarke, Assistant Commissioner — Phone 465-1630
Division: Finance and Management Services — Date/Time 03/30/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 04/28/2005
Agency: Department of Health and Social Services

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB022-DHSS-HCS-Revised-04-28-05

ANALYSIS CONTINUATION

If a serious complication resulted in the mother's or baby's transfer to a hospital, there would be additional costs which would reduce and possibly offset any savings. The birthing center would still be paid it's facility fee and the hospital would be paid a facility fee as well. Additionally, if emergency transport was required, those costs would have to be factored in. In contrast, a hospital birth with serious complications would not incur the birthing center fee or the transport fee.

There is a question whether birthing centers are an allowable federal Medicaid service. If birthing centers do not qualify for Medicaid reimbursement, the cost would be all GF. If they do qualify, the regular matching rate would apply.

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

FAX COVER SHEET

DATE: 3May2005 TIME: 10:55am

TO: Legal Services

NUMBER OF PAGES, INCLUDING COVER SHEET: 1

FROM: MINDY ROWLAND
SENATE FINANCE COMMITTEE SECRETARY
PHONE: 465-4935
FAX: 465-2187

NOTES: Final Please
CS SB 22 (FIN) 24-LS0209\F
Mischel 4/25/05

no changes

Thx
mmj

ADOPTED

24-LS0209\F
Mischel
4/25/05

CS FOR SENATE BILL NO. 22(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS AND DYSON

A BILL

FOR AN ACT ENTITLED

"An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.07.900(11) is amended to read:

(11) "health facility" includes a

(A) hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic; **and**

(B) birthing center if birthing centers are authorized for coverage under the state plan approved under AS 47.07.040 by the United States Department of Health and Human Services;

SENATE FINANCE COMMITTEE

5/3/2005 COMMITTEE ACTION

Bill Number	SB 22			
Amendment				
Motion	to adopt Version "F"			
Motion by	Wilken			
Objection by				
Removed				
Second Objection by	No objection			
Committee Member	Y	Vote	N	
Senator Hoffman				
Senator Olson				
Senator Stedman				
Senator Bunde				
Senator Dyson				
Co-Chair Wilken				
Co-Chair Green				
Tally				
Yea				
Nay				
Absent				
MOTION	Passed			

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Memorandum

To: Senator Lyda Green, Senate Finance Co-Chair

From: Senator Bettye Davis

Date: May 2, 2005

RE: Senate Bill 22

Since the original hearing on this bill in Senate HESS, the following information has been gathered and presented in this form for your information and use:

Senator Murkowski has received correspondence from constituents who are interested in the passage of SB 22. She has received the following information from the Congressional Liaison Office of Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), which she is sending to the constituents:

Medicaid does not provide reimbursement of stand-alone birthing centers. They are not a 1905 recognized provider. Medicaid does reimburse nurse-midwives. However, the state can authorize a higher reimbursement to midwives who can then split their fee with their facility. Payment must be recognized to be on behalf of the recognized provider -- the midwife.

Nurse mid-wife services are recognized under section 1905(a)(17) of the SSA.

In general, states determine provider reimbursement rates but they must meet the payment requirements of section 1902(a)(30(A) which requires that payments are consistent with efficiency, economy, and quality of care.

While CMS wouldn't match payments above a provider's actual costs, we would recognize the costs to the nurse midwife of providing services in a birthing center, which might include the administrative, and other reasonable costs associated with practicing in these centers, thus the higher reimbursement rate.

I feel this could be a positive methodology in order to accomplish the desired result. I would like to see the department look into this possibility.

The following figures illustrate the state's likely cost savings by passing SB 22, making birth center facility fees a qualified expense under Medicaid. Based on testimony from the Department of Health & Social Services, these numbers assume the federal government will refuse to participate, requiring the state to pay the facility fee from state funds. Although this does not take into account the raising of Midwives' fees, the state still saves money.

Birth Center Costs:

Facility	City	Cost of care	Facility Fee	Newborn Care	Grand Total
The Midwives BC	Anchorage	$3665	$1200	$390	$5255
Geneva Woods BC	Anchorage	$4225	$1500	$610	$6335
AK Family Health & BC	Fairbanks	$4220	$1600	$615	$6435
Juneau Family BC	Juneau	$4200	$1800	$818 5 exams	$6818
Mat-Su Midwifery	Wasilla	$4251	$1800	$517	$6568
Woman's Way Midwifery	Soldotna	$3400	$1250	$650	$5300
Frontier Midwifery	Soldotna	$3650	$1200	$580	$5430

"Cost of care" includes prenatal, postpartum, and birth charges. It excludes labs. "Newborn Care" includes immediate care at delivery and four newborn exams, except where noted.

MD/OB Costs:

City	MD/OB Cost	Notes
Anchorage	$5100	
Anchorage	$4600	Includes postpartum
Anchorage	$4358	
Wasilla	$3700	Includes postpartum
Wasilla	$3685	7-9 prenatal visits
Soldotna	$3082	
Soldotna	$2940	Includes labs and ultrasound
Homer	$2940	

Except where noted, "MD/OB costs" include 10 prenatal visits, but do not include labs, postpartum maternal care, or immediate (at delivery) newborn care.

Hospital Costs:

City	Cost of 1 day stay	Routine Nursery Care	Epidural
Anchorage	$4000		$2000
Anchorage	$3932	$575 per night	
Fairbanks	$3200	$900-$1800	$3200
Juneau	$3200 (approx)		
Soldotna	$5000-$7000	$1800-$2500	

These numbers understate hospital birth costs by excluding charges such as oral or topical pain medications, episiotomy, perineal repair, fetal monitoring, or hospital materials charges (e.g.: gloves, gauze, sterile bedclothes, etc). Birthing centers either do not perform or do not charge separately for these.

Grand Totals and cost to the state:

City	Hospital Grand Totals (low)	Hospital Grand Totals (high)	Hospital Medicaid (GF only) low	Hospital Medicaid (GF only) high	Bcenter Medicaid (GF only) low	BCenter Medicaid (GF only) high
Anchorage	$9,365	$10,175	$4,683	$5,088	$3,228	$3,918
Fairbanks	$8,585	$9,500	$4,293	$4,750	$4,018	
Juneau	$8,285	$9,200	$4,143	$4,600	$4,309	
Wasilla	$9,017	$10,000	$4,509	$5,000	$4,184	
Soldotna	$10,240	$13,082	$5,120	$6,541	$3,275	$3,315

Chart assumes a 25% epidural rate in hospitals. National average is 40% for small hospitals, 66% for large.
Where epidural cost is not available for a city, the Anchorage rate was used.
Where any other cost was unavailable for a given city, the statewide median was used.

Chart assumes the federal government pays 50% of all hospital charges
Chart assumes the federal government pays 50% of all birthcenter charges except the facility fee, in which the federal government may not participate. This chart therefore assumes birthcenter facility fees are 100% GF.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148
Toll free: (800) 770-3822

Session: (Jan - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 22

"An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

Sponsor Statement

Currently in Alaska, Medicaid does not cover licensed birthing center facility fees, often forcing pregnant women to choose a hospital birth where costs to the state are significantly greater than those at a birthing center. The average cost from four hospitals in Anchorage, Fairbanks and Juneau of a "natural" birth is $3,667.00. This figure does not include epidural anesthesia or the use of pitocin to enhance the strength of labor, internal fetal monitoring and forceps or vacuum assisted deliveries. A cesarean section on average would cost an additional $4,385.75. The facility fees for three birthing centers in Alaska averages $1,400.00.

If birthing center facility fees were to be reimbursed by Medicaid or Denali KidCare, the option of a birth center birth could be made available to even more women. It's a logical step towards saving the state money and allowing families on the Denali KidCare program to choose their preferred location to give birth. I urge you to support the passage of this legislation

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

THE BIRTH CENTER EXPERIENCE

Birth Centers Lead Cost Containment Efforts While Providing Quality Care

> *"Few innovations in health service promote lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety. The results of this study suggest that modern birth centers can identify women who are at low risk for obstetrical complications and care for them in a way that provides these benefits."*
>
> New England Journal of Medicine, 12/28/89

What is a birth center?

- The birth center is a homelike facility, existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth.
- Birth centers are guided by principles of prevention, sensitivity, safety, appropriate medical intervention, and cost effectiveness.
- Birth centers provide family-centered care for healthy women before, during and after normal pregnancy, labor and birth.

What is the birth center experience?

- The quality of care in birth centers reported in the "The National Birth Center Study" reflects the low overall intrapartum and neonatal mortality rate of 1.3/1000 births; 0.7/1000 if lethal anomalies are excluded. These rates are comparable to studies of low risk, in-hospital births.[1]
- The cesarean section rate for women receiving care in birth centers averages 4.4%, approximately one half that in studies of low risk, in-hospital births.[1]
- Birth centers nationally have consistently displayed charges for care for normal birth that average up to 50% less than regular hospital stays and 30% less than short stays - including practitioner fees.[2, 3]
- More than half of birth centers include routine laboratory exams, childbirth education, home visits, extra office visits, and initial newborn examinations in their charges.
- Most major health insurers reimburse contract with birth centers for reimbursement. Because charges reflect cost and since the birth center is a single service unit, there is no opportunity for cost shifting or operating the birth center as a "loss leader" to other services.
- 98.8 percent of women using the birth center would recommend it to friends and/or return to the center for a subsequent birth.[1]

What are the potential benefits to families?

- The birth center approaches pregnancy and birth as a normal family event until proven otherwise. The program encourages family involvement and provides a safe environment for families to experience the social, emotional, and spiritual renewal inherent in birthing forth new life -- while attending to the possibility that a problem may arise that will require medical intervention or care in the acute care setting of the hospital. This is in opposition to the view that pregnancy is an illness and birth a medical/surgical event that needs to be cured.
- The birth center program of education encourages parents to become informed and self-reliant; to assume responsibility for their own health and the health of the family.
- The birth center brings generations together to celebrate new life by encouraging grandparents and children to participate in the birth center program.
- Birth centers have demonstrated that they are a viable alternative to unattended home birth and to costly hospital acute care for 20 years. It is now time to mainstream these services.

What are the benefits to business and industry?

- Birth centers offer business and industry direct savings in the cost of health benefits. If only 100,00 births were attended in birth centers, annual savings could be almost $314 million.[2, 3]
- The birth center program provides a starting base for the wellness and prevention programs being established in industry.
- The family in the hinge pin of the employee. Industry's support of a program that encourages family unity, self-determination and responsible health can only improve employee performance.
- Birth center care encourages childbearing women (who may also be employees) to be confident in the design of their bodies. Such confidence, in turn, builds self-esteem and starts the young family off on thinking of pregnancy, birth and family health as wellness, not disease.
- The nine-month intensive focus on improving family health by promotion of lifestyle changes in pregnancy can have a significant ripple effect in the long-term improvement of family health.

How will it affect the hospital acute care service?

- Birth centers have had a major impact on humanizing the acute care maternity services provided by hospitals. Note the rise in hospital birthing rooms, in privileges for nurse-midwives, in childbirth education programs, and in more liberal attitudes about family participation.
- Birth centers are showing that the majority of women can safely proceed through pregnancy and birth using acute care services only as needed. In a wellness orientation to pregnancy and birth birth centers would be the managed care gatekeepers for the acute care obstetric newborn services.
- Birth centers eventually will help to reduce the number of costly hospital beds and expand primary care services.
- Birth centers will help to reduce dependency fostered by institutional confinement and strengthen the family's ability to share responsibility for maternity care and family health.
- Birth centers will help to develop a system of care based first, on the needs of the family and second, on the needs of medical education or product promotion.

How will it affect the obstetricians?

- Birth centers provide an opportunity for obstetricians and family physicians to learn and practice midwifery - time and education intensive, "with woman" - care.
- Birth centers provide an opportunity for obstetricians to invest in a service in which they can expand their interests.
- Birth centers offer obstetricians an opportunity to develop teams of professional care providers that will improve primary care services to families and better use their specialist skills.

How is the quality of care assured in birth centers?

- Through the promotion of state regulations for licensure (37 states currently license birth centers).
- Through established National Standards (adopted 1985).
- Through a Continuous Quality Improvement Program for Birth Centers (model program available).
- Through accreditation by the Commission for the Accreditation of Birth Centers.

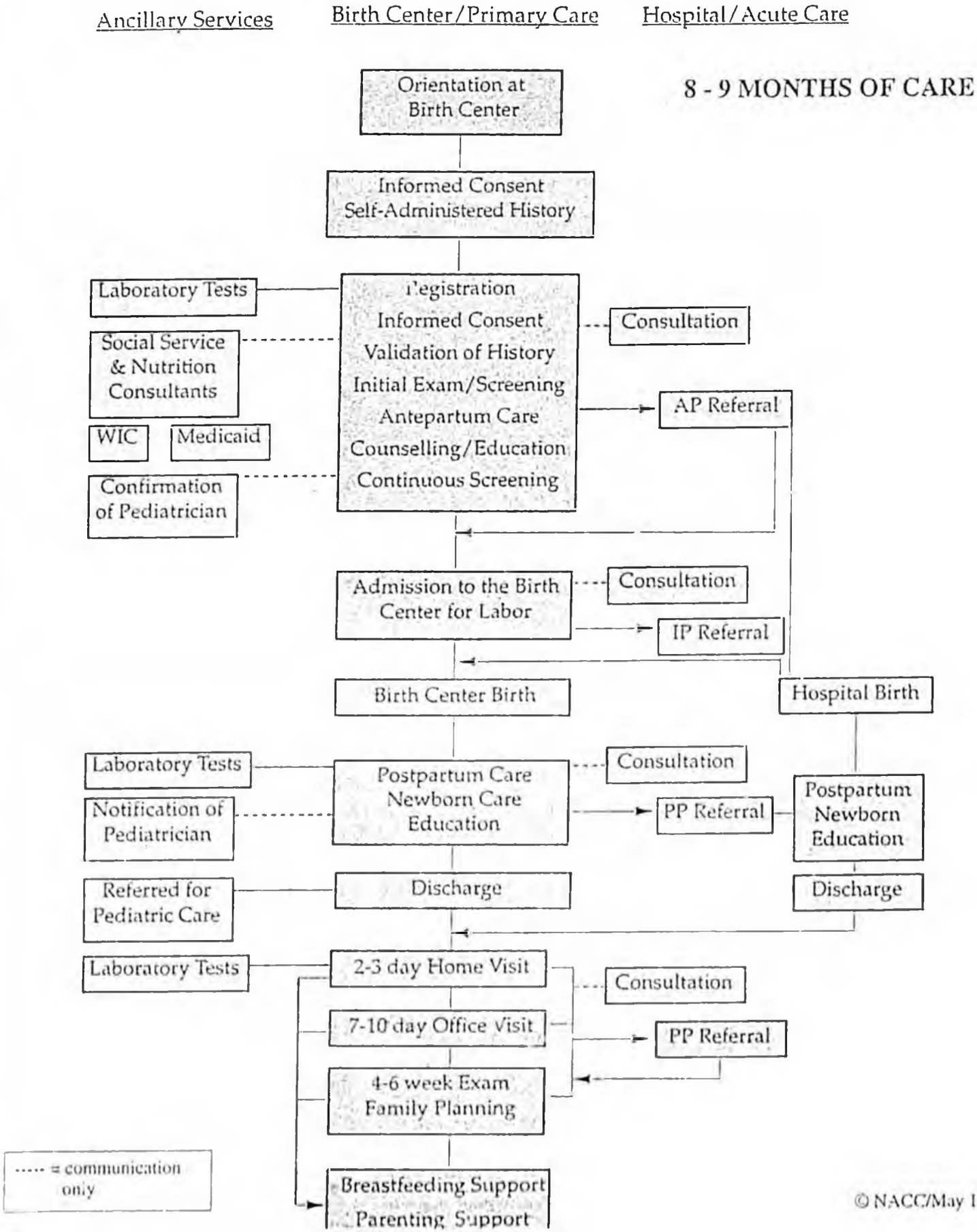
How do birth centers contain costs?

- By retaining autonomy (control) over birth center operations and program regardless of ownership (some hospitals own freestanding birth centers).
- By providing "high touch" rather than "high tech" care, birth centers minimize the overuse of technology.
- By providing a program of primary care that emphasizes education, wellness, prevention, self-help and self-reliance in family health maintenance.
- By using staff efficiently; staff are only in-house when a mother is in-house. Since birth centers do not compete with emergency services or hospital acute care, levels of staff are used efficiently and appropriately.
- By sharing responsibility with the childbearing family for health and prevention of illness.
- By using existing community services when available (instead of creating costly duplications) for transport services, social services, medical consultation, laboratories, etc.
- By using established policies and procedures for screening and transfer of women with problems to acute care services.
- By using low cost construction that meets safety codes.

REFERENCES

1. Rooks, J., et al., "Outcomes of Care in Birth Centers: The National Birth Center Study", *New England Journal of Medicine*, 321:1804-1811, (December 28), 1989
2. Health Insurance Association of America, *Source Book of Health Insurance Data - 1996*, 1996, Washington, DC.
3. National Association of Childbearing Centers, *NACC 1996 Annual Survey Report of Birth Center Experience*, 1997, Perkiomenville, PA.
4. Rooks, J., et al., "The National Birth Center Study: Part I - Methodology and Prenatal Care and Referrals", *Journal of Nurse-Midwifery*, Vol. 37, No. 4: 222-253, July/August, 1992
5. Rooks, J., et al., "The National Birth Center Study: Part II - Intrapartum and Immediate Postpartum Neonatal Care", *Journal of Nurse-Midwifery*, Vol. 37, No. 5: 301-340, September/October, 1992
6. Rooks, J., et al., "The National Birth Center Study: Part III - Intrapartum and Immediate Postpartum Neonatal Complications and Transfers, Postpartum and Neonatal Care, Outcomes and Client Satisfaction", *Journal of Nurse-Midwifery*, Vol. 37, No. 6: 361-397, November/December, 1992

The Birth Center
Primary Care in an Integrated Health Care System



COST DIFFERENTIAL FOR BIRTHING CENTERS AND HOSPITALS IN ALASKA

ANCHORAGE

Geneva Woods Birth Center	$1200.00
Providence Hospital	$3460.00(1).
Alaska Regional	$3475.00(2)

JUNEAU

Juneau Family Birth Center	$1200.00
Bartlett Regional Hospital	$2695.00-$3850.00 (mom) plus $1170.00-$1755 (baby) (3)

FAIRBANKS

Alaska Family Health & Birth Center	$1200.00
Fairbanks Memorial Hospital	$2500.00-$3500.00 (4)

1. Quote is for Providence Hospital, uncomplicated delivery and 24 hour stay after delivery. Epidural anesthesia is $1300.00 additional. Cesarean section is $7104.00 for 3 day stay, not including anesthesia or physician charges.
2. Cesarean section at Alaska Regional is $7206.00.
3. Bartlett Regional Hospital does not have all-inclusive pricing. They quote a range of prices and everything from an IV to oxygen and medication is an additional charge. Cesarean section in Juneau costs $7203.00-$8295.00 (mom) with an additional charge for the baby of $1995.00-$2310.00.
4. Fairbanks Memorial does not have all-inclusive pricing and charges for labor and delivery by the hour. Baby is an additional charge, as is any medication, oxygen, etc. Cesarean section is approximately $8,000.00.

Juneau Family Birth Center

The JFBC midwives have attended 392 (as of September 30, 2003) births since opening in April 1998. This number includes all women who started their labor intending to deliver at the birth center or at home.

1998 77 women served
30 women prenatal care only
6 hospital support
41 births attended Births in Juneau 407
11 home births
27 birth center births
3 hospital transports
0 cesarean sections

1999 118 women served
36 women prenatal care only
5 hospital support
79 births attended (18.8% of Juneau births-421)
17 home births
46 birth center births
16 hospital transports
9 cesarean sections

2000 101 women served
39 women prenatal care only
5 hospital support
68 births attended (16.2% of Juneau births-421)
12 home births
48 birth center births
8 hospital transports
7 cesarean sections

2001 **118 women served**

45 prenatal care only

10 hospital support

73 births attended (17% of Juneau births-435)

9 home births

56 birth center births

8 hospital transports

4 cesarean sections

2002 **125 women served**

42 prenatal care only

14 hospital support

83 births attended (20.5% of Juneau births-405)

14 home births

55 birth center births

14 hospital transports

6 cesarean sections

2003 **140 women served (as of September 30, 2003)**

6 hospital support

48 births attended

4 home births

33 birth center births

7 hospital transports

6 cesarean sections

Total births attended to as of September 30, 2003 by JFBC midwives - 392

Total women served by the birth center- 700

Statistics as of August 24, 2003

Number of women transported in labor	56	15.5%
Number of cesarean sections	32	8.2%
(Number of cesarean sections nation wide		28%)
Number of transports of mom postpartum	6	1.8%
Number of transports of baby postpartum	7	1.8%
Baby deaths at birth 0		
Baby deaths before 6 weeks 2		
One of heart problems at 5 weeks		
One of a birth defect incompatible with life		
Homebirths	67	17.3%
Breastfeeding rate for the first 6 weeks		98%
(Most of our moms breastfeed for years, but we have no official way of tracking this)		
Average baby weight		8 lbs

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

◂ Previous Volume 321:1804-1811 December 28, 1989 Number 26 Next ▸

Outcomes of care in birth centers. The National Birth Center Study

JP Rooks, NL Weatherby, EK Ernst, S Stapleton, D Rosen, and A Rosenfield

Abstract

We studied 11,814 women admitted for labor and delivery to 84 free-standing birth centers in the United States and followed their course and that of their infants through delivery or transfer to a hospital and for at least four weeks thereafter. The women were at lower-than-average risk of a poor outcome of pregnancy, according to many but not all of the recognized demographic and behavioral risk factors. Among the women, 70.7 percent had only minor complications or none; 7.9 percent had serious emergency complications during labor and delivery or soon thereafter, such as thick meconium or severe shoulder dystocia. One woman in six (15.8 percent) was transferred to a hospital; 2.4 percent had emergency transfers. Twenty-nine percent of nulliparous women and only 7 percent of parous women were transferred, but the frequency of emergency transfers was the same. The rate of cesarean section was 4.4 percent. There were no maternal deaths. The overall intrapartum and neonatal mortality rate was 1.3 per 1000 births. The rates of infant mortality and low Apgar scores were similar to those reported in large studies of low-risk hospital births. We conclude that birth centers offer a safe and acceptable alternative to hospital confinement for selected pregnant women, particularly those who have previously had children, and that such care leads to relatively few cesarean sections.

ARTICLE

- Table of Contents
- Find Similar Articles in the Journal
- Notify a friend about this article
- Journal Watch (General) Summary

SERVICES

- Add to Personal Archive
- Download to Citation Manager
- Alert me when this article is cited

MEDLINE

- Related Articles in Medline

Articles in Medline by Author:

- Rooks, J. P.
- Rosenfield, A.
- Medline Citation

Source Information

Center for Population and Family Health, School of Public Health, Columbia University, New York.

The following figures illustrate the state's likely cost savings by passing SB 22, making birth center facility fees a qualified expense under Medicaid. Based on testimony from the Department of Health & Social Services, these numbers assume the federal government will refuse to participate, requiring the state to pay the facility fee from state funds. The state still saves money.

Birth Center Costs:

Facility	City	Cost of care	Facility Fee	Newborn Care	Grand Total
The Midwives BC	Anchorage	$3665	$1200	$390	$5255
Geneva Woods BC	Anchorage	$4225	$1500	$610	$6335
AK Family Health & BC	Fairbanks	$4220	$1600	$615	$6435
Juneau Family BC	Juneau	$4200	$1800	$818 5 exams	$6818
Mat-Su Midwifery	Wasilla	$4251	$1800	$517	$6568
Woman's Way Midwifery	Soldotna	$3400	$1250	$650	$5300
Frontier Midwifery	Soldotna	$3650	$1200	$580	$5430

"Cost of care" includes prenatal, postpartum, and birth charges. It excludes labs. "Newborn Care" includes immediate care at delivery and four newborn exams, except where noted.

MD/OB Costs:

City	MD/OB Cost	Notes
Anchorage	$5100	
Anchorage	$4600	Includes postpartum
Anchorage	$4358	
Wasilla	$3700	Includes postpartum
Wasilla	$3685	7-9 prenatal visits
Soldotna	$3082	
Soldotna	$2940	Includes labs and ultrasound
Homer	$2940	

Except where noted, "MD/OB costs" include 10 prenatal visits, but do not include labs, postpartum maternal care, or immediate (at delivery) newborn care.

Hospital Costs:

City	Cost of 1 day stay	Routine Nursery Care	Epidural
Anchorage	$4000		$2000
Anchorage	$3932	$575 per night	
Fairbanks	$3200	$900-$1800	$3200
Juneau	$3200 (approx)		
Soldotna	$5000-$7000	$1800-$2500	

These numbers understate hospital birth costs by excluding charges such as oral or topical pain medications, episiotomy, perineal repair, fetal monitoring, or hospital materials charges (e.g.: gloves, gauze, sterile bedclothes, etc). Birthing centers either do not perform or do not charge separately for these.

Grand Totals and cost to the state:

City	Hospital Grand Totals (low)	Hospital Grand Totals (high)	Hospital Medicaid (GF only) low	Hospital Medicaid (GF only) high	Bcenter Medicaid (GF only) low	BCenter Medicaid (GF only) high
Anchorage	$9,365	$10,175	$4,683	$5,088	$3,228	$3,918
Fairbanks	$8,585	$9,500	$4,293	$4,750	$4,018	
Juneau	$8,285	$9,200	$4,143	$4,600	$4,309	
Wasilla	$9,017	$10,000	$4,509	$5,000	$4,184	
Soldotna	$10,240	$13,082	$5,120	$6,541	$3,275	$3,315

Chart assumes a 25% epidural rate in hospitals. National average is 40% for small hospitals, 66% for large.
Where epidural cost is not available for a city, the Anchorage rate was used.
Where any other cost was unavailable for a given city, the statewide median was used.

Chart assumes the federal government pays 50% of all hospital charges
Chart assumes the federal government pays 50% of all birthcenter charges except the facility fee, in which the federal government may not participate. This chart therefore assumes birthcenter facility fees are 100% GF.

State of Alaska
Department of Community and Economic Development
Division of Occupational Licensing
Board of Certified Direct-Entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2580
E-mail: license@dced.state.ak.us

Instructions to Primary Preceptor

* Regulation 12 AAC14.210(f) require that you keep a record of the applicant's performance of practical skills.

* As primary preceptor you are responsible for verifying that each skill which was completed under the supervision of a secondary preceptor is verified by completion of the form **"Preceptor Verification of Practical Skills List for Alaska CDM's"** (page 46 of the skills document). The secondary preceptor(s) must complete this form and submit it to you to file with the skills list document.

* You must keep this list in your files.

- **Do not submit the "Practical Skills List for Alaska Certified Direct-Entry Midwives" to the board unless they make a specific request to review it.** However, to confirm that the skills list has been completed, you must complete form number 08-4215(h) contained in the "Application for Certification as a Direct-Entry Midwife." The title of form 08-4215(h) is **"Certification of Completion of the Practical Skills List for Alaska CDM's."**

SS/tlf298ss
122303b

Department of Community and Economic Development
Division of Occupational Licensing
Board of Certified Direct-entry Midwives
P.O. Box 110806, Juneau, Alaska 99811-0806
(907)465-2580
E-mail: license@dced.state.ak.us

Certification of Completion of the Practical Skills List for Alaska CDM's

THIS FORM IS TO BE COMPLETED BY THE APPLICANTS PRIMARY PRECEPTOR TO VERIFY THAT THE APPLICANT HAS COMPLETED THE SKILLS LIST REQUIRED BY 12 AAC 14.210(f)

I _____ certify that I have acted as the primary
Primary Preceptor Name

preceptor for _____. By my signature below, I verify that this apprentice
Apprentice Name

has completed all of the practical skills listed on the PRACTICAL SKILLS LIST FOR ALASKA CERTIFIED DIRECT-ENTRY MIDWIVES.

I further certify that for each skill completed under the supervision of a secondary preceptor, I have received the form "Preceptor Verification of Practical Skills List for Alaska CDM's" (page 46 of the skills list) signed and notarized by the secondary preceptor, verifying that the skill(s) has been completed.

I am in possession of the completed skills list and agree to keep it as required by 12 AAC 14.210(f) and will make it available for the board's review upon request.

_____
Primary Preceptor's Signature

Date: _____

SUBSCRIBED AND SWORN TO before me this _____day of _____, 20_____

NOTARY SEAL

_____
Notary Signature

My Commission Expires: _____

Preceptor Verification of Practical Skills List for Alaska CDMs

Applicant's Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Primary Preceptor's Name: _____

Secondary Preceptor's Name: _____

Make a copy of this form for each preceptor who has initialed skills in the *Practical Skills List for Alaska CDMs*. Have them fill out this form, have the form notarized, and return it to the Primary Preceptor.

Preceptor Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

I, _____, affirm and have witnessed that the applicant,

_____, has acquired and is proficient in the performance of the skill(s) that I initialed on the *Practical Skills List for Alaska CDMs*.

Preceptor's Signature: _____

Date: _____

Subscribed and sworn to before me this _____ day, of the month of _____ in the year _____.

Notary Seal

_____
(Notary Signature)

My Commission Expires: _____

Preceptor Verification of Practical Skills List for Alaska CDMs

Applicant's Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Primary Preceptor's Name: _____

Secondary Preceptor's Name: _____

Make a copy of this form for each preceptor who has initialed skills in the *Practical Skills List for Alaska CDMs*. Have them fill out this form, have the form notarized, and return it to the Primary Preceptor.

Preceptor Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

I, _____, affirm and have witnessed that the applicant,

_____, has acquired and is proficient in the performance of the skill(s) that I initialed on the *Practical Skills List for Alaska CDMs*.

Preceptor's Signature: _____

Date: _____

Subscribed and sworn to before me this _____ day, of the month of _____ in the year _____.

Notary Seal

_____

(Notary Signature)

My Commission Expires: _____

Preceptor Verification of Practical Skills List for Alaska CDMs

Applicant's Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Primary Preceptor's Name: _____

Secondary Preceptor's Name: _____

Make a copy of this form for each preceptor who has initialed skills in the *Practical Skills List for Alaska CDMs*. Have them fill out this form, have the form notarized, and return it to the Primary Preceptor.

Preceptor Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

I, _____, affirm and have witnessed that the applicant,

_____, has acquired and is proficient in the performance of the skill(s) that I initialed on the *Practical Skills List for Alaska CDMs*.

Preceptor's Signature: _____

Date: _____

Subscribed and sworn to before me this _____ day, of the month of _____ in the year _____.

Notary Seal

_____
(Notary Signature)

My Commission Expires: _____

Costs/Savings to Medicaid for Hospitals vs. Birth Centers

Average birth center facility fee:

$1500.00

What Medicaid may pay for the facility fee:

$1000.00

Average # of women per year turned away because they cannot afford the birth center facility fee:

80

Total average cost to Medicaid for facility fees for 80 women:

$80,000.00

Minimum charges incurred in hospital per day, as a result of being turned away from birth center birth:

$2650.00 per birth*

Total average cost to Medicaid for 80 women requiring hospital birth because they cannot pay the birth center facility fee:

$212,000.00

***The charges incurred in hospital per day do not include costs of labs, epidurals, interventions, or supplies.**

Mat-Su Midwifery, Inc.

2650 Broadview Ave., Wasilla, AK 99654
907-373-3420 Fax 907-376-7847

Facsimile Transmittal Sheet

DATE: 2-24-05

TO: Senate Finance Committee

FROM: Sharon Evans

TOTAL NUMBER OF PAGES TRANSMITTED INCLUDING COVER SHEET: 3

SUBJECT: Correction of Addendum and contents

COMMENTS: In reviewing the Addendum, I found one page missing and the page numbers incorrect. Please find the corrected Addendum and updated information. Thank you. Sharon K. Evans, CDM, CPM

PS: The 9 page report sent yesterday will be re-sent (in the next few days) with updated statistics to include Geneva Woods Birth Center.

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL ABOVE NUMBER.

Judi C. Davidson, CDM, CPM
Pamela J. Embler, RN
Sharon K. Evans, CDM, CPM
Peggy Halsey, CDM
Melissa Mayo, CDM, CPM
Esther Miller, AM
Jessica Sawyer, AM

Addendum

Newspaper Article.	Anchorage Daily News Article dated February 17, 2005	(2 pages)
Website Articles.	How Much Labor is in a Labor Epidural	(1 page)
	Labor Epidurals & Outcomes	(1 page)
	Technology and Public Health	
	How Much, How Often, And For Whom?	(2 pages)
	The Induction Seduction: Pitocin Induced Labor	(2 pages)
	What's Right For You?	(1 page)
	The Risks	(1 page)
	Some Statistics for Pregnancy, Labor, and Birth	(5 pages)

Labor epidurals and outcome.

Gaiser RR.

Department of Anesthesia, Pharmacology, Obstetrics and Gynaecology, Hospital of the University of Pennsylvania, Philadelphia, PA 19104, USA. gaiserr@uphs.upenn.edu

The use of epidural analgesia for labor continues to increase dramatically. It been suggested that epidural analgesia increases the risk of cesarean section, operative vaginal delivery, and prolonged labor. These issues have been extensively investigated. The use of epidural analgesia does not increase the risk of cesarean section. It may affect the incidence of forceps delivery, but it depends on the medications used. Epidural analgesia does prolong labor, although the clinical significance of this prolongation has not been shown.

PMID: 15679055 [PubMed - in process]

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Tricia Hulse

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 0 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Ryan Gallagher

Ryan Gallagher

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely, Denise S. Hibben

As a mother of 3, it is a hardship to pay a birthing center fee out of pocket. It would be so much more inexpensive for the state of Alaska to pay for a birthcenter birth - maybe a few thousand dollars as opposed to a few tens of thousands of dollars for a hospital birth.

Please, Please pass SB22 to give mothers another option for childbirth.

Thank you, Denise S. Hibben

5672

Some Statistics for Pregnancy, Labor, and Birth

Please note: some of these statistics are facts – we do in fact have an accurate account of how many babies are born each year in the US. Some of these statistics are research results, which are facts, but based on a specific sample of women in specific settings. Some are estimates, like the percentage of women who have experienced sexual abuse. No statistic is ever a guaranteed predictor.
However, I find it helpful when I'm planning classes to have at least a ballpark figure of how common something is, and how likely it is that my students will experience it. So, in that spirit, here are some numbers:

Demographics

- Babies born each year in the world: _____ In the U.S: 4,091,063 births in 2003 (CDC).
- In Washington State: 80,474 in 2003 (CDC) In King County: 26,032 in 2002 (WA Vital Stats)
- Age of mothers... percentage of all mothers who were in this age group: 10-14 years old: .2% of mothers. 15-19: 11%. 20-24: 25%. 25-29: 26%. 30-34: 23%. 35-39: 11%. 40-44: 2%. 45-54: .13% (CDC – 2001)
- Age of mothers... amongst 1000 women in this age group, how many had babies in 2003: 10 – 14 year olds: .6 per 1000. 15 – 19: 41.7; 20 – 24: 102.6; 25 – 29: 115.7; 30 – 34: 95.2; 35 – 39: 43.8; 40 – 44: 8.7. 45 – 54: .5 www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09.pdf
- Unwed mothers: 34.6% of mothers in 2003 (CDC)
- Average number of children born to a woman over a lifetime, in U.S. in 2000: 2.1 (CDC)
- Twins are 2.9% of live births. Higher order multiples: .18% (CDC)
- Most women who gave birth had wanted to become pregnant either prior to (18%) or at the time (45%) they became pregnant. However, almost 4 out of 10 pregnancies were unplanned, that is, the women did not want to become pregnant at the time they conceived this pregnancy; this includes 32% who had hoped to become pregnant at some point in the future, and 6% who had never wanted to become pregnant. (LM)
- Infant mortality. 6.63 infant deaths per 1,000 live births in 2004. There are 39 other countries with lower infant mortality rates. (CIA). Nearly 1 in 10 infant deaths were from sudden infant death syndrome (SIDS). There were a total of 2,648 deaths from SIDS in 1999. (CDC)
- Histories that expectant moms bring into the room with them:
    1. Pregnancy history: Approximately 35% of women will have had an abortion before the age of 45. Approximately 25 – 30% of pregnancies end in miscarriage, so many of the women will have experienced miscarriage. 25% of couples experience infertility at some point in their lives. In 2001, 40,000 babies were born in the US as a result of fertility treatments (source). This is about 1% of the babies born in that year.
    2. Abuse history: Approximately 1 in 3 women have been sexually abused at some point in their lives. 31% of American women report having been physically or sexually abused by a husband or boyfriend at some point in their lives. (*Commonwealth Fund survey, 1998).* Of the women who experience abuse at some point in their lives, 30% report it began during their pregnancy. It is estimated that 6 – 20% of pregnant women will be physically abused during pregnancy.

Pregnancy

Prenatal care (includes info on low birthweight and preterm babies

- About 3 in 10 women have a visit to a health care provider to plan their pregnancy before they conceive. (LM)
- Women who received prenatal care in their first trimester: 84.1% (CDC 2003). 83.2% (WA)
- Women receiving late or no prenatal care: 3% (WA 2001)
- Prenatal Caregivers: 77% OB/Gyn. 7% Family Physician. 13% Midwife. 4% Nurse or PA
- Preterm birth (before 37 weeks gestation): 12.1% nationwide in 2003 (CDC) In Washington, 12% in 2001 (WA)
- Low birthweight: 7.9% nationwide in 2003 (CDC).
- Proportion of infants who did not survive first year amongst very low birth weight (1500 grams or less) 51%. Amongst moderately low weight (1500-2499 grams) 14%. (MO)
- Value of prenatal care. Rates of complications among high-risk patients in a prenatal care program (including education, more frequent visits, and more provider attention) compared to non-participants. Preterm birthrate: 7.4 vs. 9.1% Rate of low birthweight babies: 5.8 vs. 6.4% (MO) Preterm labor episodes successfully stopped: 11.4 vs. 6.6%
- Cost of prenatal care for one mother: $702. Cost savings available in the first year of care for an infant of normal birthweight rather than low birthweight: $59,700.
- Smoking in pregnancy: 11% in 2003 (CDC)

Childbirth Education / Sources of Information

- 36% of women report taking classes: 70% of new moms, 19% of experienced moms (LM)
- Of those who took classes, 88% at hospital or caregivers' office, 4% at home, 7% at a community site. (LM)
- Most important sources of information about pain relief]: 25% relied most on doctor or midwife. 15% on classes, 9% on friends or relatives, 3% Internet. (And own experience for multiparous women.) (LM)

Varintions in Pregnancy:

- Gestational Diabetes: 3.5% (WA)
- Pregnancy Induced Hypertention: 5% Eclampsia: .4% (WA)
- Prolapsed cord: 1.9 per 1000. CDC: NCHS: Births: Final Data for 2000
- Abruptio placenta: 5.5 per 1000 CDC: NCHS: Births: Final Data for 2000

Group B Strep

- Before prevention methods were widely used, approximately 8,000 babies in the United States would get GBS disease each year. One of every 20 babies with GBS disease dies from infection. (CDC - www.cdc.gov/ncidod/dbmd/diseaseinfo/groupbstrep_g.htm)
- 30 – 40% of pregnant women normally carry the bacteria (in the throat, intestines, or vagina) without having any illness. Newborn babies can be infected before birth if vaginal bacteria infect the amniotic fluid, during birth, or after birth by close physical contact with mother
- Most GBS infections occur in babies less than 3 months of age, with an incidence of about 1 case per 1000 births
- If a mother is a carrier of GBS, there's a 50% chance her baby will be infected. Less than 1% of full-term babies who become carriers of GBS develop GBS meningitis of other severe GBS infection
- If baby is born prematurely, especially before 32 weeks, then the mother's antibodies to GBS

are not transferred across the placenta and the baby is at much greater risk of GBS disease.

Source for last four items: http://www.meningitis.ca/groupbstrepdisease.html

Due Dates:

- Preterm (before 37 weeks): 12.8% (WA)
- Term (37-41 weeks): 79% (WA)
- Post-term babies (after 42 weeks): .07% (WA)

Induction / Augmentation

- 44% of surveyed women say their doctors tried to induce their labors. 4 out of 5 inductions started labor. (LM)
- In Seattle area, hospitals with Pitocin induction rates of 5 – 20% were St. Joseph, Stevens, Swedish Ballard, Tacoma General, Valley General, Valley Medical, and Whidbey. Hospitals with induction rates between 21 – 50% were Auburn, Evergreen, Group Health, Overlake, Providence Everett. These hospitals did not report: Northwest, St. Clare, Swedish First Hill, and UWMC. Pitocin augmentation rates generally ranged from 15 – 60%. (CEAS)
- Reasons for induction: 59% of induced moms report that induction was for medical reasons only, 18% for non-medical reasons only, and 16% for medical and non-medical reasons in combination. (LM)
- Of those who were induced: 19% say induction was because "I wanted to be done with my pregnancy and have my baby." 11% said "this helped ensure my chosen caregiver would attend my birth." 6% said "I wanted to control the timing of my birth to make work or personal plans" and 11% provided other non-medical reasons. (LM)
- Means of induction: of moms who were induced, they report 86% oxytocin, 59% amniotomy, 31% sweeping membranes, 28% prostaglandin gel, pouch, or tablet. (LM)
- Of 19 Seattle hospitals, 10 say they "often" use Pitocin, 9 say sometimes. 9 "often" use prostaglandins, 9 "sometimes" and only St. Francis says "never." For rupture of membranes, 10 say often, 8 say sometimes, Evergreen says 'rarely'. For Foley / dilators, 6 say sometimes, 11 say rarely, and Auburn and Whidbey say never.
- Augmentation: Moms report: 54% had membranes broken, 53% artificial oxytocin. (LM)

Care During Labor and Medical Interventions

Electronic Fetal Monitoring

- Used in 84% of all live births. (CDC)
- By moms' report: 93% of moms had EFM: 73% had EFM alone, 20% had EFM combined with a handheld device such as a Doppler. Among those using EFM, 66% were monitored continuously, 23% were monitored most of the time. Only 4% were monitored intermittently, and only 7% had only a baseline measure. Only 6% were never attached to a fetal monitor. (LM)
- Of women who had electronic monitoring, 70% were monitored externally. 22% had both external and internal EFM, and 4% were monitored only by internal EFM. (LM)
- Increase in risk of c-section associated with the use of EFM: 41% (MO)
- Significant differences observed in one-minute Apgar scores below 4 among infants who received continuous EFM: None (MO)
- False positive rate for multiple late decelerations in fetal heartbeat...: 99.8% (MO)
- World Health Organization: In conclusion, the method of choice for the monitoring of the fetus

during normal labour is intermittent auscultation.... Individualized care of the labouring woman is essential, and this may be achieved more smoothly by the personal contact required by regular auscultation. Only in women with increased risk, such as labours which are induced or augmented, complicated by meconium-stained amniotic fluid or by any other risk factor, does electronic monitoring seem to be advantageous. In the majority of labours without increased risk, electronic monitoring increases the number of interventions with no clear benefit for the fetus and with a degree of additional discomfort for the women. (WHO)

Food in Labor

- 56% of moms say they were *interested* in drinking something, and 27% in eating something between when their labor began and when they gave birth. At birthplace, 34% were *permitted* to eat or drink, only 13% were allowed to eat in labor. Looking only at vaginal births, 35% *actually* did drink something, 14% ate something.
- In the Seattle area, the following hospitals allow food in labor: Auburn Regional Medical Center, Group Health, Northwest, St. Francis, Stevens, Swedish Ballard, Tacoma General. UWMC, Valley General, Whidbey General. The following say it is the provider's decision: Providence Everett, St. Clare, St. Joseph, Swedish First Hill. Overlake, Evergreen, and Valley Medical do not allow food in labor. (CEAS)

I.V. / Heplock

- 86% of moms receive an IV (LM)
- Of 19 hospitals in the Seattle area, 15 say they "often" use IV's, 4 say "sometimes". 11 say they "often" use heplocks, the rest say "sometimes." (CEAS)

Urination

- 52% of moms had a catheter to remove urine (LM)

Group B Strep

Incidence: 10 – 30% of all adults are colonized with group B streptococcus. 12 – 35% of pregnant women. Chance of transmission to fetus / infant: 40 – 75%. Disease in infants (presumably this means symptomatic infectious disease) 1 – 2% (1 – 3: 1000 live births) (MB)

Length of Labor

- By moms' reports: average length 10.3; 43% say 1-6 hours, 7% more than 24 hours (LM)
- Friedman curve (obstetrical definition): From 4-10 cm dilation, a good rate is 3.0 cm / hr. Minimum is 1.2 cm / hr.
- Leah Albers study of 'normal' birth without intervention: 4-10 cm: nulliparas 7.7 hours on average (19.4 hours still within range of normal), with normal progress defined as half a centimeter per hour; second stage 53 minutes average (up to 147 normal.) For multips: 5.7 hours / 13.7 hours and 17 minutes/57 minutes.

Comfort Techniques

- 71% did not walk around once they were admitted to the hospital. Primary reason: connected to things (67%), pain medications (32%), caregiver telling them not to walk (28%), choosing to stay in one place (21%) (LM)
- Non-drug methods of pain relief: 61% used breathing techniques, 60% used movement or position changes. 32% used hands-on techniques such as massage and touch; 30% used mental strategies such as relaxation or visualization. 15% used hot or cold objects, 12% used environmental changes such as music or aromatherapy, 8% used showers, 6% used tubs, 5% used birth balls, 1% used sterile water injections. (LM)
- Moms' report of effectiveness of pain relief: 89% said tub or Jacuzzi was somewhat helpful (49% said very helpful). Other positive ratings: Hot or cold objects: 82%. Hands-on: 81%, position changes 79%, environment changes 76%, birth balls very helpful to 32% of those who

used them. (LM)

- Breathing techniques were rated as at least somewhat helpful by 69% (22% said very helpful), but 30% rated them as not very helpful or not helpful at all. (LM)

Pain Medication

- By mothers' report: 80% used some pain medication: 63% had epidurals, 30% had narcotics. 5% had general anesthesia, 2% were given nitrous oxide, 2% were given pudendal or other local blocks. (LM)
- Moms' report of effectiveness of pain relief: 78% said epidural was very helpful; Narcotics rated 66%, pudendal or other local blocks 57%, nitrous 52%. (LM)
- Common narcotics at Seattle area hospitals (how many hospitals use): Stadol – 13; Fentanyl – 11; Morphine – 8; Nubain – 6; Demerol – 2. (CEAS)
- Epidural Rates at Seattle hospitals: 5% - Whidbey (approx). 39 – 69% - Auburn, Group Health, Highline, Overlake, Providence Everett, St. Joseph, Swedish Ballard, Tacoma General, Valley General, Valley Medical. 70 – 90% - Evergreen, Northwest, St. Clare, St. Francis, Stevens, UWMC. No rates reported: Swedish First Hill. (CEAS)

Epidural Side Effects

For *all the details* on research results, see separate article.

What parents know about epidural side effects (from LM survey taken after birth):

	Agree strongly %	Agree somewhat	Disagree Somewhat	Disagree Strongly	Not Sure
Epidurals provide more effective pain relief than any other method	54	23	5	6	12
E. require certain interventions such as EFM and IV	34	29	6	4	28
E. often involve interventions such as Pitocin or catheter	24	29	13	9	26
E increase the chance of fever	4	16	23	16	40
E increase chance of baby eval for infection	5	12	24	18	41

Positions for Birth

- 74% lay on their backs, 23% upright (propped up, squatting or sitting), 3% side-lying, 1% hands and knees. (LM)

Episiotomy, Perineal Lacerations, Stitches

- Seattle hospitals: Less than 25% - Evergreen, Highline, Swedish Ballard (according to records), Group Health, St. Joseph, UWMC, Valley General (approximate rates). 30 – 60% - Northwest, Stevens, Valley Medical (approx). 80-90% - St. Francis, Tacoma General (approximate). Hospitals not reporting rates: Auburn, Overlake, Providence Everett, St. Clare, Swedish First Hill, Whidbey General
- Moms report: 52% had stitches to repair tear or cut. 27% had episiotomy.

Forceps and Vacuum Extractor

- Moms report: 7% vacuum extraction, 3% forceps.

Cesarean Rates and Rates of VBAC (Vaginal Birth After prior Cesarean)

- Cesarean rate recommended by World Health Organization: 12%
- Current rates in United States. From The Center for Disease Control: www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09.pdf

Mat-Su Midwifery, Inc.

2650 Broadview Ave., Wasilla, AK 99654
907-373-3420 Fax 907-376-7847

Facsimile Transmittal Sheet

DATE: 2-23-2005

TO: Senate Finance Committee

FROM: Sharon K Evans representing Midwives Assn. of Alaska & Birth Centers

TOTAL NUMBER OF PAGES TRANSMITTED INCLUDING COVER SHEET: 24 (9 Pages front)

SUBJECT: SB 22 - Research

COMMENTS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL ABOVE NUMBER.

Judi C. Davidson, CDM, CPM
Pamela J. Embler, RN
Sharon K. Evans, CDM, CPM
Peggy Halsey, CDM
Melissa Mayo, CDM, CPM
Esther Miller, AM
Jessica Sawyer, AM

Mat-Su Midwifery, Inc.

2650 Broadview Ave., Wasilla, AK 99654
907-373-3420 Fax 907-376-7847

Facsimile Transmittal Sheet

DATE: 2-23-2005

TO: Senate Finance Committee

FROM: Sharon K. Evans representing Midwives Assn. of Alaska & Birth Centers

TOTAL NUMBER OF PAGES TRANSMITTED INCLUDING COVER SHEET: 24 (1) (18 Pages first) (2) Pg 10-24

SUBJECT: SB 22 - Research

COMMENTS:

IF YOU DO NOT RECEIVE ALL PAGES, PLEASE CALL ABOVE NUMBER.

Judi C. Davidson, CDM, CPM
Pamela J. Embler, RN
Sharon K. Evans, CDM, CPM
Peggy Halsey, CDM
Melissa Mayo, CDM, CPM
Esther Miller, AM
Jessica Sawyer, AM

February 22, 2005

TO: Members of the Senate Finance Committee
RE: SB 22

Dear Senator,

After detailed research, the following information has been collected for your review:

- Average cost for an MD or OB normal vaginal delivery, without complications (no labs)
- Average cost for an MD or OB c-section, or complicated delivery
- Average hospital costs for both normal and complicated delivery
- Average cost for an uncomplicated birth center birth
- Average cost for a birth center transport and subsequent hospital expenses
- Birth center statistics for the years 2002– 2004
- Hospital statistics for the year 2003 (from Vital Statistics)

MD or OB Average Cost for Low Risk NVD W/0 PN Labs	MD or OB Average Cost for care w/ C-Section, w/o labs	Grand Total MD or OB for Low Risk NVD & Hospital Costs W/ a 1 Day Stay	Grand Total MD or OB for C-Section & Hospital Costs w/ a 3 day stay
$5000.00	$6,000.00	$11,575.00	$18,125.00

The costs reflected above are conservative. Cost comparisons for some doctors and hospitals in other cities are quoted on the following pages. Dr. or OB labs were not included here, but some are reflected on the following pages. Postpartum or newborn exams are not included. Labs were not included in the hospital cost comparisons, so those costs would need to be added to the above prices, as would the use of sterile and non-sterile supplies, IV costs, etc., making the grand total higher by several hundred or thousands of dollars in actuality.

Hospital statistics for 2003 were obtained through Vital Statistics and are reflected in the following pages. Many of the hospital prices are either quotes from the hospital or some patients have faxed their itemized hospital statements for our review, so some charges were taken from the offered statements.

6 Birth Centers In Alaska	Birth Center Average Cost for Low Risk NVD and includes PP and NB care w/o labs& including facility fee	Birth Center Transport (minus facility fee) in labor resulting in NVD, 1 day stay, epidural, newborn care and BC charges for PN care	Birth Center Transport (minus facility fee) resulting in C-S, 3 day stay, epidural, newborn care and charges for PN care
Anchorage	$6000.00	$12,125.00	$16,225.00

The above averages include prenatal care, postpartum and newborn care and the cost of the transfer (hospital costs) The averages above do not include labs, since the Dr. or OB costs did not include labs

Legend:
C-S = cesarean section
FHT = fetal heart tones
FP = failure to progress
PN = prenatal
PP = postpartum
PROM = premature rupture of membranes
PPROM prolonged w/o Labor or FP
NB = newborn
NVD = normal vaginal delivery
PCS = primary c-section
RCS = repeat c-section
U/S = ultrasound
VB = vaginal birth
VBAC = vaginal birth after c-section

In some instances (few) an ambulance was called to transport the mother or newborn. The cost of ambulance services should be added to the total cost of transport. The fee ranges from $350.00 to $500.00 for ambulance services, depending on how far they are from the hospital.

During the Senate HESS Hearing, Dr. Jacobs stated midwives should have a 0% transport rate if they truly know how to risk out their patients. The following information is a collection of statistics from seven birth centers in Alaska. As will be demonstrated, the reasons for transports were as a result of following Alaska State regulations for Certified Direct-entry Midwives, and not through mismanagement. There is no way to rule out for a certainty if a woman will fail to progress in labor, if her baby will turn breech or if her baby will need to be transported. On the following pages our statistics show the numbers, the reasons, and the outcomes for each transport.

# Birth Centers in this study	Total Births 2002	Total Transports 2002	Total PP or NB Transports 2002
6	302	27	3

# Birth Centers in this study	Total Births 2003	Total Transports 2003	Total PP or NB Transports 2003
6	289	33	3

# Birth Centers in this study	Total Births 2004	Total Transports 2004	Total PP or NB Transports 2004
7	485	33	4

# Birth Centers in this study	Total Births 2002-2004	Total Transports 2002-2004	Total PP or NB Transports 2002-2004
7	1076	93	10

The most common reasons the women in this study were transported are as follows:

Failure to progress in labor. These women either progressed to a point and stopped, or remained at the same dilation for longer than is acceptable, or the baby was in an unfavorable position, or after pitocin induction fetal heart tones showed the baby couldn't stand the forces of labor, so a c-section was performed. Most required pitocin augmentation to deliver, and most delivered vaginally. Some had c-sections.

Failure to progress with prolonged rupture of membranes. Some of these women had ruptured membranes with no labor. All attempts at natural induction did not work, or they reached our regulation time-limit, so had to go to the hospital. These women are usually transported via car, not ambulance.

Immediate Postpartum: Retained Placenta.
All of the women transported for retained placenta required manual removal, usually with pain relief. Our regulations stipulate that if the placenta is not born within 1 hour of delivery, transport is required. Our statistics show 6 women were transported for this condition.

Newborn:
Most newborns were transported for transient tachypnea (rapid breathing), which resolved on its own. Babies were transported per regulations.

One baby had recurrent apnea (stops breathing), that eventually required a monitor. All others had good outcomes.

Number of women requiring a c-section out of 1076 live births from 2002-2004:

2002	2003	2004	Total
14	12	11	37

Thirty seven c-sections out of 1076 births gives the birth centers an average c-section rate of **3.44%** for the last three years.

Episiotomy Rate	Perineal Repair Rate	Fee Paid for Perineal Repair Rate	Transport Rate
0%	12%	$000	8.6%

Episiotomy is rare among midwives. The 0% rate indicated is because the midwives have not performed one in years, if ever. Perineal injuries, from small nicks to second degree lacerations happen about 12% of the time, and mostly with first-time mothers. Midwives are permitted to perform episiotomy in an emergency, but rarely find the need to do so. Midwives are allowed by law to use a local anesthetic (Lidocaine) to numb the area so the woman can be fairly comfortable while the midwife sutures. Women report they feel better and heal faster without an episiotomy; so the procedure is reserved for emergencies.

Episiotomy is common, almost routine, in the hospital. Doctors are paid for the service of episiotomy and perineal repair. Hospitals are paid for the supplies necessary to perform the service. Midwives are not paid.

Across the nation birth center studies are proving that low-risk women choosing birth center care are at a definite advantage. C-section rates are lower than hospitals by and large (and should be). Fewer pre-term babies are seen in birth center statistics because of the extra time and nutritional counseling midwives offer. This saves the State a lot of money as a small but growing number of Alaskan families are opting for natural, un-medicated birth center birth.

Please note the statistics herein regarding the 7 mentioned birth centers does not include other midwives. There are other licensed midwives in the state of Alaska doing home births.

There have been a few midwives that have lost their licenses or certification because they did not follow protocol, did not make wise choices and had a bad outcome. We cannot deny the few bad outcomes by these midwives or non-licensed midwives. The same is true for doctors.

Midwives do not offer pain medication in birth centers. Water is used to help control pain. We call it our "liquid epidural." As birth center studies bear out, more and more women are opting for drug-free births.

The birth centers in this study had an 8.6% transport rate, which is below the average, for a low risk population. Some of the birth centers had lower individual transport rates.

In the following pages you will find statistics and information on epidurals, pitocin induction as well as an article from the Anchorage Daily News claiming "a study clears the use of epidurals" in earlier labor. These articles have been included to show you the trends, not only in Alaska, but across the nation. It is hoped you will see that the birth centers in this study have better outcomes, lower risk factors, and cost-effective services that should be available to anyone seeking out-of-hospital birthing care

Sincerely,

Sharon K. Evans, CPM, CDM

Sharon K. Evans, CPM, CDM

OB/MD Cost Comparison

OB/DR Location	OB cost 9 months care for normal low-risk women & delivery	OB w/C-section
Wasilla	$3700 (labs/additional tests not included)1 pp exam included	
Wasilla	$3685 (includes 7-9 prenatals only, no labs, no pp exams)	
Soldotna	$$3082.00 (not including labs, includes NVD	$4127.00+
Soldotna	$2940.00 (including labs, u/s, pap)	
Homer	$2940.00 (not including labs)	$3886.00 (labwork not included)
Anchorage	$5100.00 (includes 10 PN visits, no PP or NB care)	$6300.00
Anchorage	$4358.00 (includes 10 PN visits, no PP or NB care)	$5455.00
Anchorage	$4600.00 (includes 10 PN visits and PP care)	$3600.00 (plus cost of PN, PP visits and labs0)

Birth Center Cost Comparison

Facility	Location	Cost 9 mo care including normal delivery	Facility Fee	Newborn Care	Cost Perineal Repair
AK Family Health & BC	Fairbanks	$4220.00 (labs not included; includes pn/pp/NVD	$1600.00	$615.00 (immed & 4 nb exams)	not paid
Geneva Woods BC	Anchorage		$1500.00		
Juneau Family BC	Juneau	$4200.00 (not including labs, includes pn/pp and birth)	$1800.00	$818.00 (immed & 5 nb exams)	not paid
Mat-Su Midwifery	Wasilla	$4851.20 (includes labs/pn & pp visits and birth)	$1800.00	$517.00 (immed & 4 nb exams)	not paid
The Midwives BC	Anchorage	$3665.00 (labs not included. PN, PP, birth included)	$1200.00	$390.00 immed & 4 nb exams)	not paid
Woman's Way Midwifery	Soldotna	$3400 (not including labs, includes pn/pp visits, birth)	$1250.00	$650.00 (immed & 4 nb exams)	not paid
Frontier Midwifery	Soldotna	$3650.00 (not including labs, includes pn/pp and birth)	$1200.00	$580.00 (immed & 4 nb exams)	not paid

Hospital Cost Comparison

Location:	Cost of 1 day stay hosp/ normal birth	Cost of 2 day stay in hosp/normal	Routine Nursery Care	C-section 3 night stay	C-S 4 night stay
Soldotna	$5000 00 to $7000 00	$2000.00 each additional day	$1800.00 to $2500.00	$18,000.00	$22,000.00
Palmer					
Juneau	$3200.00 range				
Homer					
Fairbanks	$3200 00	$3500.00 to $6000.00	$900 00 to $1800 00	$8500.00 to $10,000.00	$10,000.00 to$12,000 00
Anchorage	$4000.00	$5000 00			
Anchorage	$3932 00	$5531 00	$575 00 per night	$8123 00	$9833 00
Anchorage					
Anchorage					
Anchorage					

Location	Pitocin Aug or	epis/perineal repair	epidurals
Soldotna			$500.00 injectio
Palmer			
Juneau			
Homer			
Fairbanks	$1000.00+	$500.00	$3200 00
Anchorage	$500.00		$2000.00+
Anchorage			
Anchorage			
Anchorage			
Anchorage			

Alaska 2003 Birth Data by Facility*

Source: Alaska Bureau of Vital Statistics

Legend	Facility	2003 VB	2003 VBAC	2003 PCS	2003 RCS	2003 Total Births	2003 CS Ratio	2003 VBAC Rate
PN prenatal								
PP postpartum								
	AK Native Medical Center	1,126	69	83	73	1,351	11.5%	48.6%
NB newborn	Alaska Regional Hospital	506	7	134	96	743	31.0%	6.8%
NVD normal vaginal de	AVERAGE Hospital in USA							
PCS primary c-section	Bartlett Regional Hospital	196	3	92	62	353	43.6%	4.6%
	Bassett Army Hospital	486	8	40	27	561	11.9%	22.9%
VB vaginal birth	Central Peninsula Gen. Hosp.	308	4	30	40	382	18.3%	9.0%
	Cordova Community Hospital	5	0	0	0	5	0%	---
	Elmendorf USAF Hospital	521	4	94	55	674	22.1%	8.8%
RCS repeat c-section	Fairbanks Memorial Hospital	766	17	171	118	1,072	27%	12.6%
	Kanakanak Hospital	46	0	0	0	46	0%	---
	Ketchikan General Hospital	152	0	31	27	210	27.6%	0%
	Kodiak Island Hospital	152	1	22	15	190	19.5%	6.3%
	Manilaq Medical Center	79	0	0	0	79	0%	---
	Norton Sound Regional Hospital	104	0	0	0	104	0%	---
	Other Facility	63	1	19	6	89	28.0	14.3%
	Petersburg Medical Center	23	0	0	0	23	0%	---
c-s c-section	Providence Hospital	1,762	28	508	214	2,512	28.7%	11.6%
	Providence Seward Medical Center	2	0	0	0	2	0%	---
	Samuel Simmonds Memorial Hosp	30	0	0	0	30	0%	---
	SEARCHC Mt. Edgecumbe	47	1	11	7	66	27.3%	12.5%
	Sitka Community Hospital	29	2	9	5	46	32.6%	25%
VBAC VB after c-s	South Peninsula Hospital	86	1	27	8	122	28.7%	11.1%
	Valdez Community Hospital	23	0	3	0	26	11.5%	---
u/s ultrasound	Valley Hospital	366	8	73	38	485	22.9%	17.4%
	Wrangell General	6	0	0	0	6	0%	---
	Yukon-Kuskokwim Delta Hosp.	348	0	17	5	370	5.9%	0%

*Birth Centers and homebirths have been omitted from this chart because neither birth centers nor direct-entry midwives can legally attend VBACs in Alaska

Birth Center Statistics 2002

Facility	# Births 2002	Transports 2002
AK Family Health & BC	80	9
Geneva Woods BC		
Juneau Family BC	86	10, 1 PP mom, 2 NB
Mat-Su Midwifery	107	8
The Midwives BC	no data	
Woman's Way Midwifery	8	0
Frontier Midwifery	21	0

Facility	Transport Reasons 2002	Outcomes 2002
AK Family Health & BC	3 FP=c-s, 2 ROM no labor, 3 FP=NVD, 1 nb transient tachypnea	3 c-s, 5 NVD, 1 NB, all recovered
Geneva Woods BC		
Juneau Family BC	10 FP, 1 pp mom retained placenta, 2 NB transient tachypnea	5 c-s, 5 NVD, 1 manual removal placenta, 2 NB good outcomes
Mat-Su Midwifery	FP(1); prolonged ROM (7)	1c-section for FP; 7 NVD with PA
The Midwives BC		
Woman's Way Midwifery		8 NVD
Frontier Midwifery	0	0

Legend:

BC = Birth Center
C-S = cesarean section
FHT = fetal heart tones
FP = failure to progress
PN = prenatal
PP = postpartum
PROM = premature rupture of membranes
PPROM prolonged w/o Labor or FP
NB = newborn
NVD = normal vaginal delivery
PCS = primary c-section
RCS = repeat c-section
ROM = rupture of membranes
U/S = ultrasound
VB = vaginal birth
VBAC = vaginal birth after c-s

Birth Center Statistics 2003

Facility	# Births 2003	# Transports 2003
AK Family Health & BC	60	5
Geneva Woods BC		
Juneau Family BC	78	14 and 1 PP mom, 2 NB
Mat-Su Midwifery	93	6
The Midwives BC		
Woman's Way Midwifery	34	8
Frontier Midwifery	24	0

Facility	Transport Reasons 2003
AK Family Health & BC	1 FP, 2 NB transient tachypnia, 2 PP moms manual removal placenta
Geneva Woods BC	
Juneau Family BC	10 FP, 1 breech, 2 meconium stained fluid, 1 nonreassuring FHT
Mat-Su Midwifery	MSM: prolonged ROM (5), FP (1)
The Midwives BC	no data
Woman's Way Midwifery	PPROM/FP 1, FP 2, prolapsed cord 1, surprise breech 1, placental abruption 2, pain management 1
Frontier Midwifery	0

Facility	Outcomes 2003
AK Family Health & BC	1 NVD, 2 NB in good shape, 2 PP w/ d&c
Geneva Woods BC	
Juneau Family BC	8 c-s, 6 NVD, 1 manual removal placenta, 2 NB good outcomes
Mat-Su Midwifery	6 NVD with PA
The Midwives BC	
Woman's Way Midwifery	4 c-s, 4 NVD
Frontier Midwifery	0

Legend:
BC = Birth Center
C-S = cesarean section
FHT = fetal heart tones
FP = failure to progress
PN = prenatal
PP = postpartum
PROM = premature rupture of membranes
PPROM prolonged w/o Labor or FP
NB = newborn

Birth Center Statistics 2004

Facility	# Births 2004	# Transports in labor
AK Family Health & BC	59	8
Geneva Woods BC	148	
Juneau Family BC	67	10 & 1 PP mom and 1 NB
Mat-Su Midwifery	118	7 , 2 pp moms
The Midwives BC	50	7
Woman's Way Midwifery	24	1
Frontier Midwifery	19	2

Facility	Transport Reasons 2004
AK Family Health & BC	4 FP, 4 PPROM. 3 NB for transient tachypnea, no further complications.
Geneva Woods BC	
Juneau Family BC	10 FP; 1 PP mom retained placenta, 2 NB, 1 systemic cyanosis, 1 transient tachypnea
Mat-Su Midwifery	MSM: 2 (FP); FP, prolonged ROM and FP 3, retained placenta 2.
The Midwives BC	FP 3, Late FHR decels 1, preterm labor 2, PROM@34 wks 1
Woman's Way Midwifery	FP
Frontier Midwifery	Sciatic nerve pain, malpresentation; 1 NB w/ recurrent episodes of apnea

Facility	Outcomes 2004
AK Family Health & BC	2 C-S, 6 VD, 3 NB w/good outcomes
Geneva Woods BC	
Juneau Family BC	5 c-s, 5 NVD, 1 manually removed placenta on PP mom, 2 NB w/goo
Mat-Su Midwifery	MSM: 1 C-S for FP; 5 NVD with PA
The Midwives BC	1 c-s, 6 Vaginal deliveries
Woman's Way Midwifery	C-S
Frontier Midwifery	1 c-s; NB eventually put on a monitor for recurrent episodes/apnea

Legend:
BC = Birth Center
C-S = cesarean section
FHT = fetal heart tones
FP = failure to progress
PN = prenatal
PP = postpartum
PROM = premature rupture of membranes
PPROM prolonged w/o Labor or FP
NB = newborn

Addendum

Newspaper Article:	Anchorage Daily News Article dated February 17, 2005	(2 pages)
Website Articles:	How Much Labor is in a Labor Epidural	(2 pages)
	Technology and Public Health: How Much, How Often, And For Whom?	(1 page)
	The Induction Seduction: Pitocin Induced Labor	(2 pages)
	What's Right For You?	(2 pages)
	Some Statistics for Pregnancy, Labor, and Birth	(5 pages)

50 cents

Anch

Anchorage Daily News

Thursday, February 17, 2005

Study clears earlier epidural use

■ NOT SO! Previous studies claimed anesthetics in early labor increased chance of C-section, prolonged labor.

By JEFF DONN
The Associated Press

BOSTON — Pregnant women can be given a low-dose epidural early in labor without raising their chances of a Caesarean section, according to a study that could change the way obstetricians practice and make childbirth a lot less painful for many mothers-to-be.

The finding could lead doctors to consider offering early epidurals to hundreds of thousands more American women in first time labor each year.

Though medical authorities recently dropped their reservations about early epidurals, some doctors and patients still shy away from them. They worry that the painkiller's numbing effect will interfere with a woman's ability to push and thus prolong labor and prompt a C-section.

This study appears to debunk the notion about C-sections and calls into question the one about prolonged labor too.

"Women often feel guilty or weak when they request an epidural early in labor. I hope this study will help women see that there is no shame in asking for an epidural," said lead author Cynthia Wong of Northwestern University in Chicago. "The message for women and their obstetricians and gynecologists is that there is no reason why women who want an epidural should not get it when they first request it."

The study was reported in today's New England Journal of Medicine.

Epidurals deliver numbing medicine through a skinny plastic tube that is threaded into the back, close to spinal nerves, mostly bypassing the mother's bloodstream. More recent techniques, sometimes called "walking epidurals," provide lighter doses, al-

See Page A-7, **EPIDURAL**

> *"I hope this study will help women see that there is no shame in asking for an epidural."*
>
> — Cynthia Wong, Northwestern University

Anchorage Daily News ★

EPIDURAL: *No shame in using it*

Continued from A-1

low women to push and even enable them to walk throughout labor.

Doctors have welcomed epidurals as an alternative to "systemic" pain medicine through the bloodstream, which can leave a woman feeling nauseated and doped up and even enter the baby's body.

The Northwestern University study tested a type of low-dose pain relief known as a "combined spinal epidural." A small dose of pain reliever is first injected into the spinal fluid, and the epidural is later fed through the same hole into a space a bit farther from the spine.

In this study, 728 women in first-time labor were divided into two groups. One group received the spinal shot and then got epidurals when the cervix was dilated to about 2 centimeters. The other group initially received pain-relieving medicine directly into their bloodstreams, and put off epidurals until 4 centimeters if they could tolerate the pain.

In the end, the C-section rate was statistically a tie: 18 percent in the early epidural group and 21 percent in the delayed group.

The early epidural group also delivered 90 minutes sooner than the other women, who averaged eight hours in labor. However, Gary Hankins, an obstetrician at the University of Texas Medical Branch at Galveston who helped shape the medical guidelines, said it is not clear if that finding would apply broadly.

Anchorage Daily News

Anch

17, 2005

Lisa DeCook of Glenview, Ill., was a study subject in the early epidural group and delivered her daughter vaginally. She said the pain before the epidural was intense.

"Then once I got it, I really don't remember feeling any pain or contractions. It was good for me," she said. She chose an epidural on Tuesday when she vaginally delivered her second healthy baby, a boy, at Northwestern Memorial Hospital.

The finding seems to contradict some previous research showing that women who got early epidurals underwent more C-sections. In 2002, the American College of Obstetricians and Gynecologists recommended against epidurals before 4 centimeters of dilation. In July, though, it dropped a specific threshold.

"There's really no reason to withhold the treatment if a woman is in terrible pain at 1 or 2 or 3 centimeters dilation," said David Birnbach, a University of Miami anesthesiologist who is on the College of Obstetricians committee that devises the guidelines.

As for why the earlier research reached a different conclusion, it could be that some of the women had underlying problems — such as an unusually big baby — that can cause more pain, make women request early epidurals and also require a C-section, researchers said.

This study examined only first pregnancies, but C-sections are less frequent and therefore less of a worry in later pregnancies.

Other studies would be needed to settle whether early epidurals promote C-sections at higher doses or in case of medically induced labor, doctors said.

1: Anesthesiology. 2000 Mar;92(3):851-8. Related Articles, L

Comment in:
- Anesthesiology. 2001 Jan;94(1):178-9.

LWWonline

How much labor is in a labor epidural? Manpower cost and reimbursement for an obstetric analgesia service in a teaching institution.

Bell ED, Penning DH, Cousineau EF, White WD, Hartle AJ, Gilbert WC Lubarsky DA.

Department of Anesthesiology, Duke University Medical Center, Durham, North Carolina 27710, USA. bell0027@mc.duke.edu

BACKGROUND: Some anesthesiologists avoid provision of obstetric analg services (OAS) because of low reimbursement rates for the work involved. T study defines the manpower costs of operating an OAS in a tertiary referral center and examines reimbursement for this cost. METHODS: The time sper providing OAS in a total of 55 parturients was studied prospectively using a modification of classic time and motion studies. RESULTS: Mean duration c OAS in our population was 412 +/- 313 min. Mean bedside anesthesia staff t was 90 +/- 40 min, and mean number of visits to each patient's bedside was 6 +/- 2.0 visits. Assuming staffing on demand for service (intermittent staffing minimum of 2.5 full-time equivalent (FTE) attending anesthesiologists was required to meet demand. With intermittent staffing, labor cost was $325 per patient. Actual practice at Duke University Medical Center is around-the-clo (dedicated) staffing, which requires 4.4 FTEs at a cost of $728 per patient. Neither average indemnity reimbursement ($299) nor Medicaid reimburseme ($204) covered the cost per OAS patient. Breaking even is possible under indemnity reimbursement because operating room reimbursement subsidizes OAS costs. Breaking even cannot occur with Medicaid reimbursement under any circumstances. CONCLUSIONS: Obstetric analgesia services requires a minimum of 2.5 FTE attending anesthesiologists at Duke University Medical Center. With the current payer mix, positive-margin operating room activitic associated with the obstetric service are not sufficient to compensate for the losses incurred by an OAS. Around-the-clock dedicated obstetric staffing (4.

current data that support their use only to correct specific medical complications. They claim that continuous one-on-one care reduces the need for most obstetrical interventions for low-risk women and that research supports the safety of out-of-hospital births for such women.

Few medical institutions can afford one-on-one care, the limiting factor most often cited by physicians. Obstetricians are generally responsible for more than one birth at a time, in addition to other clinical work, and the vast majority of obstetricians believe these "standard" medical procedures make birth safer. Many even believe that out-of-hospital birth is patently unsafe. Furthermore, doctors must balance their scientific knowledge against the threat of lawsuits and the competitive nature of the medical marketplace.

Consumers also often demand a painless birth, which necessitates the use of technology. Indeed, early feminists clamored for pharmaceutical advances to help ease the burdens of childbirth. In the midwifery model, labor pain is managed by constant emotional support, walking, massage, baths, showers and giving the mother control over her environment.


Epidural Procedure

While no caregiver wishes their patients' pain to consume the birth experience, medical research has raised concerns about the routine use of epidural anesthesia. Though generally considered safe, epidurals are associated with an increase in prolonged labor, back pain, nausea, severe headaches, the use of forceps, vacuum extraction and c-sections. There is little research exploring the long-term effects of epidural anesthesia on mothers and newborns.

Home | Childbirth | Birth Stories | Glossary | The Law | Talkback | Resources | ITVS

- Childbirth In America
- Fact
- Women's Right
- Technology & Public Health
- Four Stories & Suggestions
- Glossary
- The Film
- Take Action
- Resources

Broadcast Schedule

Downloadable Guides

Get the Video

TECHNOLOGY AND PUBLIC HEALTH: HOW MUCH, HOW OFTEN AND FOR WHOM?

The American medical system is considered to be among the most technologically advanced in the world, and in a culture where we believe anything is possible, we expect this technology to improve our lives and solve our problems. We do, in fact, spend more per birth than any other country in the world. Each year, approximately 4 million babies are born in the U.S., most in a hospital with a physician in attendance.

Why then do we rank last among the industrialized nations in infant mortality and low birth weight (24th in the world)? Why are African American babies two to three times more likely to die during childbirth than their white counterparts and African American women four times more likely? What does our medicalized "average" childbirth reveal about our society's support of women and children?

Childbirth is an individual, singular experience with inherent risks and benefits. What should the average, healthy woman expecting a child know? What safe options exist? Are all options available? Should they be? For the average low-risk woman, what are the risks and benefits of technology in the birth room? Should every birth make use of the latest technology?

Midwives and obstetricians often disagree on the role of technology in the birth room. A standard physician-attended birth usually includes the administering of intravenous fluids (IVs), the use of continuous electronic fetal monitoring and the widespread application of regional and epidural anesthesia. Cesarean sections - where the baby is surgically removed from the mother's abdomen - occur in more than one in five births (22 percent). 40 percent of all vaginal births are accompanied by an episiotomy, a surgical cut to widen the vaginal opening.

Many midwives question the necessity of these interventions and point to

The Induction Seduction: Pitocin Induced Labor

By Shari Becker

Selective Inductions

Many induced deliveries are for personal reasons, often convenience, rather than "medical" ones. Some doctors offer inductions to their patients if the doctor may be unavailable when mom goes into labor. "You have the right to decide how your baby is delivered," Dileo says, "so long as it doesn't harm you or your baby." The American College of Obstetricians and Gynecologists sanctions the use of Pitocin to induce labor for convenience once a woman has reached her 39th week of pregnancy and her cervix is ripe, he adds. To determine whether or not a cervix is "ripe," doctors check a woman's "Bishop's Score," a numerical score based on dilatation, thinning (effacement) and head descent, explains Dr. Kritz.

Not all delivery practitioners and medical institutions agree with the American College of Obstetricians and Gynecologist's sanctions, however. Ratta explains that Massachusetts General's protocol states that inductions may not be performed until the 41st week of pregnancy, if the cervix is ripe, and the patient desires. This time frame is based on research that indicates a baby may not remain healthy in the womb once week 42 has passed. After week 42 the baby can outgrow its supply of placenta, and the remaining amniotic fluid may not be sufficient to sustain the baby's metabolic needs, says Kritz.

ZONES
Aception
Ask an Expert
Announcements
Baby Books
Baby Names
Birth Stories
Chat & Boards
Childbirth Choices
Children's Books
Contraction Tool
Cord Blood
Due Date Calculator
E-Cards

Educational Toys
Family Magazine
Free Stuff
Glossary
Mom to Mom
Photo Contest
Pregnancy Journals
Recalls
Recipes
Safety
Shopping
Sleep
Travel

The Risks

So, you've reached week 40 and you want your baby delivered - now. You may request an induction from your doctor, if your cervix is ripe. According to Dr. Kritz, Pitocin used to induce before the cervix has softened can cause serious complications including a risk of placental abruption or harm to your baby.

"If your body goes into labor, your body is saying, 'I'm ready to deliver.' If your labor is artificially induced, it likely won't work as well, and your body might stop midway," says Ratta. In other words if your cervix isn't ripe, your body is not ready to deliver, and an induction will increase your risk of an emergency C-section.

Another risk is posed when "Pitocin is used incorrectly and causes hyper-stimulation, which brings on a 'mother' contraction, [which impacts the supply of blood and oxygen to the fetus] and affects the heart rate of the baby [fetal distress]," explains Dileo. Sometimes, though, these "mother contractions," called tetanic contractions, are simply fluke reactions to the drug. "In rare cases, [these strong contractions] can lead to tearing of the uterus," states the USP Drug Guide.

Previous Page Next Page

Email This Page To A Friend
Printer Friendly Version

The Induction Seduction: Pitocin Induced Labor

By Shari Becker

What's Right For You?

Any pregnant woman may find herself in a position where she needs to be induced for medical reasons, and all moms-to-be should be aware of this possibility. Induced births are often wonderful experiences, and fortunately with modern medicine it is possible to induce delivery of a baby who might otherwise suffer from serious health risks.

But, when faced with the option of an induction, especially a selective one, women need to know of the risks and the facts. In deciding which kind of delivery practitioner you want to use, consider each one's stance on drug-induced labor. Doula, Robin Elise Weiss, founder of childbirth.org and currently About.com's pregnancy guide, believes that "in general you'll probably find OBs are quicker to jump to pit [in using Pitocin] than midwives, though it's certainly case by case." In addition, an Ob/Gyn who works for a private practice may have a different policy on inductions than a doctor who works in a hospital setting. The latter will need to follow the hospital's protocol, says Ratta. She adds that while she does use Pitocin in deliveries, she will not perform an induction simply because a patient requests one. "It is not what midwives do," she says, and in fact, she "strongly advises against [a non-medically necessary induction] as it is inherently risky." Dr. Kritz believes that selective induction goes against the traditionally, non-interventionist philosophy of the family practitioner, as well. If she induces a delivery, it is typically because a woman has gone into labor on her own but is not progressing.

Educational Toys
Family Magazine
Free Stuff
Glossary
Mom to Mom
Photo Contest
Pregnancy Journals
Recalls
Recipes
Safety
Shopping
Sleep
Travel

Expecting moms also need to think about the delivery process and their faith in their bodies. "I think Pitocin is over-used in many ways," says Weiss. "You see it used routinely for the delivery of the placenta, rather than waiting or allowing nature to take its course. At the births I've been present at, I find it being used more and more, particularly without waiting for the woman's body to kick in." That said, many women don't mind not waiting for their bodies to kick in and prefer to be in control of the labor experience. As long as they understand that "Pitocin is not a benign drug," warns Dr. Kritz. Pitocin, like "any medication used well, can be wonderful, and like any medication used improperly, can be a disaster," says Dr. Dileo.

Given the ease with which doctors induce, many women when offered the possibility of ending their pregnancies early, feel thrilled, but are simply never made aware of the risks. Many women are uninformed, says Ratta, and it is left to the physician, who is often pressed for time, to teach them. "I don't believe women get true informed consent, about most anything, including Pitocin," says Weiss. Informed as pregnant women may be, once in the delivery room --in labor, and possibly on painkillers-- many women feel vulnerable. A birth plan that takes many different possibilities into account can help you be prepared, and empowered to make decisions consistent with your personal needs and values should any unexpected events occur during delivery. In the end, remember that the most important part of the delivery process is the little person you're delivering.

Previous Page

About the Author

Shari Becker is a writer specializing in children's topics. A former editor and producer, she has worked with such companies as Time for Kids, Nickelodeon and Scholastic. Currently living in Massachusetts with her husband and new daughter, Shari is focusing on her own projects and has just been awarded a contract for a brand new children's book.

All articles by Shari Becker

March 4, 2005

907-465-3805

To: Senate H&SS Committee
RE: SB22

Dear Senator Lyda Green:

This letter is to express my support of SB22, which would allow for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. Hospitals are paid facility fees. Insurance companies pay the facility fee (80-100%), but Medicaid does not. What about those of us who want to deliver out-of-hospital? More and more low risk women are opting for out-of-hospital births, with Mat-Su Midwifery doing close to 100 birth center births per year, or approximately 1/4 of the births in the Valley. As Midwives' statistic show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benifit, and the state of Alaska will save money.

Sincerly, Anette I. Jews
Alaska mom

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 0 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Deanne Mercuri, ANP

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had no babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

If I was aware of birth Centers when I had my children, that would have been my choice. In many Respects I felt abused by the nurses at the hospital.

Ceena Warner

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 2 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Tara Gerrick

Every woman deserves to choose her birth site. Tara

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The ~~Midwives Birth Center~~ Other Midwife in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

I think it is unfair that I am forced to have a hospital or home birth when I want to have my baby at The Midwives BIRTH CENTER. If Medicaid pays the Hospital - why WON'T THEY PAY My midwives - ESCpecially BECAUSE IT IS SOOOO much cheaper? PLEASE BE FAIR!

Renae Long

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 0 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Dali E Helt

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

I am on Denali Kid Care and I feel I should have the choice to have my baby at the Birth Center not just in my home or at the hospital.

Corene Stansberry

January 25, 2005

To: Senate HESS Committee
RE: SB22

Dear Senators:

I have had 1 babies with the midwives at The Midwives Birth Center in Anchorage. I am in favor of SB22 passing, allowing for birth centers to be paid for their facility fees. If a woman wants a birth center birth, the facility fee has to come out of her pocket at this time. More and more low risk women are opting for out-of-hospital births, with The Midwives Birth Center doing close to 50 birth center births in 2004 (their first year of business). Hospitals are paid very high facility fees. What about those of us who want to deliver out-of-hospital? As midwives' statistics show, birth centers are a safe, cost-effective option. I would like to have the option to choose a birth center over the hospital, so I am asking you to please support SB22. The young families of Alaska will benefit, and the state will save money in the long run.

Sincerely,

Lanae J. Rhoads

Lanae J. Rhoads

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/11/05

FURTHER: (Finance)

Date of 5-Day Notice: 1/13/05
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2.2.05

Health, Education and Social Services Committee considered SENATE BILL NO. 22

SB 22 MEDICAID COVERAGE FOR BIRTHING CENTERS

"An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	1/18			X	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
	✓			
	✓			
CHAIR:	✓			