



Transforming Maternity Care

A High Value Proposition

Priorities for Moving to a High Quality, High Value Maternity Care System from the Perspective of Maternity Care Clinicians and Health Professions Educators

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Transforming Maternity Care Maternity Care Clinicians and Health Professions
Educators Stakeholder Workgroup

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Introduction

The transformation of maternity care to improve quality and value will depend, to a very large extent, on the clinicians who provide this care and the health professions educators who train these clinicians. Physicians, nurses, certified nurse-midwives, other certified midwives and other professionals support or participate in the delivery of prenatal care, labor and delivery care, and after delivery and newborn care, and their educators include many of the same professionals as well as others.

While “woman-centered” maternity care appropriately provides the pregnant woman with key decision-making responsibility, her caregivers’ approaches to practice have tremendous influence on how informed and educated she is in making decisions, and on what care she actually receives. Thus, clinicians and their educators are key to the transformation of the maternity care system.

Numerous factors influence a clinician’s approach to his or her practice. Many influences on practice are unrelated to evidence of effectiveness or risk of harm, or fail to correspond with the provision of high quality/high value maternity care. For example, payment mechanisms may provide incentives for far more intensive care than is clinically warranted. Liability concerns may lead to invasive approaches even in low-risk scenarios. Performance metrics can have unintended consequences on clinician behavior. To improve the value of maternity care, the factors that influence provider practice must be those which assure the best pregnancy outcome for a given woman, with consideration of the values important to her and her care providers.

Finally, practice style and clinical decisions are direct reflections of not only the clinician’s experience, but also the clinician’s initial and ongoing training. We must transform the educational curriculum, the settings in which clinicians train, and the emphasis of their education and training. Ideally, education and training must reflect the best available scientific evidence and a firm understanding of what pregnant women want and need from their care providers. This strategy must be applied to continuing education intended to maintain ongoing clinical competency, as well as that required to maintain appropriate certification and/or licensure.

Maternity care clinicians and educators must be at the forefront of transforming maternity care. Through collaborative efforts among the various professional organizations, and working alongside other stakeholders in the delivery of maternity care, these professionals will play an essential role in achieving the vision of the Childbirth Connection 90th Anniversary Symposium

Performance Measurement and Leveraging of Results to Improve Maternity Care

Current Problems:

Maternity care in the U.S. is characterized by unwarranted variations in care and outcomes, lack of application of evidence-based strategies and overuse or routine application of many interventions within populations for whom they are not beneficial. Furthermore, there is still much to be learned about the physiology of birth and the related effects of interventions on outcomes, all which are needed to establish benchmarking goals and ideal rates, for example, of growing practices like elective repeat cesarean section and induction of labor.

Although U.S. health care systems are beginning to embrace performance measurement, there remain multiple challenges to implementing performance measurement that can lead to an improvement in patient outcomes. Some of the key issues are:

- Multiple organizations promote multiple performance measures. Many still require validation to assure that they are tightly linked to patient outcomes. There is not a single, national set of measures which is simultaneously meaningful to hospital and healthcare systems, payors and purchasers, clinicians and other providers of care, education, accreditation and licensure organizations, and consumers and their families.
- There are gaps in needed maternity care measures. The National Quality Forum (NQF) has endorsed a set of 17 maternity care measures (at time of writing, subject to final report from NQF). Nearly all of these measures are focused on hospital care and there are no measures devoted to patient experience or access to care.
- Performance reporting is currently cumbersome and resource-intensive for both health care organizations and clinicians. Data collection is not seamlessly integrated into existing data systems and data systems are far from standardized. Paper-based data collection, such as chart review, can retrieve accurate clinical information but is burdensome. Most clinicians and hospitals use electronic claims submission, but claims data lack much of the diagnostic and care information that is needed to make them useful for performance assessment and quality improvement. Vital statistics such as birth certificates do capture many key data elements, but are not adequate for performance measurement sources because they also lack critical clinical data. The addition of more performance measures without attention to the feasibility of data collection will not help to move forward improvements in maternity care.
- Clinicians and hospitals have raised concerns over performance measurement and public reporting because of the difficulties attaining appropriate case-mix adjustment that would allow for accurate outcome comparisons across providers. Some process-type measures, however, should not be subject to case-mix adjustment because all women should receive certain types of care.

Successfully dealing with these issues will require targeted strategies and cooperative action across the various stakeholders in maternity care. We offer the following recommendations as priority strategies for aligning performance measurement with improving the quality of care.

Recommendations:

1. Health care systems should develop, field-test and submit additional performance measures to fill the current gaps with particular attention to patient experience and outcomes of care. Additional measures should cover key aspects across the continuity of maternity care, from preconception to postpartum and newborn care.

a. Strategies:

- Develop new performance measures that capture physiologic birth and the experience of women giving birth in the US system. Continue to validate measures currently in use to assure that they are tightly linked to patient outcomes. Regularly review measures for reliability, validity and relevance.
- Develop new performance measures that describe important dimensions of patient experience, including cultural competency, quality of the patient-provider relationship, respect, informed choice, and information giving and gathering.
- The most likely users of maternity care measures for public reporting include purchasers, states, Medicaid programs, the U.S. Department of Veterans Affairs and the Department of Defense (VA/DoD) systems, quality collaboratives, consumers and advocacy organizations. These groups should be enlisted to push for development of harmonized, feasible, comprehensive measures with measure developers.
- Identify funding to commission an experienced developer to produce a patient experience of care survey instrument focused on maternity care for use in the public domain. This survey should serve as the basis for adding patient experience performance measures in the public domain as detailed above.

b. Lead responsibilities:

- Prominent maternity measure developers include health care facilities and integrated systems, regional quality collaboratives and national organizations such as the Agency for Healthcare Research and Quality (AHRQ).
- All relevant maternity care professional provider organizations should be encouraged to work with measurement development organizations to support the development, testing and submission of measures.

c. Challenges and solutions:

- Current measure development is driven largely by the goals of the developer organizations, which may not align with a focus on the most important areas of measurement for driving improvements. A unified measurement development strategy may require starting with some measures of normality to which all can agree and developing additional measures from there. Measures such as the rate of “normal birth” tracked in the United Kingdom’s National Health Service should be examined as possible models.

- There are currently several proprietary tools to measure patient satisfaction with care; although these instruments may not capture key elements of patient experience it would be important to examine them as starting points as well. A public domain patient experience tool, such as a maternity-specific modification of the AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) instrument would be a desirable outcome.
- d. Mechanisms for collaboration:
 - NQF and the Joint Commission call for, endorse, disseminate and help systems implement new measures. Using existing NQF contacts, bring key groups into the dialogue. Individual organizations (professional societies and health care organizations) could also volunteer to be the measure “sponsor” with NQF.
- e. Timeline for achievement:
 - *Developers:* Initial meeting of stakeholder groups within one year, the by end of April, 2010.
 - *Users:* Joint group of professional organizations, healthcare foundations and other funders convene to fund development testing

2. Create seamless integration of current routine data collection and performance measure reporting.

- a. Strategies:
 - Enhance and improve routinely collected vital statistics such as the birth certificate as the basis for data collection on performance, using the electronic medical record (EMR) development underway through the current federal stimulus package to more accurately populate the birth certificate fields.
 - Merge de-identified routine vital statistics and hospital discharge data with performance reports and make these data available to clinicians and hospitals to provide feedback on their performance so that they can improve their systems of care.
 - Providers of out-of-hospital maternity care should also collect and report data in a standardized way, even if not all of their data reporting is electronic. Capturing the process of care and outcomes from these settings is important and can serve as a benchmark for appropriate intervention care for women experiencing low-risk physiologic pregnancy and childbirth.
- b. Lead responsibilities:
 - Stakeholders include including Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS), Medicaid, VA/DoD, and maternity care performance measurement developers and endorsers, along with the EMR developers should be involved. The stakeholders, including all relevant professional groups involved in maternity care, hospitals, payors, government agencies, researchers and

quality experts, should also be enlisted in streamlining data collection as they develop measures.

c. Challenges and solutions:

- This recommendation will require bringing together disparate groups with different needs and agendas. The focus should be on improving the quality of maternity care since improved quality and cost effectiveness in maternity care typically go hand in hand.
- Clinicians may “push back” against performance measurement requirements. Until recently, few health care organizations normalized feedback to clinicians on their outcomes, or expected evidence-based strategies as an integral part of professional practice in maternity care.
- Some states have experimented with providing coverage for home births in exchange for data reporting in order to develop an evidence base for evaluation of this service. This may serve as a model in other settings as well.
- There may also be opportunities to integrate with ongoing federal Health Information Technology (HIT) and EMR development initiatives and those included in the 2009 stimulus package.

d. Mechanisms for collaboration:

- There is a uniform birth certificate in use nationally, developed and maintained by the NCHS in collaboration with state vital statistics branches. An exploratory meeting of NCHS, AHRQ and other key stakeholders could provide an opportunity to kick off this discussion. Several professional organizations such as ACNM have existing datasets that gather the outcomes and processes of care. Similarly, the Midwives Alliance of North America (MANA) Division of Research has developed a web-based data collection tool, and the American Association of Birth Centers (AABC) has a uniform data set that is an online clinical data registry. A state or regional pilot may serve as a way to develop an enhanced or augmented birth certificate.

e. Timeline for achievement:

- Initial meeting by the end of 2009.

3. Create mechanisms for sharing and benchmarking clinician-level best practice data.

a. Strategies:

- Do a comparative analysis of existing programs for performance feedback at the provider level to identify which are best practice models that could be disseminated. Use of current models such as the well-established Northern New England Perinatal Quality Improvement Network (NNEPQIN) and their OBNET birth registry could serve as examples for ways to benchmark in support of improving quality.

b. Lead responsibilities:

- Payors, health care systems, quality improvement organizations, all relevant professional societies and childbirth advocates need to come together for this activity. A large health care foundation could act as a convener for exploring and supporting expansion of best practices.

c. Challenges and solutions:

- Private payors and healthcare organizations often compete with each other and may not want to share proprietary information and products. Where local, state and regional efforts have been successful these organizations and providers are likely to be loyal to their own methods. A one-size fits all approach is not necessary as long as similar care and outcome goals are chosen. In other patient safety endeavors, even financially competitive organizations seem willing to share best practices and learn from each other. AHRQ's TeamSTEPPS program offers one such model on a national level.

d. Mechanisms for collaboration:

- Professional societies, quality improvement organizations, government and purchasers of care should work together to disseminate successful strategies for improving care. Public payors such as Medicaid can help to lead this effort since they are least likely to be in competitive relationships with private payors. Large healthcare-oriented foundations such as the Commonwealth Fund and The Robert Wood Johnson Foundation (RWJF) could help bring organizations together to catalog best practices.

e. Timeline for achievement:

- Initial exploration for funding this activity should occur by the end of 2009.

Payment Reform to Align Incentives with Quality

Current Problems:

The United States spent 2.3 trillion dollars on health care in 2005, yet 47 million people were uninsured and thousands of men, women and babies died simply because we tolerate disparities in payment, access and care delivery in this country. Our current system of care costs too much, provides too little and protects too few. The WHO ranks the US 37th in health system performance, but much lower for fairness in financial contribution. Our current system of payment for health care is unsustainable and will require broad revisions in health insurance financing, health care payment systems, and how patients are compensated for recovery assistance from adverse events. Any new payment scheme must minimize perverse incentives which could lead to the underutilization of effective care, or the inappropriate overuse of unnecessary or low value care.

The global fee for maternity care creates perverse incentives that are poorly aligned with overall quality and value. Rather than focusing on the goal of an overall optimal outcome of care, an incentive is created to seek opportunities to get paid for discrete, specific services that can be charged outside the global fee. This may lead to overuse of certain procedures and, in turn, provides disincentives for important aspects of maternity care which do not generate significant reimbursement. For example, in general, prenatal care is relatively undervalued compared with care provided during labor and delivery. Further, postpartum care/counseling is usually bundled with the labor and delivery fee, and likewise does not receive appropriate emphasis in the reimbursement system.

Most faculty practice plans incentivize the volume of services delivered based on productivity formulas, which creates a disincentive to spend time teaching. Clinicians cannot take the time to teach the way they would like, because doing so is not financially rewarded in a way commensurate with clinical productivity. This creates a clinical training system where “teaching on the fly” is the norm, consisting of exposing the learner to whatever experiential knowledge he or she can gain along the way while within the learning environment. Further, the aspects of clinical care which receive the greatest financial rewards are acute, hospital-based care practices along with technologic interventions and diagnostic procedures. This creates an incentive to preferentially teach high-technology, highly intervention-based care procedures, thus perpetuating a high-tech, interventionist practice style.

Recommendations:

1. Consider alternatives to the global fee system that would encourage re-orientation of the maternity care system from acute care and disease management to wellness promotion and disease prevention with attention to factors that elevate risk in certain populations. Clinicians are discouraged from providing those aspects of maternity care, such as prenatal care, which emphasize time-consuming face to face education and counseling needed to promote physiologic childbearing experiences. Certain prenatal care strategies which are known to be associated with significant decreases in prematurity receive much less clinician emphasis than those which involve expensive technology and/or laboratory assessments. Designing a system focused on wellness and prevention will require robust support of the public health system and of safety net providers to ensure equity.

a. Strategies:

- Unbundle global fee systems and reimburse maternity care providers commensurate with their efforts and outcomes demonstrated. Prenatal care shares many characteristics of a preventive health visit and could be reimbursed as a capitated care management payment, as described by Miller¹. Physiologic childbirth would then be reimbursed as an episodic care payment. More acute and/or complicated procedures may require additional reimbursement. It would be counter-productive to use these tools to reduce short term costs, as that would re-introduce perverse volume- and procedure-driven behavior.
- Develop maternity care teams who can best provide the most appropriate type of care based on patient acuity and provider education. These teams could appropriately value the services covered by a care management payment. Look specifically at appropriate payment systems to reimburse rural maternity care teams for whom issues of volume, coverage area and patient acuity are not adequately addressed by the current reimbursement model, which negatively impacts quality of care and provider recruitment to underserved areas.
- Reimburse those providers who teach learners about these strategies with salaries competitive to those who provide episodic interventional care. This may require pilot measures to assign value to teaching units. Properly assigning units of value to teaching has always been challenging because the return on investment is so far downstream.
- Encourage and fund demonstration projects that would develop alternative payment schemes to maximize outcomes and processes, as opposed to being procedure-driven.
- As the current liability environment incentivizes over-use of testing and procedures, alternatives such as alternative dispute resolution, health care courts, adverse event funds/trusts must be employed. Every effort should be made to reduce liability by promoting a culture of safety throughout the healthcare system.

b. Lead responsibilities:

- Advocacy at Center for Medicare and Medicaid Services (CMS) and the appropriate resource utilization committee (RUC) are necessary to lead the change to unbundle the global fee system and encourage other payors to follow suit. Advocacy to do so must come from a coalition of professional organizations representing maternal health care interests.

c. Challenges and solutions:

- The lack of cooperation among professional groups representing maternity care providers and the lack of political will from those who can generate federal legislative initiatives.

d. Mechanisms for collaboration:

- Major professional organizations such as the American Academy of Family Physicians (AAFP), the American College of Nurse-Midwives (ACNM), the

¹ Miller HD. From volume to value: Transforming health care delivery systems to improve quality and reduce costs. Network for Regional Healthcare Improvement, 2008.

American College of Obstetricians and Gynecologists (ACOG), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) need to coalesce their interests in promoting these concepts through their resource utilization committees (RUCs). This would also be an agenda item for the organizational boards to discuss and assign work groups. Willing participants from insurers and health care reform politicians need to be recruited to work with this coalition.

e. Timeline for achievement:

- Discussion by organizational boards in 2009 with work groups starting in 2010.

2. Adjust clinical faculty payment formulas to align with quality teaching

contributions. Protected faculty teaching time should be incentivized similarly to that of clinical production. Evaluation data from the learners themselves can help define a cadre of clinicians who are most effective, allowing others to pursue clinical production/income.

a. Strategies:

- Establish academic/teaching incentive plans that run parallel to clinical production formulas.
- Develop teaching models which allow nursing and midwifery educators to teach multidisciplinary students and resident physicians skills that align with their expertise.
- Teaching models should include performance improvement assessments as a way of developing critical appraisal skills for valuing evidence-based clinical practice.

b. Lead responsibilities:

- Development of cooperative, incentivized education programs needs to be a joint effort between colleges of nursing, colleges of medicine and the clinical institutions themselves (hospitals/clinics) which will generate a cohesive mandate to the individual providers providing the teaching and/or clinical services. This in turn will dictate to department and division chairs a way to select and incentivize those most appropriate for teaching and those most appropriate to provide only clinical care.

c. Challenges and solutions:

- Current reimbursement formulas do not allow proper incentive of basic outpatient teaching versus the incentives provided through the insurers for procedural medicine and expensive technologies. Until the payors themselves incentivize directly for these services, major challenges exist within faculty productivity formulas.

d. Mechanisms for collaboration:

- The potential for collaboration in teaching institutions is significant across colleges of nursing, colleges of medicine and hospitals themselves. Leadership in these three entities need to cooperate to assure that the best possible education is provided to learners and assure that the best possible outcomes for the patients. Provider organizations such as ACOG, AAFP,

ACNM and AWHONN should approach the Health Resources and Services Administration (HRSA) about funding projects that demonstrate interdisciplinary care in teaching and calculate an equitable payment system.

- Involve the Accreditation Council for Graduate Medical Education (ACGME) and the relevant residency review committees (RRCs for Ob/Gyn and Family Medicine) in discussions about teaching and learning standards and multidisciplinary learning.

e. Timeline for achievement: begin in 2010

3. Establish that maternity care is a critical component of public health/preventive medicine which should be valued as among the most important public health strategies in future health care reform.

a. Strategies:

- Establish a payment system using outcomes data based on prevention.
- Encourage institutions to teach maternity care as a wellness model.
- Encourage educators across professions (nurses/midwives/physicians) to educate one another about the best evidence for safe and effective care within their area of expertise.

b. Lead responsibilities:

- Nursing school and medical school leaders/deans should work together in order to establish the appropriate cadre of educators in maternal health regardless of degree.

c. Challenges and solutions:

- The potential mingling of productivity/practice plans and the perception that a disproportionate amount of funding will necessarily come from physician clinical practice plans.

d. Mechanisms for collaboration:

- In addition to the need for cooperation among nursing, midwifery and medical schools, collaboration with respected accreditation and certification authorities is needed in order to obtain buy-in for the acceptance of a new model of teaching clinicians. For example, for obstetrics and gynecology, the Residency Review Committee (RRC) and the American Board of Obstetrics and Gynecology (ABOG) need to accept a new model of mixed clinician teaching using advanced practice nurses and/or midwives. Leadership in these organizations should attend each other's annual meetings and discuss this as an agenda item.

e. Timeline for achievement:

- Begin 2009. Organize teams to draft demonstration projects that would plan models in 2010. Implement models in 2011.

Improved Functioning of the Liability System

Current Problems:

The current system creates numerous problems including liability insurance that is unaffordable for many providers. Unaffordable premiums push providers to accept more work than they can attend safely. Providers in states with unaffordable liability premiums often move to other states, limit their practice to exclude maternity care, or retire early. A “consumer” model for health care contributes to the belief among many patients that they are entitled to expect a perfect outcome every time; at the same time there are inadequate systems to meet the onerous financial needs of families with babies whose long term health is compromised, pushing them to the tort system. All these factors limit access to care for women. There are emerging efforts in patient safety and error reduction programs that can identify and address system issues and reduce compensable injuries as well as other poor outcomes.

Recommendations:

1. Make alternative dispute resolution methods and liability limiting legislation legal in all states.

a. Strategies:

- Increase the use of binding arbitration, specialized health courts, early resolution programs, limitations on non-economic damages awards, and state no-fault compensation programs, such as the Florida Injury Neurological Compensation Association.
- Support legislation, such as the 2008 Baucus Health Reform Plan, which promotes the formation of specialized health courts that use judges and panels skilled in negligence reviews instead of the current tort system. Juries recognize the injured's need for financial assistance with health care bills and compensation for medical error; however, their lack of medical knowledge often leads to capricious and inflated awards.
- Early resolution programs should include provisions for admitting error with an apology without admission of fault so apologies do not become prima facie evidence of negligence.
- Draft model no fault programs that provide immediate payments to families for health care and special medical supplies
- Increase the number of professional organizations that define and publish standards for expert witnesses

b. Lead responsibilities:

- The American Academy of Family Physicians (AAFP), the American Association of Nurse Anesthetists (AANA), the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), the American Society for Anesthesiology (ASA), and the Association of Women's Health and Neonatal Nurses (AWHONN) should be the lead organizations in this reform.

c. Challenges and solutions:

- As mentioned above, any reform involving the legal system will require the support of the legal associations, such as the state bar associations. Changing laws in all 50 states will be time consuming. Cooperation from the insurers' associations and the state governments will be essential for this reform.

d. Mechanisms for collaboration:

- Federal efforts must be integrated in the expansion of access to health care.
- A possible collaborator is the organization Common Good, whose purpose is the promotion of health courts.
- To be successful, these efforts must engage trial lawyer organizations to help mediate the balance between improving patient care and assuring due process for the injured.
- Other stakeholders are listed in Table 1.

e. Timeline for achievement:

- Tort reform and medical error reduction strategies must begin in the 2009 and 2010 legislative sessions at the state and federal levels.

2. Physician, midwifery and nursing education must integrate error reduction, patient safety, evidence based practice, and team functioning throughout their curricula to decrease future medical error and liability claims.

a. Strategies:

- Co-education of nursing, midwifery, medical, pharmacy and other health care students will increase understanding of differing scopes of practice, and increase communication skills and team practice in maternity care. Many groups have added safety components to their curriculum; however, this movement must be broad-based and integrated between specialties.
- The use of obstetrical emergency drills, such as shoulder dystocia team drills, may improve team performance during obstetrical emergencies.
- Organizations should develop and disseminate check lists to enhance clinical decision making; for example, a checklist to determine the suitability of a trial of labor after cesarean and a checklist to determine safest route of birth for an obese woman with gestational diabetes.
- State insurance regulators should require that insurers discount liability insurance premiums for those who demonstrate regular participation in quality improvement programs and medical safety programs.
- Organizations must discipline disruptive or unsafe providers.
- Medical errors can be reduced by supporting systems which provide better rest for all maternity care providers, including nurses. These include limited residency hours, use of birth hospitalists (laborists) including use of midwives as hospitalists for low-risk births, and attention to adequate staffing and scheduled breaks.

b. Lead Responsibilities:

- The professional organizations, led by the American Academy of Family Physicians (AAFP), the American Association of Nurse Anesthetists (AANA),

the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), the American Society for Anesthesiology (ASA), and the Association of Women's Health and Neonatal Nurses (AWHONN) along with the educational organizations (Table 2) should lead these strategies.

c. Challenges and solutions:

- It will be a challenge to convince providers that integration of safety techniques will save time and costs in the future. Reducing the fatigue of physicians, midwives, and nurses as a safety measure requires an increase in workforce during a time of high workforce retirement through aging. Increased education of physicians, midwives and nurses will require increased federal and state funding to support programs. Time and appropriate compensation for safety activities will need to be built into healthcare systems.

d. Mechanisms for collaboration:

- The accreditation corporations and continuing education divisions for the professional associations should work with each other to implement these strategies. Strategies implementation can be started at the 2009 annual meetings.

e. Timeline for achievement:

- Beginning immediately and continuing for at least 5 years.

3. Create state sovereign immunity or liability coverage programs for health care provider education.

a. Strategies:

- Educational programs must provide liability coverage for faculty and students. In some programs faculty and students purchase their own insurance in the private market, which is often prohibitively expensive. Faculty and student coverage and fear of vicarious liability decrease the willingness of private practices to precept students. State or national liability pools for educators, students, and preceptors or limited state sovereignty programs for faculty, such as that used in Puerto Rico, should be enacted.

b. Lead Responsibilities:

- The Accreditation Commission for Midwifery Education (ACME), the Accreditation Council for Graduate Medical Education (ACGME), and the Midwifery Education Accreditation Council (MEAC) should be the lead organizations in this effort, working with individual State legislative and judicial authorities.

c. Challenges and solutions:

- Designing a state program that could include both private and state educational organizations will be difficult. Broad participation will be necessary in non-sovereign immunity programs to establish sufficient funds for negligence claim defense and settlement.

d. Mechanisms for collaboration:

- ACOG, AAFP and the ACNM should call a special conference in fall 2009 in Washington to work with state government organizations to draft model law for the states.

e. Timeline for achievement:

- Draft work on a model policy should be done in 2010 with legislative efforts to enable this model initiated in 2011.

(See Tables 1 & 2, Appendix 1)

Disparities in Access and Outcomes of Maternity Care

Current Problems:

In 2003, the landmark publication from the Institute of Medicine of the National Academies (IOM), *Unequal Treatment*, documented the existence of racial and ethnic disparities in health outcomes. The committee found that provider bias, stereotyping, prejudice and clinical uncertainty resulting from clinicians' inaccurate and incomplete understanding of information from patients likely made some contribution to racial and ethnic disparities in healthcare outcomes. Thus, this contribution to racial and ethnic disparities in health outcomes is especially pertinent for healthcare providers and their educators.

Thousands of men, women, and children died simply because we tolerate disparities in the way care is accessed and delivered in this country. Our current system of care costs too much, provides too little, and protects too few. Healthy People 2010 has documented many recent maternity-specific disparities:

- Black children are 2-3 times more likely to die before their first birthday than white children.
- Black women are almost twice as likely to suffer a pre-term delivery and four times as likely to succumb to a pregnancy-related death.
- Black newborns are 2-3 times more likely to be born very pre-term (<32 weeks) compared to white infants.
- Black, Hispanic and Native-American women are significantly less likely to receive early prenatal care.

The renewed national focus on pre-term birth and its relationship to health disparities was embraced in the 2007 IOM report, *Preterm Birth--Causes, Consequences and Prevention*, and at the 2008 Surgeon General's Conference on Preterm Birth Prevention. At both venues the need for research and interventions to eliminate health disparities, as well as the need for care delivered by culturally competent providers, were stressed.

Health system process barriers are varied:

- Out of pocket costs for care are more likely to prevent low income families from accessing care as these costs are higher as a percentage of income.
- Entry barriers for those seeking maternity care may include daunting documentation for patients seeking care in communities that no longer can afford to work in the spirit of presumptive eligibility.
- Transportation barriers, even in urban areas, may preclude access to timely maternity care for mothers with many competing priorities.
- Many women feel isolated as they may no longer have access to an extended family or friendship structure.
- Mistrust in the health system is often reinforced by health provider offices that are not welcoming or accommodating, often because of their own limited resources.
- Communication skills of staff and providers that do not promote respect, collaboration and transparency often make it difficult for patients to identify a medical home, preferring instead to opt for episodic care at the local hospital Emergency Department.

- Continuity and quality of care may be more challenging for patients receiving care in public health facilities, as they are less likely to be linked to subspecialty services.

Recommendations:

1. Improve cultural competency in the patient-provider relationship. This would require engaging in cross-cultural activities to improve communication and language skills. Doing so would help to re-establish the trust lost among minority communities who have felt disrespected and “experimented on” by the current medical system. This has led to problems with adherence by patients and clinical uncertainty by providers, compromising the care of an already vulnerable population. Several excellent tools have been developed to teach improved communication skills and cultural competence that would begin to illuminate how bias and stereotyping affect the way patients are treated sub-optimally. For larger healthcare organizations, a cultural competency needs assessment tool may help leadership identify areas of particular concern to the populations in their service area.

a. Strategies:

- Re-design health professions curricula to practice communication and interviewing skills with an emphasis on exploring and eliminating biases and stereotypes, and on improving techniques that value collaboration and respect for all patients and members of the healthcare team.
- Improve transparency and make patients and their families partners in the health care decision-making process to help align expectations of care between patients and providers through open disclosure practices, ready access to interpretation services, and access to culturally competent health education materials.
- Incorporate questions regarding cultural competency into all credentialing and licensure examinations for all health professionals.
- Joint Commission should make all elements of Culturally and Linguistically Appropriate Services (CLAS) standards mandatory.
- ACGME and other health professional credentialing bodies should include cultural competence in Core Competencies.
- Address disparities through the implementation of hospital quality improvement (QI) activities, e.g., Mass General Hospital has created a Disparities Solutions Center and published a monograph including guidance for hospital leaders.²

b. Lead responsibilities:

- Maternity care provider organizations and their credentialing bodies should collaborate with organizations with proven expertise in cultural competence, such as the National Center for Cultural Competence (NCCC), to develop curricula at the graduate level and for continuing education.

² Betancourt JR, Green AR, King RR, Tan-McGrory A, Cervantes M and Renfrew M. Improving quality and achieving equity: a guide for hospitals leaders. The Disparities Solutions Center, Massachusetts General Hospital, RWJF 2009.

- c. Challenges and solutions:
 - Learning the cultures of others requires acceptance and motivation. The professional associations will need to model culturally competent behavior to their members in their governance, policy proposals, and publications.
- d. Mechanisms for collaboration:
 - The maternal child professional organizations should work with representatives of the National Association of Hispanic Nurses (NAHN), the National Black Nurses Association (NBNA), and the National Coalition of Ethnic Minority Nursing Association (NCEMNA) to plan culturally competent segments for their national educational meetings and publications. See lead responsibilities.
- e. Timeline for achievement:
 - Planning for culturally competence continuing education should begin in 2009 for 2010 sessions.

2. Increase recruitment of under-represented minorities into the health professions. A “tipping point” for cultural competency could be created by increasing recruitment of minorities into the health professions. This would require improving opportunities as early as grade school in math and science skills, as well as exposure to members of the healthcare professions for mentoring and role-modeling.

- a. Strategies:
 - Professional associations should develop programs similar to the *Great American Teach In*, where nurses, midwives, and physicians visit the early primary grades telling students about health careers.
 - Professional associations should assist with developing integrative educational modules for early primary grades that demonstrate health in action.
 - Professional associations should work with colleges and universities to develop or refine distance education programs to improve access to minority communities.
- b. Lead responsibilities:
 - Maternity care organizations should partner with academic institutions at the grade school level as well as with state education departments to design curricula and mentoring strategies.
- c. Challenges and solutions:
 - Gaining access to primary level schools and their curricula is difficult but could be accomplished by motivated professional organizations.
- d. Mechanisms for collaboration:
 - The maternal child professional organizations should work with representatives of the NAHN, the NBNA, and the NCEMNA to plan culturally competent segments for their national educational meetings and publications.

e. Timeline for achievement:

- Planning for culturally competence continuing education should begin in 2009 for 2010 sessions.

3. Promote and conduct research to determine the causes of, and possible solutions for, health disparities. Maternity care clinicians and health professions educators must continue to promote and conduct research to determine the causes of health disparities and how to eliminate disparities created by health system processes. Research should aim to better understand how different factors may operate among subgroups of women as well as the role of acculturation within subgroups.

a. Strategies

- Explore alternative models that are not dependent on individual behaviors and characteristics but, rather, that model the role of fundamental societal structures for understanding the roots of disparities. Methods such as community-based participatory research approaches and ecologic analyses using structural variables have the potential to explain variation in outcomes.
- Undertake multilevel modeling including geo-mapping that accounts for both higher level structural variables and individual characteristics as these approaches are likely to lead to the most comprehensive understanding of disparities and strategies for eliminating them.
- Integrate electronic birth certificate data with electronic medical record information to better identify risk factors and risk demographics for adverse maternal and infant outcomes.

b. Lead responsibilities:

- Federal and private funders must consider the complex and pernicious nature of disparities in maternal and infant outcomes when initiating funding announcements.
- The research community must consider the complex nature of disparities in an effort to avoid repeating the past failed attempts at adequately explaining why health disparities exist.

c. Challenges and solutions:

- We can only count what we measure. Innovative methods for measuring the social constructs of race and ethnicity and how these constructs are perceived by individuals are desperately needed. Funding for maternal and child health (MCH) disparities needs to be identified as a priority area, as presently much of the funding to address disparities has been focused on chronic disease conditions

d. Mechanisms for collaboration:

- Health and health systems research has been primarily in the domain of researchers whose strength is the biological basis of health and disease. While outcomes are ultimately mitigated through biological processes, social structures likely influence human biology. Hence, collaboration with research colleagues in the social sciences the

evolving field of psycho-neuro-immunology, ethnography, and medical anthropology holds promise.

e. Timeline for achievement:

- To some extent, implementation of these strategies is underway. Nurturing these efforts will depend on public and private funding in order to advance the field and insure sustainability of research efforts.

(See Appendix 2)

Clinical Controversies

Current Problems: Typical current practice often does not reflect reliable implementation of best available evidence, limiting women's access to best practice birth care choices.

- **VBAC:** Since the mid-1990's, the rate of vaginal birth after a prior cesarean (VBAC) in the U.S. has steadily declined, contributing significantly to the overall rise in cesarean rates. In spite of the evidence regarding the advantages of VBAC compared to elective repeat cesarean section for select clients, and the "downstream" adverse effects for mothers and babies documented for cesarean sections, most women who seek VBAC do not have this option, primarily because they can not find a willing provider or hospital. Access to VBAC has been eroded due to a complex web of variables, including perverse payment incentives, obstetrical or institutional practice guidelines, and perceived increase in liability.
- **Elective Induction of Labor:** Elective induction of labor has risen steadily over the past decade. Current estimates are that 50% of all women are exposed to some sort of induction agents or techniques. Wide practice variation exists, unrelated to risk status of women. Induction for provider or client convenience or for medical indications that are unsupported by evidence, such as suspected macrosomia, often results in more harm than good. Additionally, this practice increases the costs associated with childbirth.
- **Vaginal Breech Birth:** Following publication of the multi-center Term Breech Trial in 2000, international professional obstetric organizations such as the Royal College of Obstetricians and Gynaecologists (RCOG) and ACOG, issued guidelines discouraging vaginal breech. The result was a virtual elimination of this option in the US and UK, and sharp reduction in vaginal breech birth rates around the globe. More recently, with a better understanding of this trial's limitations, these same organizations have revised their guidelines, providing practitioners and women with an opportunity to consider the option for vaginal breech delivery. In spite of these changes, planned vaginal breech births in the US remains rare. Consequently, obstetric residents have few opportunities to learn the skill, there is a shrinking cadre of skilled providers for either planned or previously undiagnosed breech births and women with breech babies at term are routinely offered only a cesarean delivery.
- **Out-of-Hospital Birth:** Planned out-of-hospital birth remains relatively infrequent in the U.S., representing only 1-2% of births; however, it remains a focus of charged debate. There is evidence from observational studies suggesting that, for appropriately selected low risk women, planned hospital birth is no safer than planned out-of-hospital birth. In fact, hospital births may even increase some complications. Further, there are clear benefits to out-of-hospital birth in the setting of an integrated system of care that can provide timely intervention for complications in terms of reduced use of intervention, cost and increased satisfaction that should encourage wider use. However, midwives with nationally recognized credentials practicing outside the hospital are marginalized and constrained due to unfavorable licensing laws, poor or absent third party reimbursement, lack of liability insurance, and barriers to collaborative care systems for consultation and transfer. Few maternity care professionals are exposed to out-of-hospital birth in their training or have opportunities to work positively and collaboratively with midwives who

specialize in this care. Women who choose out-of-hospital birth often lack access to caregivers with nationally recognized credentials, birth centers or to the coordination within the broader health system that ensures optimum care and safety.

- **Cesarean Delivery on Demand:** Scant evidence exists for any substantial contribution of so-called “cesarean section on demand” (women requesting surgical delivery with no medical indication) to the overall rise in cesarean births. More so, the issue is a “disinformation” campaign that inflates this phenomenon, further obscuring the real contributors to the problem of unnecessary cesareans.

Recommendations:

1. Create a new, national interdisciplinary body responsible for developing and disseminating evidence-based clinical guidelines and resources for providers and consumers like the National Institute for Health and Clinical Excellence (NICE) in the UK that issues national evidence-based clinical guidelines. At present, current guidelines consistent with the evidence are often disregarded (e.g., counsel and offer VBAC to eligible women, and for breech presentation offer external cephalic version and vaginal breech). In other cases, such as out-of-hospital birth, there are recommendations in opposition of the practice without thorough discussion of the evidence. Similarly, support for maternal request cesarean was offered without adequate discussion of evidence. Chauhan et al. suggest the need for greatly improved processes for U.S. maternity care guideline development, especially in light of the large currently available evidence base of systematic reviews.³ There are transparent multi-stakeholder models that give priority to best evidence: e.g., Canada's *Family-Centred Maternity and Newborn Care: National Guidelines*⁴ and topic-specific guidelines from NICE.

a. Strategies:

- Develop national clinical guidelines/reference guides for VBAC, induction, vaginal breech and twin birth and cesarean (replicating the interdisciplinary team approach--that includes consumer representation, input by all cadres of maternity care providers as well as researchers, epidemiologists, opportunities for public comment and overall transparency--used by NICE in the UK).
- Fund and conduct further comparative effectiveness research, including studies on the relative safety of birth across all settings.
- Support the education of maternity care providers, insurers, hospitals and health care systems about the evidence supporting the safety of home deliveries for appropriate low risk women within the context of an integrated system of care.

b. Lead responsibilities:

- Multidisciplinary professional and policy groups work together to create the body (NQF could become the guideline setting group).

³ Chauhan SP, Berghella V, Sanderson M, Magann EF, Morrison JC. American College of Obstetricians and Gynecologists practice bulletins: an overview. *Am J Obstet Gynecol.* 2006 Jun;194(6):1564-72.

⁴ Health Canada. *Family-Centred Maternity and Newborn Care: National Guidelines*, Minister of Public Works and Government Services, Ottawa, 2000.

- Midwives' Alliance of North America's (MANA) Division of Research has developed and maintains a large database of prospectively entered out-of-hospital births that is available to researchers.

c. Challenges and solutions:

- Medical model practitioners express safety concerns yet generally do not consider the existing evidence base (need evidence rather than opinion and belief) related to VBAC, induction, vaginal breech, twin birth and cesarean.
- Out-of-hospital birth is potentially cost-effective for payors, purchasers and consumers, and for the health system at large.
- Insurers should evaluate the evidence of safety and cost effectiveness of out-of-hospital births in birth centers and in the home, in the setting of a comprehensive health care system that includes effective care coordination for consultation, collaboration and referral, when making coverage decisions.

d. Mechanisms for collaboration:

- Childbirth education organizations can help disseminate information to childbearing women, and incorporate evidence-based information about the safety of out-of-hospital birth, VBAC, in the training curriculum of childbirth educators.
- The interdisciplinary group (like NICE) that is created to set evidence-based guidelines must have representation from all stakeholders including women. Plans for a home birth consensus conference are underway.
- Multidisciplinary demonstration projects should be funded.

e. Timeline for achievement:

- 5 years

2. Change current obstetric practice related to vaginal birth after cesarean (VBAC), elective induction of labor, vaginal breech and vaginal twin birth, cesarean delivery on demand, and out-of-hospital birth to increase the availability of VBAC, vaginal breech and twin births, and out-of-hospital births (within an integrated system of care), and to decrease the number of elective inductions and maternal-demand cesareans.

a. Strategies:

- Create regular interdisciplinary peer clinical practice review processes within obstetric facilities, which include all cadres of maternity care providers, and make them accountable for reviewing indications for VBAC, elective induction, etc. on a case-by-case basis, and for determining best practices within the institution.
- Create community and facility-wide team-building and patient safety programs among all maternity care providers, including staff members representing anesthesia, pediatrics and risk management.

- Convene a multi-disciplinary consensus conference on vaginal breech birth, inviting international experts in vaginal breech delivery to share their data and experience.
 - Revise didactic educational requirements for providers, adding curriculum related to critical appraisal of scientific literature and evidence uptake.
 - Integrate the teaching of evidence-based practice into the clinical training setting and routine care settings so that students not only learn the theoretical principles and appraisal skills, but also learn how to incorporate these skills into their life-long learning and patient care practice.
 - Promote interdisciplinary clinical training opportunities in all settings and team-building exercises related to evidence based practices for addressing these clinical scenarios. Tie certification and maintenance of certification to requirements for interdisciplinary training and rotations across the range of settings for maternity care.
 - Improve the seamless coordination of maternity care across time, settings and disciplines for women who opt for out-of-hospital birth to ensure appropriate level of care throughout pregnancy, labor and birth, and the postpartum period, and safety and continuity of care during hand-offs. This will require the collaboration of care providers and hospitals as guidelines and policies are developed and implemented (looking to the UK and Canada for models).
 - Representatives from the major provider professional organizations should cooperate to seek funding for and carry out well-designed, interdisciplinary prospective multi-site research studies of out-of-hospital birth compared to in-hospital controls and publish results in scholarly journals.
- b. Lead responsibilities:
- Hospitals and care facilities providing maternity services, for interdisciplinary peer clinical practice review, team-building and patient safety programs, development of community care coordination strategies
 - Curriculum development bodies of relevant maternity care provider organizations for development of interdisciplinary didactic and clinical training opportunities
 - Provider professional organizations, Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH) for multi-disciplinary consensus meeting on vaginal breech birth, support for research comparing birth across settings
- c. Challenges and solutions:
- Liability reform in whatever form it takes is key to addressing these controversies.
 - The acceptance of providers to the formation of cooperative maternity care teams which represent both physicians and other cadres of maternity care providers is a challenge.
 - In a system with little or ineffective coordination across settings and providers, hospitals and hospital-based providers have accrued

negative experiences and attitudes about out-of-hospital birth as a result of receiving patients in acute condition who become their responsibility when they have had no role in their care prior to admission.

d. Mechanisms for collaboration:

- Health care organizations and integrated health systems (facilities that provide maternity services) should collaborate with professional provider groups to enact clinical strategies.
- Payor groups and clinician groups should work together to align reimbursement with practices that demonstrate evidence of effectiveness with least risk of harm.
- Liability insurers need clinical data to accurately assess risk of selected clinical practices and align coverage with evidence of safety.

e. Timeline for achievement:

- 5 years

3. Reward delivery practices supported by evidence related to VBAC, elective induction of labor, vaginal breech and vaginal twin birth, cesarean delivery on demand, and out-of-hospital birth delivered in the setting of an integrated health care system.

a. Strategies:

- Align provider payment with practice reflecting evidence based guidelines: recruit a large private insurer to do a pilot or demonstration project.
- Create ethical payment incentives for consumers (reduce co-pay or co-insurance) for the choice of best practice options related to labor and birth.
- Provide education for pregnant women facing these conditions regarding the best evidence on benefits, risks and alternatives regarding VBAC, vaginal breech, twin birth, and, in the setting of an integrated system of care, out-of-hospital birth. Provide information and develop policies and payment mechanisms that discourage and prevent elective induction of labor and cesarean on demand.
- Institutionalize support for practices that reduce routine repeat cesarean section, such as benchmarking on VBAC rates, and evaluate effectiveness of the ob/gyn hospitalist or “laborist” model to address this issue.
- Create a shared risk pool which includes an appropriate shared responsibility between hospitals/delivery facilities and practitioners working together.
- Support the creation of professional liability self-insurance programs. Self-insured programs involve pooling of financial resources to obtain insurance coverage, evidence-based and claims-based risk management, claims management, and implementation of best practices in patient safety for a defined group of members.

- Work with state regulators to evaluate discounts on premiums by insurers who provide liability coverage in return for demonstrated implementation of meaningful risk-reduction strategies and completion of patient safety programs which document reduced risk in obstetric units.⁵
 - Increase salaried positions for maternity care providers to remove financial incentives for seeking to perform services that can be charged outside the global fee, which leads to overuse of certain procedures and, in turn, provides disincentives for important aspects of maternity care which do not generate significant reimbursement based on current productivity formulas.
 - Explore options to expand access to qualified providers of out-of-hospital birth:
 - a) Evaluate the impact of amending the Social Security Act/Medicaid and Federal Employees Health Benefit Plan to include reimbursement of birth centers and out-of-hospital services provided by midwives with nationally recognized credentials.
 - b) Include birth centers in the federally-qualified community health center law.
 - Provide information to state policy makers that supports the legal recognition and appropriate reimbursement of nationally-credentialed midwives and accredited birth centers providing out-of-hospital birth.
 - Support policies that assure midwives with nationally recognized credentials have access to malpractice insurance based on risk experience and realistic options for emergency transport, physician and hospital back-up in the setting of an integrated health care system.
- b. Lead responsibilities:
- Centers for Medicare & Medicaid Services (CMS) to take the lead in re-imbursement reform.
 - Engage a large private insurer (like UnitedHealthcare) to do a pilot project related to the previous suggestions for re-imbursement reform.
 - National Association of Certified Professional Midwives (NACPM) and American Association of Birth Centers (AABC) are actively working on federal level.
 - Professional organizations across disciplines promote the rewarding of delivery practices supported by evidence.
- c. Challenges and solutions:
- The current maternity care system creates and cultivates philosophic differences between hospital-based and out-of-hospital birth attendants, because it is associated in large part with a high-tech, disease model-based style of care that has misaligned incentives through payment and liability systems.

⁵ Clark SL, Belfort MA, Byrum SL, Meyers JA, Perlin JB. Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety. *Am J Obstet Gynecol.* 2008 Aug;199(2):105.e1-7.

- d. Mechanisms for collaboration:
- We need to bring together medical, midwifery, nursing and other professional maternity care providers, with payors, facilities and policy makers, to evaluate the evidence of safety and efficacy from large observational studies and move towards the development, implementation and evaluation of pilot studies of models that integrate home birth within a coordinated system of care that can provide timely intervention for complications at the appropriate care level based on health status.
- e. Timeline for achievement:
- 5 years

Scope, Content, and Availability of Health Professions Education

Current Problems:

The following key problem areas must be addressed in the realm of education of maternity caregivers to achieve the goals and realize the vision of a high quality, high value maternity care system in the U.S.

- **The majority of providers of maternity care are specialty physicians whose training focuses primarily on high-risk pregnancy and disease management with minimal emphasis on a wellness model for maternity care and the skills and knowledge to support, protect, and promote physiologic childbirth, attachment and early parenting.** Additionally, most professional health education curricula lack sufficient content in psycho-social aspects of pregnancy and birth, qualities of culturally sensitive care, and concepts of shared decision-making.
- **The content and process of education of the range of professionals responsible for the provision of maternity services varies widely and occurs in isolation from each other.** Education programs between disciplines differ with respect to content, depth and focus of material taught, values regarding provider-patient relationships, philosophy regarding the use of technology and resources, and in what constitutes best practice.
- **The understanding and use of the best available evidence as it applies to maternity care practice is inadequately addressed in most professional training.** Despite more than ten years of information in the application of evidence-based medicine in obstetric care, little progress has been made in changing practice patterns based on this evidence.
- **Current continuing education requirements are poorly aligned across disciplines, may not be effective in influencing practice improvement, and in some domains do not reflect knowledge, skills and judgment relevant to the provision of maternity care.** The majority of continuing education programs rely on didactic methods, rather than skill-based modalities which have not been shown to result in change of practice patterns and/or patient outcomes. Potential conflicts of interest are introduced when continuing education (CE) is offered and/or funded by pharmaceutical and device manufacturers.

Recommendations:

1. Teach maternity care, starting as early as possible in provider education programs, within a wellness model utilizing a common core curriculum for all maternity care provider disciplines tailored for scope of practice, which emphasizes health promotion and disease prevention, cultural sensitivity, principles and skills to support physiologic childbearing, skills for appraisal and uptake of evidence, and a public health focus.

a. Strategies:

- Seek Congressional funding to implement innovative demonstrations for health professions education that focus on physiologic birth, principle of effective care with least harm and curriculum and practicum reform.
- Call an educational summit of educational representatives from each profession to develop a core maternity care curriculum and plan ways to integrate and coordinate education across disciplines.

- b. Lead responsibilities:
 - Leaders of the bodies that develop curricula, and oversee accreditation and certification for each of the relevant professions. For ACOG: ACGME, the American Board of Obstetrics and Gynecology (ABOG) and the Council on Resident Education in Obstetrics and Gynecology (CREOG); for ACNM: Directors of Midwifery Education (DOME) and the ACNM Education Projects Manager; for MANA: the Midwifery Education Accreditation Council (MEAC) and the North American Registry of Midwives (NARM); for Anesthesia: Council on Certification, ASA; for family practice: AAFP; for pediatrics: ABP; for nursing: the American Association of Colleges of Nursing, the National League for Nursing, and the American Nurses Credentialing Center.
- c. Challenges and solutions:
 - A focus on wellness rather than acute care and disease management in maternity health professions education will require a major paradigm shift from the existing dominant model. It will also require faculty development and significant curriculum changes.
- d. Mechanisms for collaboration:
 - Leadership summit among stakeholders
- e. Timeline for achievement:
 - 2010-2012

2. Prioritize health professions education through reformed payment systems and incentives that appropriately value teaching and attract educators to the field. Ensure that students in each discipline have opportunities early and often during their training to observe different practice styles, collaborate, and learn together from faculty that include the full range of maternity caregivers.

- a. Strategies:
 - Provide incentives, financial and other, for innovative education programs that demonstrate integrative training and clinical education outside of the hospital setting in facilities such as community health centers, public health department clinics, and free-standing birth centers.
 - Add requirement that National Health Corps Scholarship Programs (NHCS) provide clinical preceptorship rotations to interdisciplinary trainees at their underserved sites.
 - Create support for model education programs with evidence-based maternity care curricula and practicum experiences at public colleges and universities (Sakala & Corry, 2008, p. 68).⁶ For example, state policy makers could call for reform of public institutions; and federal funds could be made available for competitive awards for innovative graduate and residency education in public and private settings.

⁶ Sakala C, Corry MP. Evidence-Based Maternity Care: What It Is and What It Can Achieve. New York, Milbank Memorial Fund, 2008. 115 p.

- b. Lead responsibilities:
 - Lead responsibilities: ACGME and its respective residency review committees (RRC's), ABOG, family practice, nursing and midwifery education certification and accreditation organizations.
 - c. Challenges and solutions:
 - Interdisciplinary education requires significant reorganization of health professional education, and without strong leadership and resources for change this shift will be difficult.
 - d. Mechanisms for collaboration:
 - The potential for collaboration in teaching institutions is significant across colleges of nursing, midwifery and medicine and hospitals themselves. Leadership in these key entities need to cooperate to assure that the best possible education is provided to learners and assure that the best possible outcomes for the patients. AAFP, ACNM, ACOG, and AWHONN should approach the Health Resources and Services Administration (HRSA) about funding three projects that demonstrate interdisciplinary care in teaching care and calculate an equitable payment system.
 - Involve ACGME and the relevant residency review committees (RRCs for Ob/Gyn and Family Medicine) in discussions about teaching and learning standards and multidisciplinary learning.
 - Leadership summits of the curriculum development, certification and accreditation organizations
 - e. Timeline for achievement:
 - 2010-2011
- 3. Improve the quality, effectiveness, and relevance of continuing professional education in all maternity care professions, and align program competencies with performance measures for all maternity care professions.**

- a. Strategies:
 - Require practitioners who provide maternity care to complete continuing professional education with content specific to the practice of maternity care.
 - Require a mix of modalities for continuing education, including cognitive and hands-on modalities, such as simulation training.
 - Require submission of practice data, e.g., through chart review for continuing education credit.
 - Create a set of crosswalks between ACGME competencies for medical residents and maternity care performance measures to facilitate training and evaluation in training programs. Nursing and midwifery education and accreditation bodies should be similarly involved. For physicians, this will also require coordination with their respective Residency Review Committees [RRC's] and Certification Boards.
 - Ensure that state licensure and health system credentialing are linked to adequate achievement of practice performance goals.

b. Lead responsibilities:

- AAFP, ACNM, ACOG, ABOG, the RRC's for ob/gyn and family physicians, and nursing accreditation bodies should work *jointly* to assure that board certification, recertification and maintenance of certification are linked to demonstration of quality of care.

c. Challenges and solutions:

- A Cochrane review of effective practice shows that didactic material is not associated with change in practice, therefore hands-on modalities are needed, but they are associated with an increased cost. Devising mechanisms for financing continuing education programs is an important element because the method of financing can introduce conflicts of interest and affect the quality of the offering. Educational competencies are similar for medical education, but differ from midwifery education.

d. Mechanisms for collaboration:

- There is much opportunity for collaboration in continuing education because there is tremendous overlap of the providers involved in maternal care. State licensure boards, facility-based staff credentialing departments and organizations such as the National Association Medical Staff Services (NAMSS).

e. Timeframe for achievement:

- An initial meeting that includes key stakeholders such as ACGME will occur by the end of 2009.

Workforce Composition and Distribution

Current Problems:

- **Inefficient Workforce Utilization**

Most U.S. births involve mothers and babies who are healthy yet are attended by specialist physicians trained in high risk pregnancy and disease management, a large number of whom have little training or experience in “supporting, promoting and preserving physiological birth”-- the most appropriate form of care for these mothers.

Other providers, specifically midwives and family physicians, have a different focus and emphasis in their training and experience in maternity care, such that their skills may be better suited for supporting the physiologic birth needs of women with low-risk pregnancies. These clinicians often face barriers to providing such care, even where they are available. Midwives attended 11% of the deliveries in the US in 2006, compared to well over 50% in similar health care delivery systems in similar countries. Better utilization of these providers would increase the efficiency of maternity care, reserving the services of specialists with advanced skills for those women who appropriately need this more intensive level of care. This more appropriate matching of skills to needs would also likely lead to a more appropriate distribution of the workforce, lower overall resource consumption and prevention of the overuse of interventions.

- **Ineffective Workforce Collaboration and Coordination of Resources**

The dominant model for provider care utilization within the US maternity care system features silo-based micro-systems with multitudes of individual, parallel systems delivering patient care. Such systems lead to duplication of efforts, gaps in care and competitive environments.

Lack of coordination among provider groups results in an unreliable delivery system which takes its greatest toll on the mother and her family who do not receive the benefits of all members of the team and their areas of expertise.

This can also lead to unsafe practices when primary maternity care providers practice without access to reliable resources for consultation, collaboration and referral.

- **Workforce Supply and Demand Challenges**

Multiple trends negatively impact the growth of professions within the workforce:

- a) Retirement of the aging population
- b) Barriers within the educational “pipelines” such as school closures, insufficient financial support, lack of faculty
- c) Lack of interest in becoming an obstetrician, labor & delivery nurse, midwife or in being a family physician who provides maternity care

In addition to the common issues, there is a disproportionate shortage of the primary maternity care providers who can best deliver services for healthy, low risk women.

Generational preferences for reduced time commitments and more-controlled hours are leading providers away from the profession, resulting in potential staff shortages and alternate models of practice with less continuity of care.

Regional inequities of workforce distribution manifest in clusters of services in urban areas and lack of services in many rural settings.

Overuse of interventional services stretches the availability of the qualified workforce with documented harms and no health benefits.

Recommendations:

1. **Redesign the composition of the U.S. Maternity Care Workforce to ensure that:**

- Providers with expertise in physiological birth are the primary maternity care providers for the majority of healthy women and their babies.
 - All providers are afforded the training and experience to learn the didactic knowledge and skills to support physiologic birth.
 - The maternity care culture shifts from one of disease orientation to one of wellness by making support for physiological birth practices the norm in labor and birth care with high-risk care provided when indicated.
 - The infrastructure of institutions supports and rewards this cultural shift including alterations in policies and procedures, work schedules, job descriptions, performance evaluations, and client and staff satisfaction measures.
 - This workforce shift is supported through healthcare policy and reimbursement realignment.
- a. Strategies:
- Perform an independent, in-depth capacity assessment of existing provider workforce supply and pipeline with projections for the coming decade and beyond. Include population growth trends and other factors to allow for a final assessment of the country's maternity care needs matched to its provider workforce capacity.
 - Increase the demand for entry into the maternity care professions and develop infra-structure required to address specific needs for each profession, including but not limited to:
 - a) Exploring and replicating innovative midwifery education models, providing financial support for training, and pursuing education program accreditation for all nationally credentialed midwives.
 - b) Reducing barriers to entry and fostering efficient education options for prospective nursing students to enter maternity professional education programs, e.g. accelerated second degree programs such as BA to BSN, AD to BS and undergraduate to graduate programs.
 - c) Improving retention and new provider numbers by developing and implementing innovative career tracking options within maternity care (such as hospitalist, out-patient only, gynecology-only) for physician providers.
 - Support uniform educational and training standards for physicians, midwives and nurses in physiological birth and tie these standards to certification and licensure.
- b. Lead responsibilities:
- For the Maternity Care Workforce Capacity Assessment – an independent body such as the Pew Charitable Trust, the Robert Wood Johnson Foundation or the Commonwealth Fund.
 - For the strategies focused on provider education improvements - a collaborative taskforce comprised of representatives from the education and accrediting bodies of all maternity care professional organizations working with representatives from major universities on the recommendations specific to education.

- c. Challenges and solutions:
 - Changing professional practice and education models is a lengthy process but may accelerate as provider shortages become acute.
- d. Mechanisms for collaboration:
 - A joint statement from provider organizations calling for these strategies to be implemented
- e. Timeline for achievement:
 - Joint statement 2009
 - Task force in place 2010
 - Capacity assessment completed by 2011

2. Improve maternity care workforce distribution in geographically and socioeconomically underserved areas.

- a. Strategies:
 - Expand number of National Health Service Corps (NHSC) sites, and extend eligibility for NHSC scholarships to all nationally credentialed maternity care providers.
 - Increase funding for health care provider education in underserved areas.
 - Establish regional, interdisciplinary maternity care hubs.
 - Employ new technologies to increase accessibility to options for education and continuing competency (e.g., distance learning programs, webinars).
 - Employ new technologies to increase accessibility of specialty consultation to primary maternity care providers in remote underserved areas (e.g., telemedicine, locum tenens).
 - Consider training and credentialing primary maternity care providers (family physicians and midwives) in expanded practice skills and functions (e.g., advanced neonatal care and cesarean section or first-assist) to meet population needs in geographically underserved rural areas.
 - Provide information to state policymakers that supports the legal recognition and appropriate reimbursement of nationally-credentialed midwives and accredited birth centers providing out-of-hospital birth.
 - Continue to develop interstate models of licensure for nursing.
- b. Lead responsibilities:
 - U.S. Department of Health and Human Services (DHHS)-HRSA, using National Health Service Corps and Federally-Qualified Health Centers has taken the lead in attracting providers to underserved areas. This role should be supported and expanded to ensure a more evenly distributed workforce.
- c. Challenges and solutions:
 - It is often challenging to attract clinicians to practice in remote areas and among underserved populations; providing incentives such as student loan forgiveness programs and increasing the numbers of providers from these areas are strategies to address this problem.

- A proportion of women will always choose maternity care outside of the hospital and must have access to licensed care providers with training and experience in attending out-of-hospital birth. This is best achieved by bringing together all stakeholders, including maternity care providers, facilities, insurers, policy-makers, and consumers to decide what is required to move forward towards an integrated model of care with excellent coordination across the broader health system for women choosing this care model. The integration of certified professional midwives will require continued evaluation and acceptance of the evidence of their safety and efficacy. To truly compare this model to usual care, maternity care clinician groups and health systems must be willing to support “usual care” comparison study groups.
- d. Mechanisms for collaboration:
 - The issue of the maternity care workforce must be brought to the attention of the Department of Health and Human Services (DHHS) to start the conversation about aligning funding incentives with primary maternity care.
- e. Timeline for achievement:
 - By 2014

3. Maximize current US maternity workforce efficiency by prioritizing strategic development, implementation and support of collaborative models of practice.

- a. Strategies:
 - Identify exemplary U.S. and international models of collaborative maternity provider care and investigate strategies for shared resources and replication.
 - Investigate effective applicable business theories and models, engage expert support in designing systems level solutions for improving multidisciplinary collaboration.
 - Develop meaningful health care reform legislation requiring collaboration in this area of women’s health care.
- b. Lead responsibilities:
 - Collaborative Workforce Group comprised of multi-disciplinary professional maternity care organizations to assess efficient models of care in the U.S. and abroad that can be adapted for implementation on a regional basis
- c. Challenges and solutions:
 - Professional “turf issues” such as competition for health care dollars and patient volume
 - Issues of trust of peer competence and scope of practice
 - History of failed efforts and overall “resistance to change” within the maternity care culture
- d. Mechanisms for collaboration:
 - Legislative mandates through reform payment mechanisms
 - Ongoing communication and interaction of professional Taskforce meetings and initiatives.

e. Timeline for achievement:

- 2012-2015

Table 1: Key Stakeholders in Liability Reform

American Association of Nurse Anesthetists
American Society of Anesthesiologists
American Academy of Family Physicians
American Bar Association
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Health Lawyers Association
American Medical Association
Association of Trial Lawyers of American
Association of Women's Health, Neonatal and Obstetrical Nurses
Council of State Governments
Insurers Association of America
Midwives Alliance of North America
National Association of Certified Professional Midwives
National Association of Insurance Commissioners
National Bar Association
National Conference of State Legislators
National Governors Association
Physician Insurers Association of America

Table 2: Key Stakeholders in Changing Education to Prevent Medical Errors and Assuring Affordable Liability Coverage for Faculty, Clinical Preceptors and Students

Accreditation Commission for Midwifery Education
Accreditation Review Commission on Education for the Physician Assistant
American Academy of Family Physicians
American Academy of Physician Assistants
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American Board of Anesthesiology
American Board of Family Medicine
American Board of Medical Specialties
American Board of Obstetricians & Gynecologists
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Midwifery Certification Board
American Midwifery Certification Board
American Nurses Credentialing Center
American Society of Anesthesiologists
Commission on Collegiate Nursing Education
Council of State Governments
Liaison Committee on Medical Education
Midwifery Education Accreditation Council
Midwives Alliance of North America
National Association of Certified Professional Midwives
National Conference of State Legislators
National Governors Association
North American Registry of Midwives

Appendix 1

Liability Reference List

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