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OREGON OFFICE of RURAL HEALTH

De-siloing Maternal Healthcare: A "Better Together" Approach Where Everyone Wins

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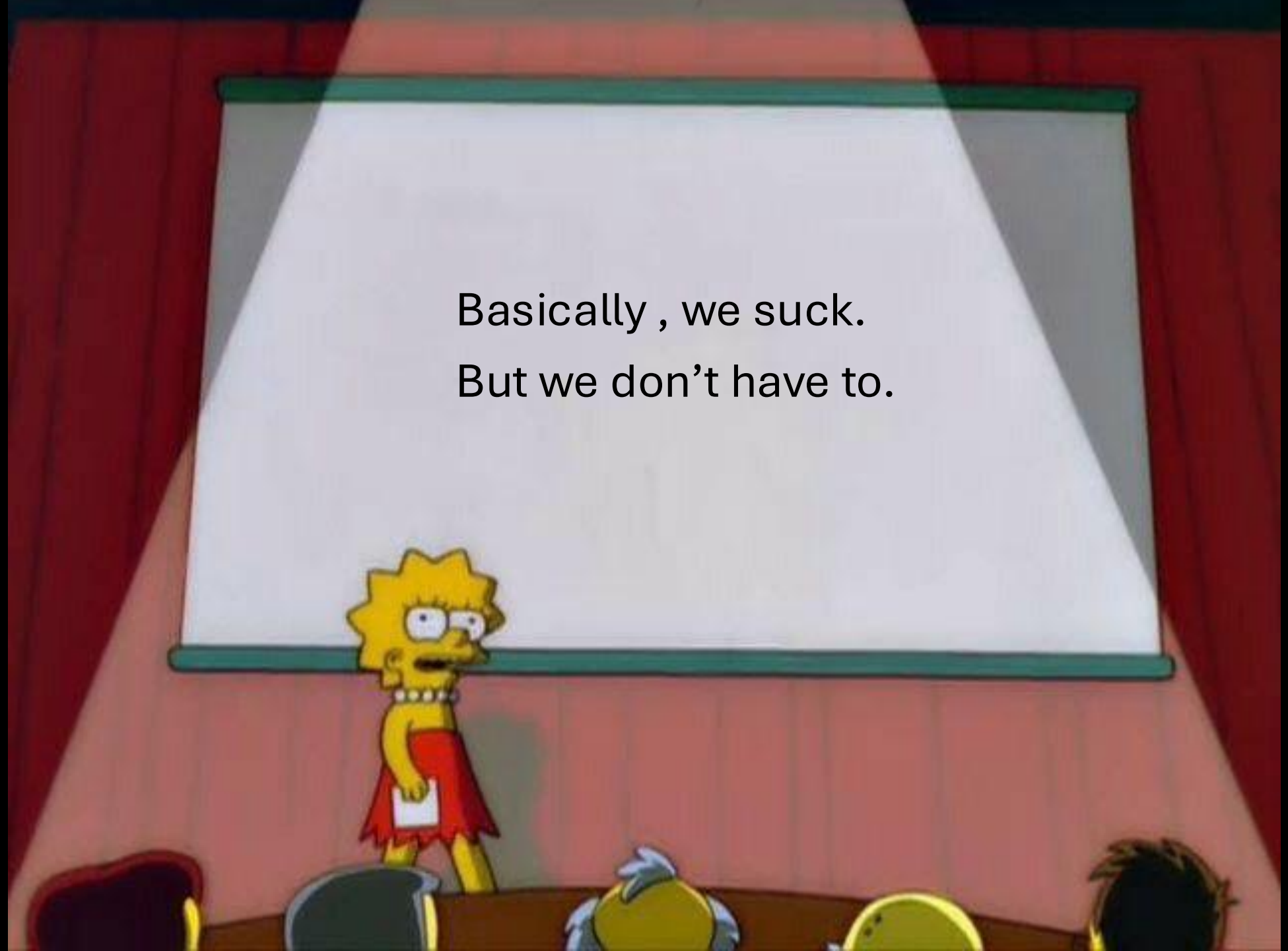
De-siloing Maternal Healthcare: A "Better Together" Approach Where Everyone Wins

The end goal

Leave this room with these realizations:

1. In 2025, in the US, we are doing maternal healthcare wrong.
2. We have all the tools needed to do this right, right now.
3. Relying on logic, and simple, evidence-based practices can turn the US into world leaders for healthcare.


Basically , we suck.
But we don’t have to.

A little background

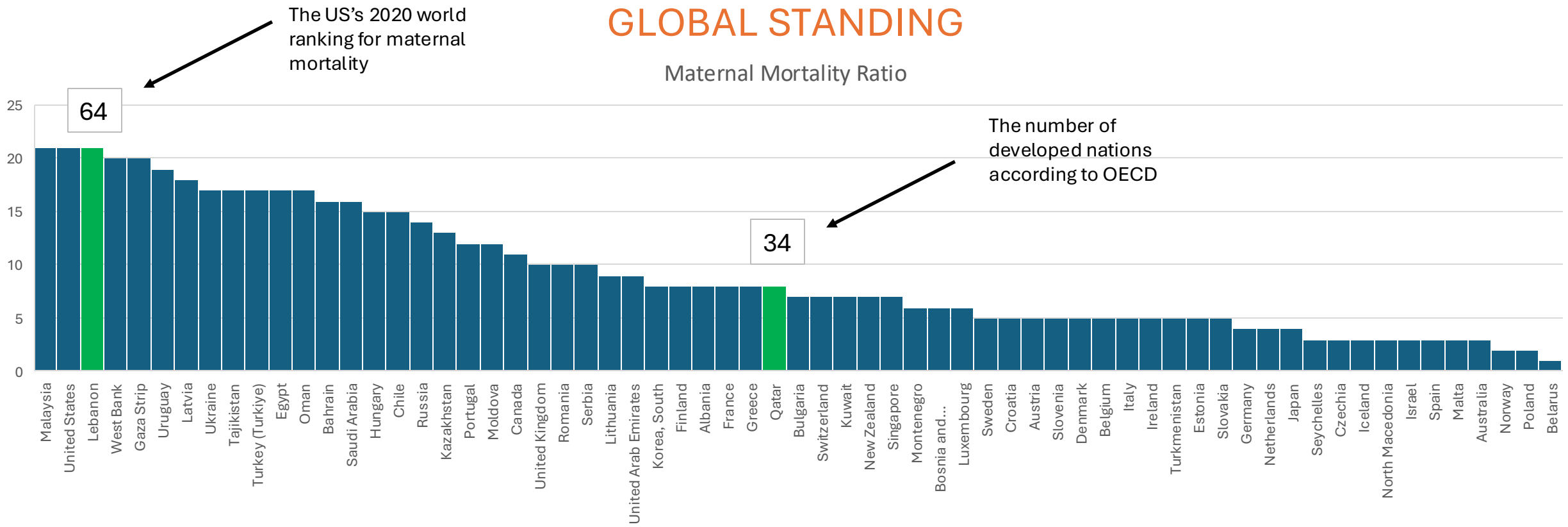
- In 1920, about 90% of all birth happened at home with midwives.
- Starting in the 1920s, obstetricians began advocating for hospital birth, twilight sleep, ether, forceps/vacuum/cesarean deliveries, and ran the nation's most successful smear-campaign against midwives.
- Midwives were systematically pushed out of the birth space.
- Today, midwives attend about 12% of all birth in the US (75% in every other developed nation).
- Forcing midwives into healthcare silos has cut off modern obstetrics from centuries-old life-improving and life-saving practices.
- Not due to evidence - midwives are still not able to practice freely in every state (for reference, it only became legal to publicly breastfeed in every state as of 2018)

Understanding Maternal Mortality: what is it, really?

- Death related to birth occurring within 12 months of the end of the pregnancy.

- What we see in the media…
- What are the primary contributors?

GLOBAL STANDING



But why?

If you want to understand any problem in America, you need to focus on who profits from the problem, not who suffers from that problem.

-- Amos Wilson

Disconnect between the pregnancy risk level and how birth is charged.

Chart 1. Pregnancy Risk Level

At least 70% of pregnancies are considered low risk. [1]

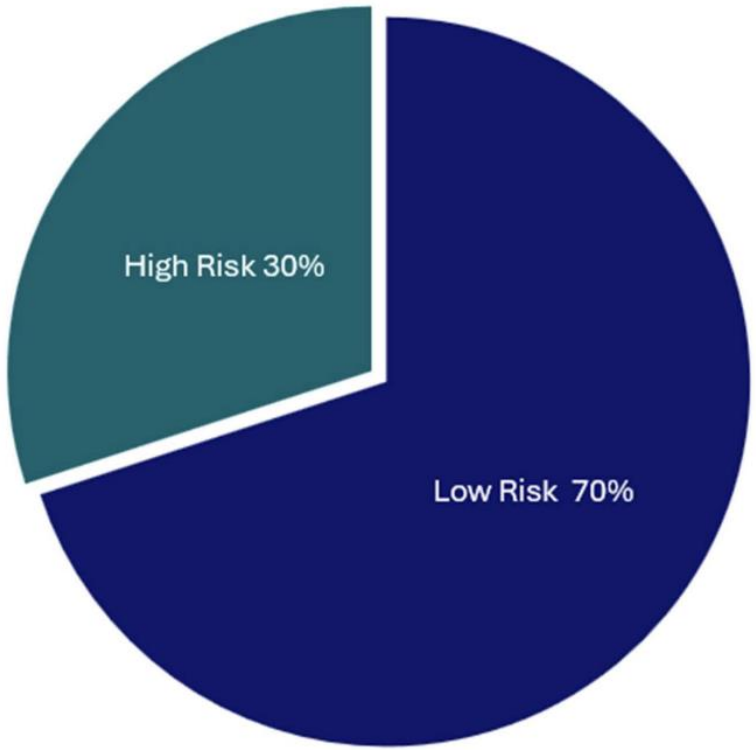
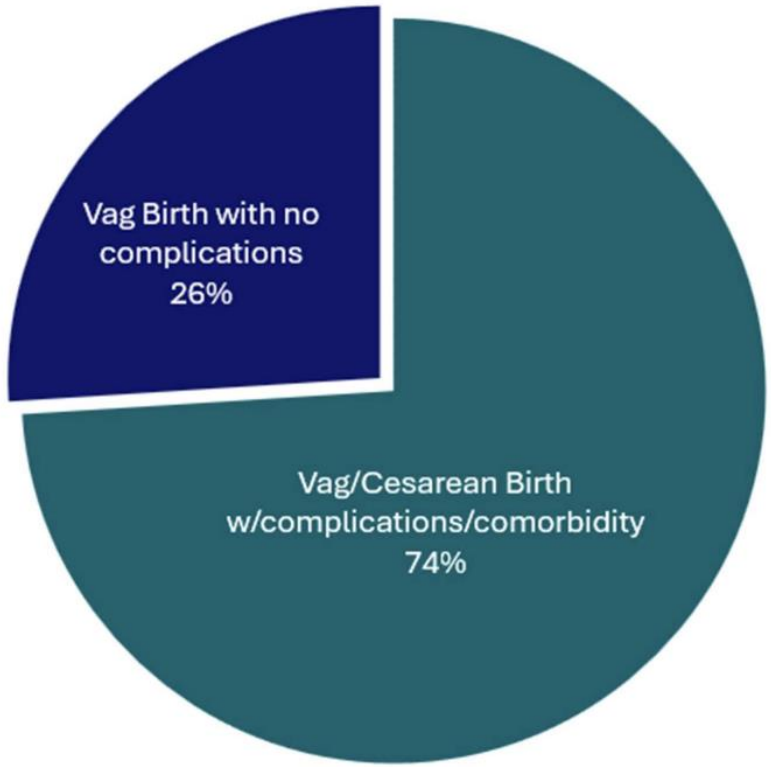


Chart 2. How Birth is Charged

Only 26% of births are charged as vaginal births with no complications[2]



[1] https://news.oregonstate.edu/news/low-risk-pregnancies-planned-home-births-just-safe-birth-center-births-study-shows#:~:text=At%20least%2070%25%20of%20pregnancies,Oregon%20State%20College%20of%20Health.

[2] Turquoise Health

American Association of Birth Centers (2025)

So we’re spending the most and getting the least. How do we fix it?

It helps to look at other models that work.

- Primary care model
- Dutch model (open facility)
- Scandinavian model
- Dental model

EVIDENCE-BASED METRICS

TRIPLE AIM

1. Improve patient experience
2. Reduce cost of care
3. Improve population health

4 CORE

1. IOL <10%
2. Episiotomy <2%
3. Cesarean rate <15%
4. EBF >75% after 48h

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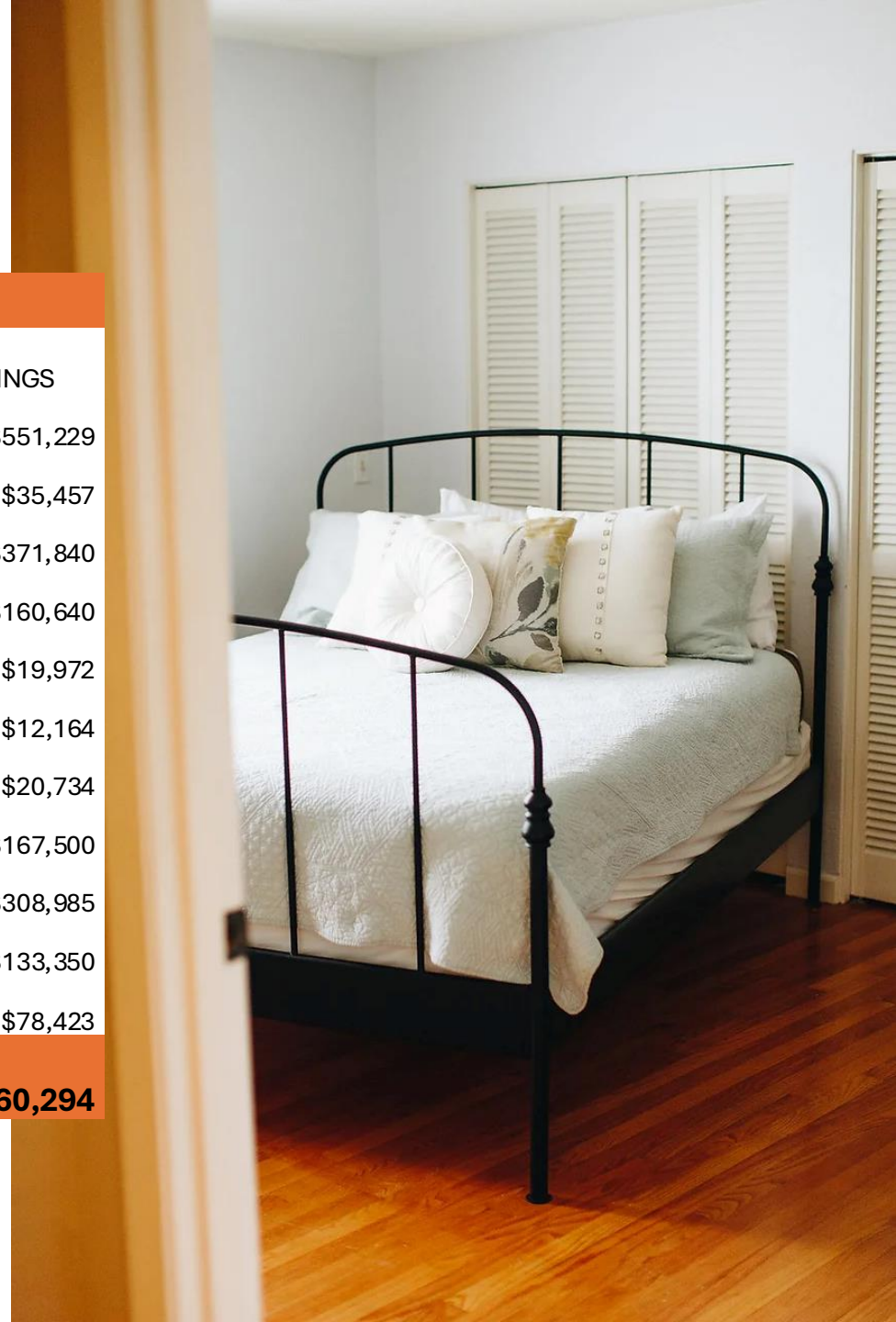
Recognizes accredited birth centers as 1st level of care

COST DIFFERENTIALS

Cost Savings for Evidence Based Care

100	Hospitals	Birth Centers	Costs	Hospitals	Birth Centers	SAVINGS
C-Sections Births (facility)	32.40%	5.64%	$20,599	$667,408	$116,178	$551,229
C-Sections Births (professional)	32.40%	5.64%	$1,325	$42,930	$7,473	$35,457
NICU Admits	8.90%	2.50%	$58,100	$517,090	$145,250	$371,840
Preterm birth rates	6.90%	4.00%	$55,393	$382,212	$221,572	$160,640
Reduced ER visits (facility)	9.80%	0.10%	$2,059	$20,178	$206	$19,972
Reduced ER visits (professional)	9.80%	0.10%	$1,254	$12,289	$125	$12,164
Reduced OBED charges	10.07%	0.00%	$2,059	$20,734	$0	$20,734
Room & Board charges	100.00%	0.00%	$1,675	$167,500	$0	$167,500
VBAC failure rate	25.00%	10.00%	$20,599	$514,975	$205,990	$308,985
Epidural Rate (10 units) (facility)	72.50%	9.00%	$2,100	$152,250	$18,900	$133,350
Epidural Rate (professional)	72.50%	9.00%	$1,235	$89,538	$11,115	$78,423
			TOTALS	$2,587,103	$726,810	**$1,860,294**



OUTCOMES

- Midwifery-led Birth Centers are outperforming hospitals for outcomes in:
- patient satisfaction, infection re-admits, breastfeeding rates, preterm birth, low birth weight, ER visits, VBAC success, episiotomy, provider trust, support for partners, medical literacy
- *3/18/2024: the most recent data was released in the American Journal of Preventive Medicine and the MMR is now 31.8 (2020 rate: 21)

2020	US Birth Centers	US Hospitals
Maternal Mortality	**0.7**/100,000	**21**/100,000 (64th in the world)*
Cesarean rate	<**6**%	**33**%
Epidural rate	**10**%	**65-80**%
NICU admit	**2.5**%	**5.6**%
Midwife-attended births	**>99**%	<**8**%

ACOG

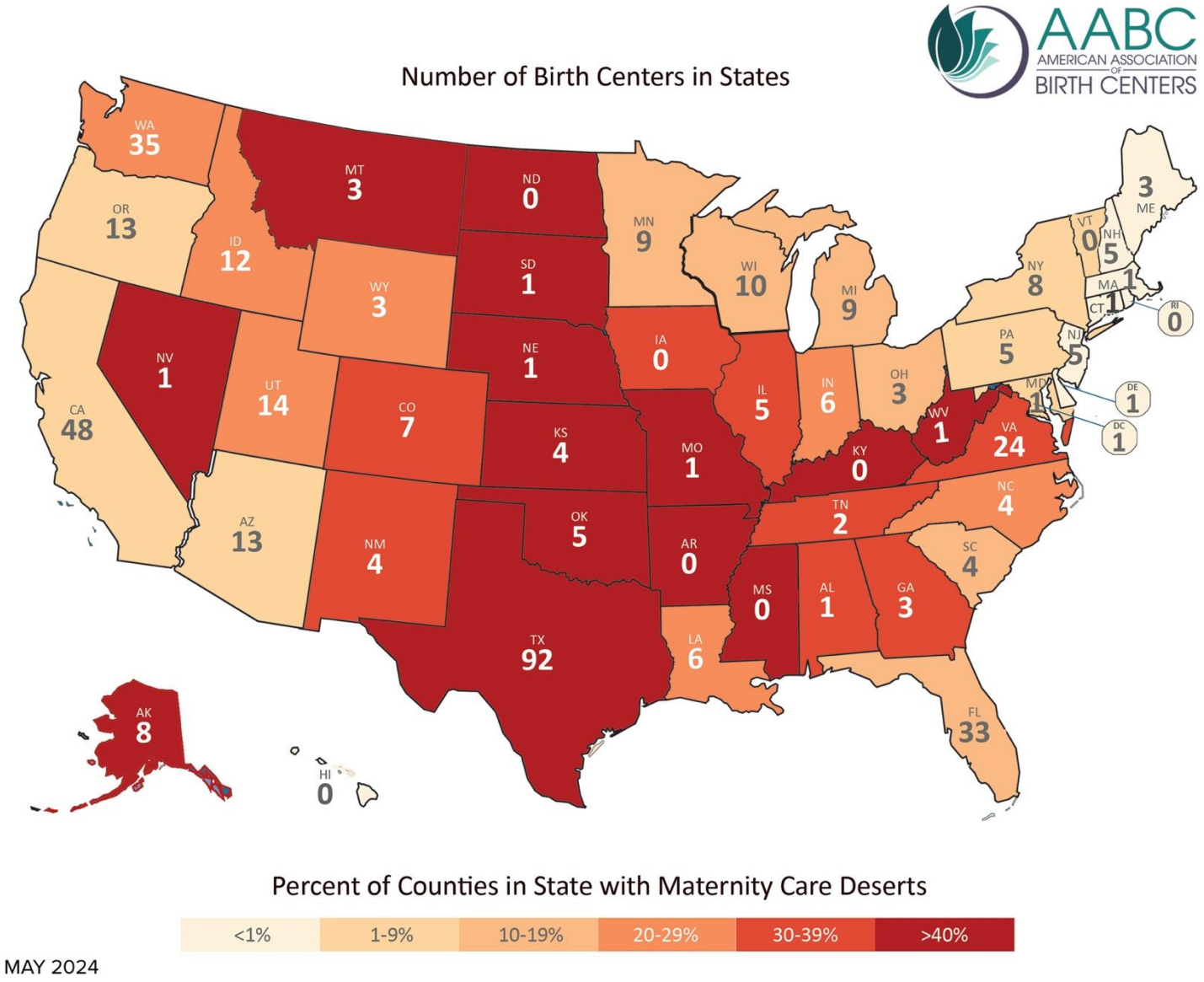
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE SOCIETY OF MATERNAL AND FETAL MEDICINE BOTH RECOGNIZE FREESTANDING BIRTH CENTERS AS **FIRST-LINE HEALTHCARE** FOR PREGNANCY AND BIRTH.

MATERNITY CARE DESERTS

Oregon Medicaid reports they expect 33% of rural hospitals in the northwest (incl WY and MT) to close in the next three years.

“We have to learn to provide healthcare in another way.”

415 v. 6,120



SO, HOW DO WE DO THIS?

1. Immediate State and national recognition and re-integration of midwives as primary care providers for pregnancy and birth.
2. Inclusion of all licensed provider types (NDs, LDEMs, CNMs, DCs, OBs).
    - Especially important during a healthcare shortage
3. Start care with midwives (Dutch/primary care/dental model).
4. Integrate midwives into every level of care.
    - Standard reimbursement at same rate regardless of provider or facility type.
    - Standardized facility code sets common to all maternity and newborn services, regardless of location, to prevent misuse of insurance dollars.
5. Operate L&D units like freestanding birth centers, not the other way around.

WHAT HAPPENS WHEN WE DE-SILO?

1. All providers (especially OBGYNs) end up practicing without fear, at the top of their license – which is massively efficient.
2. We benefit from one-another's areas of expertise and re-learn lost skills.
3. No more competition between provider types, just appropriate, risk-matched care.
4. Full continuity of care for patients and greater patient accountability and satisfaction.
5. Truly informed consent, not policy-based informed consent.

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Thank you to the 2025 Forum partners!

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