CMQCC
California Maternal
Quality Care Collaborative

Tackling the Midwife Question: What is Midwifery Integration and Why Is It Important for Pregnant and Birthing People in California?

Facilitator: Holly Smith, MPH, CNM, FACNM

Housekeeping

- All attendees are muted upon entry
- Questions will be answered at the end of the webinar and as time allows
- The webinar is recorded and will be available from the CMQCC website within 3-7 business days
- The slides will also be available for free download from the CMQCC website, www.cmqcc.org

Instructions

- You are welcome to use any of the slides provided for educational purposes
- If you modify or add a slide, please substitute your institutional logo and *do not use* the CMQCC logo
- We welcome your feedback and recommendations for improving the slide set

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Continuing Education Notice

In order to receive contact hours (RN) for this webinar, please complete the evaluation via the link, which will be sent to you 24 hours after this webinar.

You must be in attendance on the webinar for a minimum of 50 minutes for a contact hour to be awarded.

Inclusive Language Notice

Currently recognized identifiers such as **“birthing people,” “mother**,” **“maternal,” “they,” “them,**” **“she,**” **“her.”** and **“pregnancy-capable person”** are used in reference to a person who is pregnant or has given birth.

We recognize not all people who become pregnant and give birth identify as mothers or women and will use the above-recognized terms interchangeably to represent all those present in this space receiving care for pregnancy services. All persons are equally deserving of respectful patient-centered care that helps them attain their full potential and live authentic, healthy lives. The healthcare team should respect individual patient preferences regarding gendered language throughout the course of their care.

The term **“family”** is used to refer to any persons the pregnant or postpartum patient designates as such (alternatives: partners, husbands, wives, support persons, loved ones).

The term **“clinician”** is used to denote nursing and medical staff, whereas the term **“provider”** refers to a clinician with diagnosing and prescribing authority.

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Today's Panelists

Eva Goodfriend-Reaño, CNM, WHNP, IBCLC
Midwifery Clinical Chief at Highland Hospital, Alameda Health System

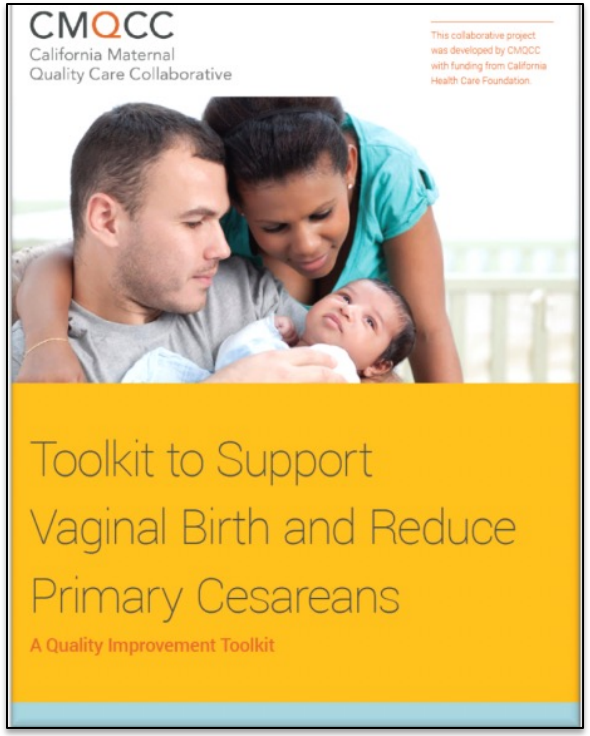
Sue Baelen, LM, CPM
Owner and Principal Midwife, Sacred Body Midwifery, San Francisco, CA

Mimi (Paulomi) Niles, PhD, MPH, CNM,
Assistant Professor at NYU Rory Meyers College of Nursing

Objectives

- Define the meaning of midwifery integration at both the macro (state and federal) and micro (clinical and interprofessional) levels.
- Describe the importance of midwifery integration as a necessary component of quality improvement in maternity care.
- Identify opportunities and challenges for midwifery integration at your facility.

Today's Webinar is Webinar **#3** in a Five-Part Series



1. The Next Step in California's Quality Improvement Journey: Integrating Midwives, Doulas, & Community-Based Birth Care *(Nov 30, 2022; recording available at cmqcc.org)*

2. Harnessing the Power of Team-Based Care to Improve Maternity Outcomes (Feb 3, 2023; *recording available at cmqcc.org)*

3. **Tackling the Midwife Question: What is Midwifery Integration and Why is it Important for Pregnant and Birthing People in California? (May 9, 2023)**

4. Partnering with Doulas (Aug 30, 2023)

5. Community Birth - Improving Transfer of Care (Oct 25, 2023)

Cesarean Disparities by Race and Ethnicity

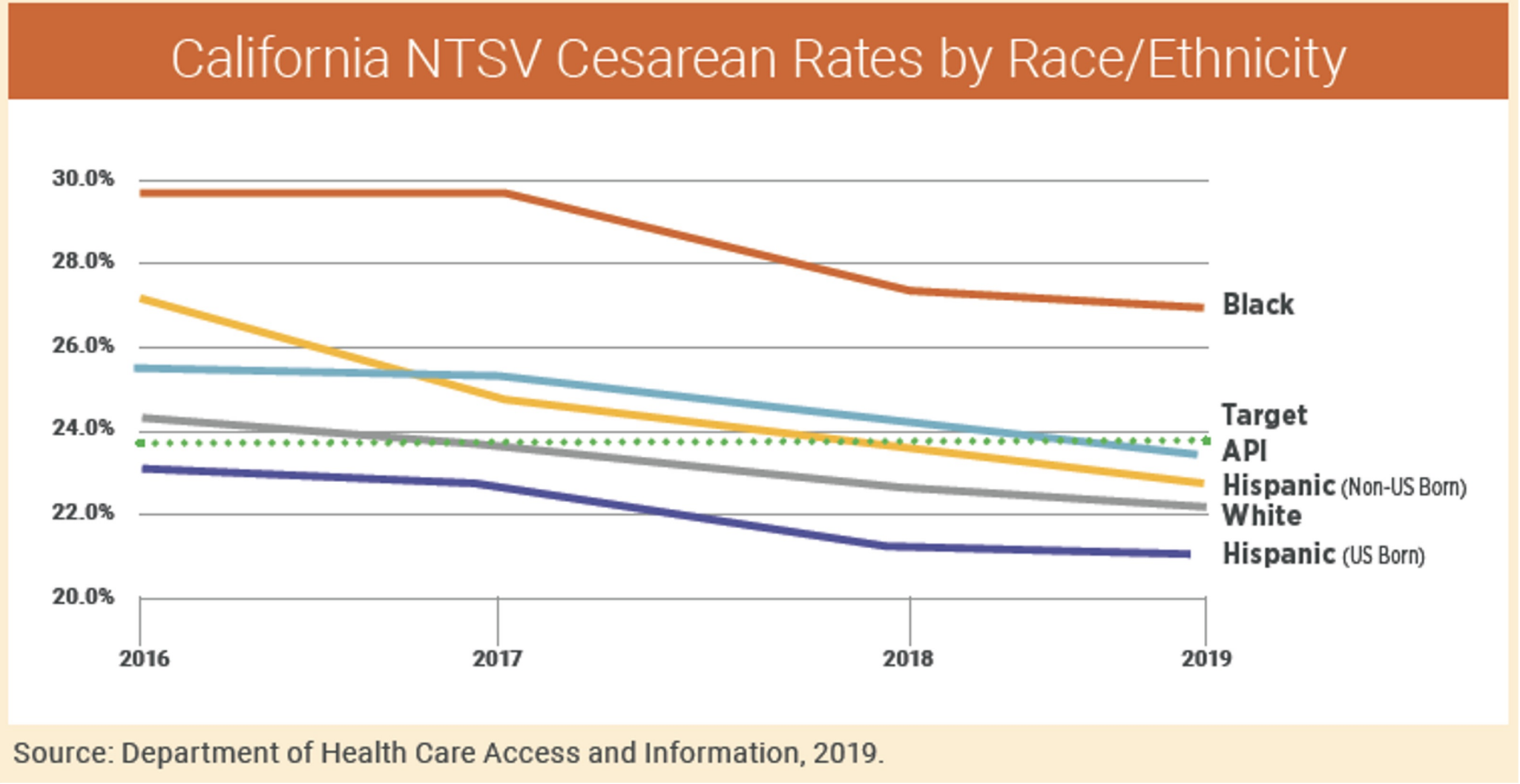


Image source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Birth Equity

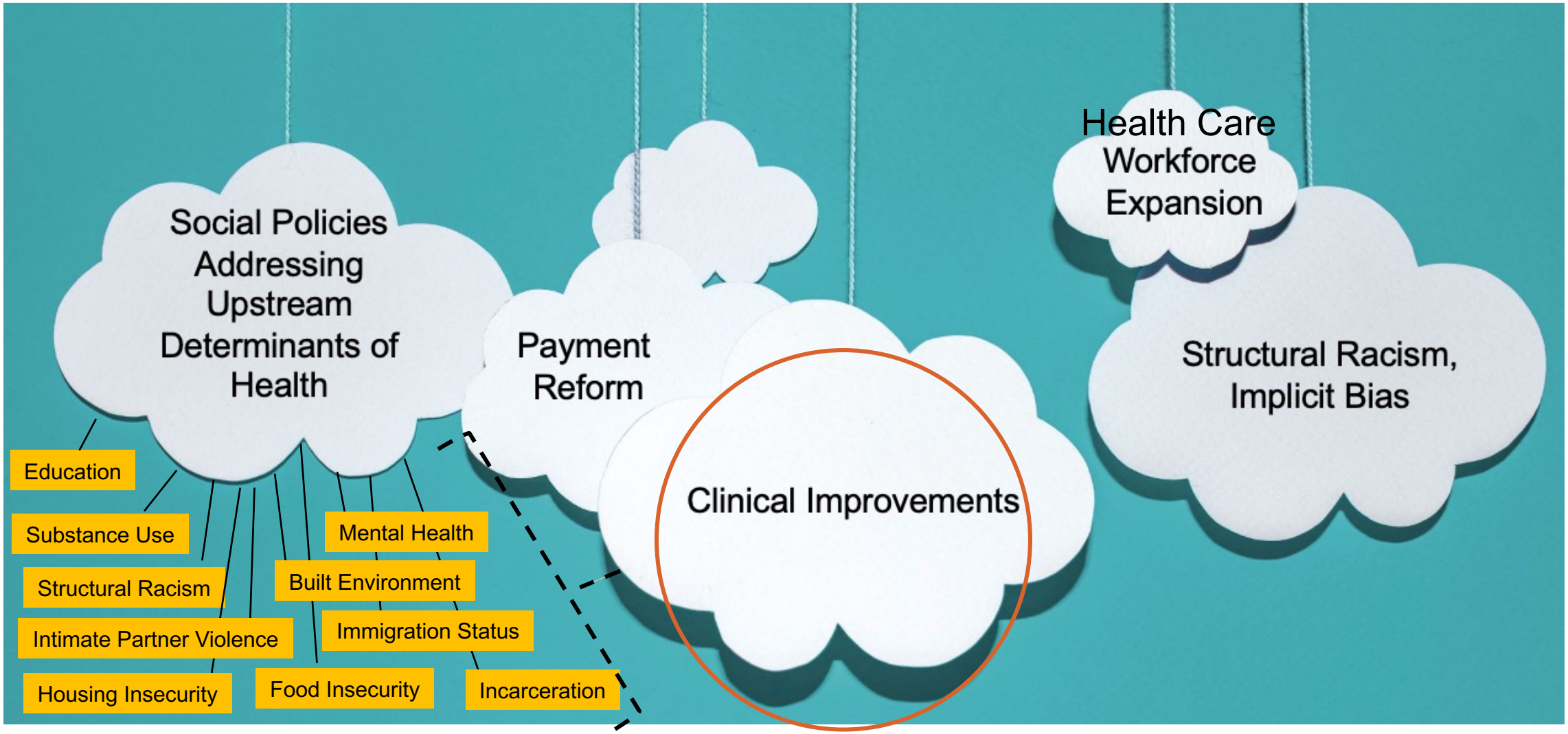
- "The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort."

– Joia Crear Perry, MD, FACOG
Founder, National Birth Equity Collaborative

Achieving Birth Equity Means

- Utilizing strategies that consider the root causes of disparities
- Considering community needs/wants in our approaches to quality improvement (patient and community-centeredness)
- Humility to accept that what we are doing right now isn't working for everyone
- Bringing all quality improvement pressure points to bear; using all the tools in the toolbox

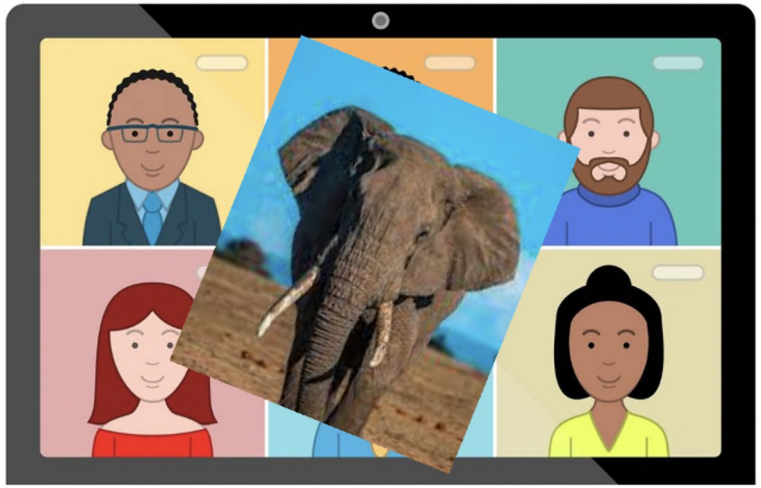
Quality Improvement Ecosystem



The Elephant in the Zoom

Level Setting: Midwives and Community Birth

Patient-Centered Care: *"Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."* – Institute of Medicine | Institute for Health Care Improvement



Respectful maternity care IS A CHOICE

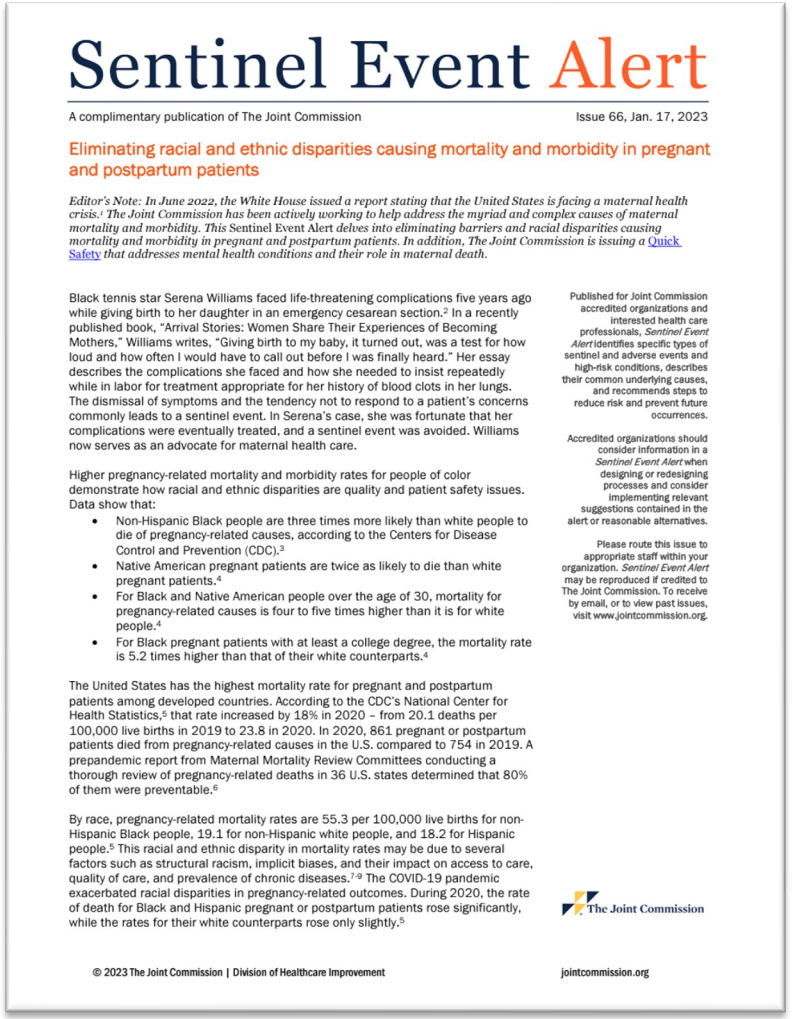
There is no singular intervention that will reduce CS rates or eliminate birth disparities – we must utilize all the tools in the toolbox.

Midwives of all credential types (CNM, CPM, CM) meet or exceed ICM training standards. All licensure types provide unique expertise and are needed to improve maternity outcomes and fill gaps in care.

Community birth is safe:

- provided by trained, skilled providers,
- risk assessment is ongoing,
- within an integrated system of care where higher levels of care and medical consultation are easily accessible

Eliminating racial and ethnic disparities causing mortality and morbidity in pregnant and postpartum patients



Sentinel Event Alert

A complimentary publication of The Joint Commission — Issue 66, Jan. 17, 2023

Eliminating racial and ethnic disparities causing mortality and morbidity in pregnant and postpartum patients

Editor's Note: In June 2022, the White House issued a report stating that the United States is facing a maternal health crisis.[1] The Joint Commission has been actively working to help address the myriad and complex causes of maternal mortality and morbidity. This Sentinel Event Alert *delves into eliminating barriers and racial disparities causing mortality and morbidity in pregnant and postpartum patients. In addition, The Joint Commission is issuing a Quick Safety that addresses mental health conditions and their role in maternal death.*

Black tennis star Serena Williams faced life-threatening complications five years ago while giving birth to her daughter in an emergency cesarean section.[2] In a recently published book, "Arrival Stories: Women Share Their Experiences of Becoming Mothers," Williams writes, "Giving birth to my baby, it turned out, was a test for how loud and how often I would have to call out before I was finally heard." Her essay describes the complications she faced and how she needed to insist repeatedly while in labor for treatment appropriate for her history of blood clots in her lungs. The dismissal of symptoms and the tendency not to respond to a patient's concerns commonly leads to a sentinel event. In Serena's case, she was fortunate that her complications were eventually treated, and a sentinel event was avoided. Williams now serves as an advocate for maternal health care.

Higher pregnancy-related mortality and morbidity rates for people of color demonstrate how racial and ethnic disparities are quality and patient safety issues. Data show that:

- Non-Hispanic Black people are three times more likely than white people to die of pregnancy-related causes, according to the Centers for Disease Control and Prevention (CDC).[3]
- Native American pregnant patients are twice as likely to die than white pregnant patients.[4]
- For Black and Native American people over the age of 30, mortality for pregnancy-related causes is four to five times higher than it is for white people.[4]
- For Black pregnant patients with at least a college degree, the mortality rate is 5.2 times higher than that of their white counterparts.[4]

The United States has the highest mortality rate for pregnant and postpartum patients among developed countries. According to the CDC's National Center for Health Statistics,[5] that rate increased by 18% in 2020 – from 20.1 deaths per 100,000 live births in 2019 to 23.8 in 2020. In 2020, 861 pregnant or postpartum patients died from pregnancy-related causes in the U.S. compared to 754 in 2019. A prepandemic report from Maternal Mortality Review Committees conducting a thorough review of pregnancy-related deaths in 36 U.S. states determined that 80% of them were preventable.[6]

By race, pregnancy-related mortality rates are 55.3 per 100,000 live births for non-Hispanic Black people, 19.1 for non-Hispanic white people, and 18.2 for Hispanic people.[5] This racial and ethnic disparity in mortality rates may be due to several factors such as structural racism, implicit biases, and their impact on access to care, quality of care, and prevalence of chronic diseases.[7-9] The COVID-19 pandemic exacerbated racial disparities in pregnancy-related outcomes. During 2020, the rate of death for Black and Hispanic pregnant or postpartum patients rose significantly, while the rates for their white counterparts rose only slightly.[5]

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The Joint Commission

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3. Provide support and options that meet the needs and expectations of patients, including those who wish to deliver in a home or birthing center environment, while managing their risk of pregnancy complications. The pregnant patient and the clinician should share decision-making. Discuss delivery options and support patients in receiving their preferences. To reduce the high incidence of low-risk C-sections, provide education and training for the interdisciplinary team to develop knowledge and skills on approaches that maximize the likelihood of a vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and nonpharmacologic), and shared decision making.

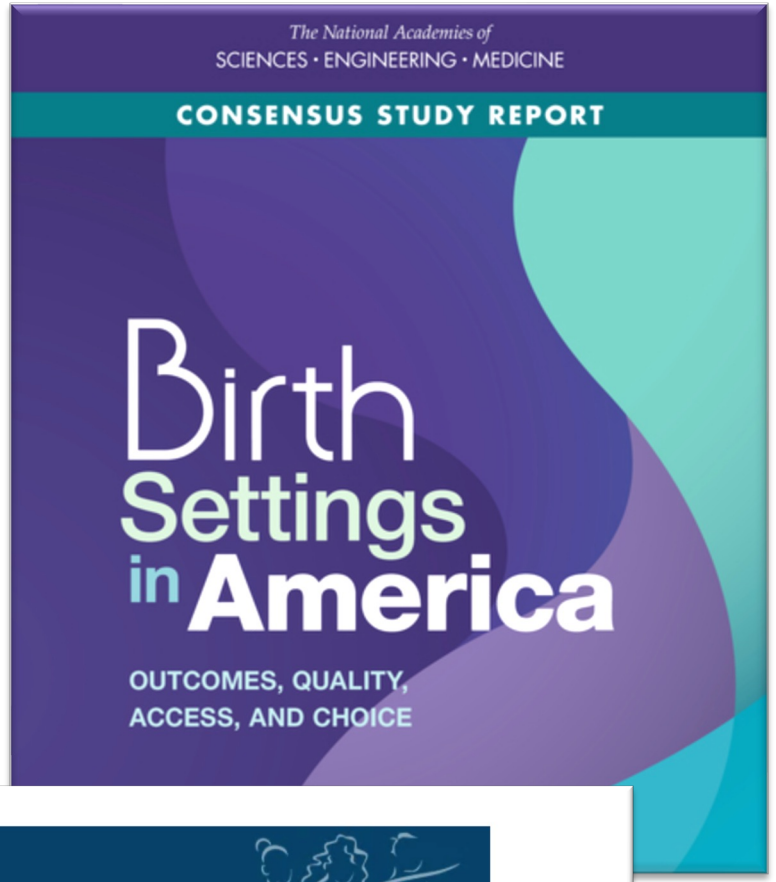
BIRTH ISSUES IN PERINATAL CARE

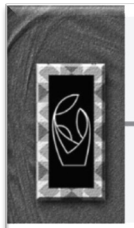
COMMENTARY | Open Access

Are perinatal quality collaboratives collaborating enough? How including all birth settings can drive needed improvement in the United States maternity care system

Audrey Levine BA, LM, CPM-retired, Vivienne Souter MD, Carol Sakala PhD, MSPH

First published: 26 October 2021 | https://doi.org/10.1111/birt.12600 | Citations: 2





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OPEN

We Are Not Asking Permission to Save Our Own Lives

Black-Led Birth Centers to Address Health Inequities

Leseliey Welch, MPH, MBA; Renee Branch Canady, PhD, MPA; Chelsea Harmell, MPH; Nicole White, BS, CPM; Char'ly Snow, MSN, CNM; Lisa Kane Low, PhD, CNM, FACNM, FAAN

Journal of Midwifery & Women's Health

Commentary

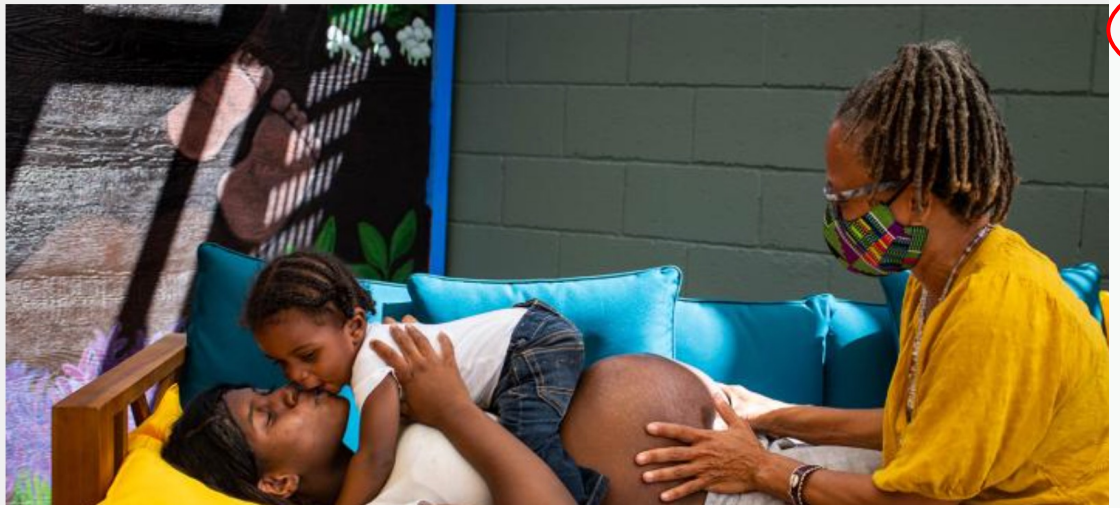
Quality Improvement in Community Birth: A Call to Action

Silke Akerson CPM, MPH, Tanya Khemet Taiwo CPM, LM, PhD, MPH, Melissa A. Denmark CPM, LM, MA, Catherine Collins-Fulea CNM, DNP, Cathy Emeis CNM, PhD, Rosanna Davis LM, Rachel A. Pilliod MD

First published: 22 August 2022 | https://doi.org/10.1111/jmwh.13398

The Commonwealth Fund

How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis



Highlights

- Midwives, incorporated fully into U.S. maternity care systems, could reduce perinatal health disparities and help address provider workforce shortages.
- The integration of midwifery care as a standard feature of maternity care services varies dramatically across states; outcomes for mothers and infants tend to be better in states with high levels of integration.
- Although the demand for midwives is growing — especially racially and ethnically diverse midwives — it remains largely unmet. Black childbearing people experience the biggest gap between demand and access.
- Legislation and regulations restricting autonomous practice, lack of federal funding for education and training, and inequitable Medicaid reimbursement rates all limit broad access to midwifery care.

Source: https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis
May 5, 2023
*Photo: Midwife Kimberly Durdin at Kindred Space LA, Los Angeles, CA

Midwifery Care

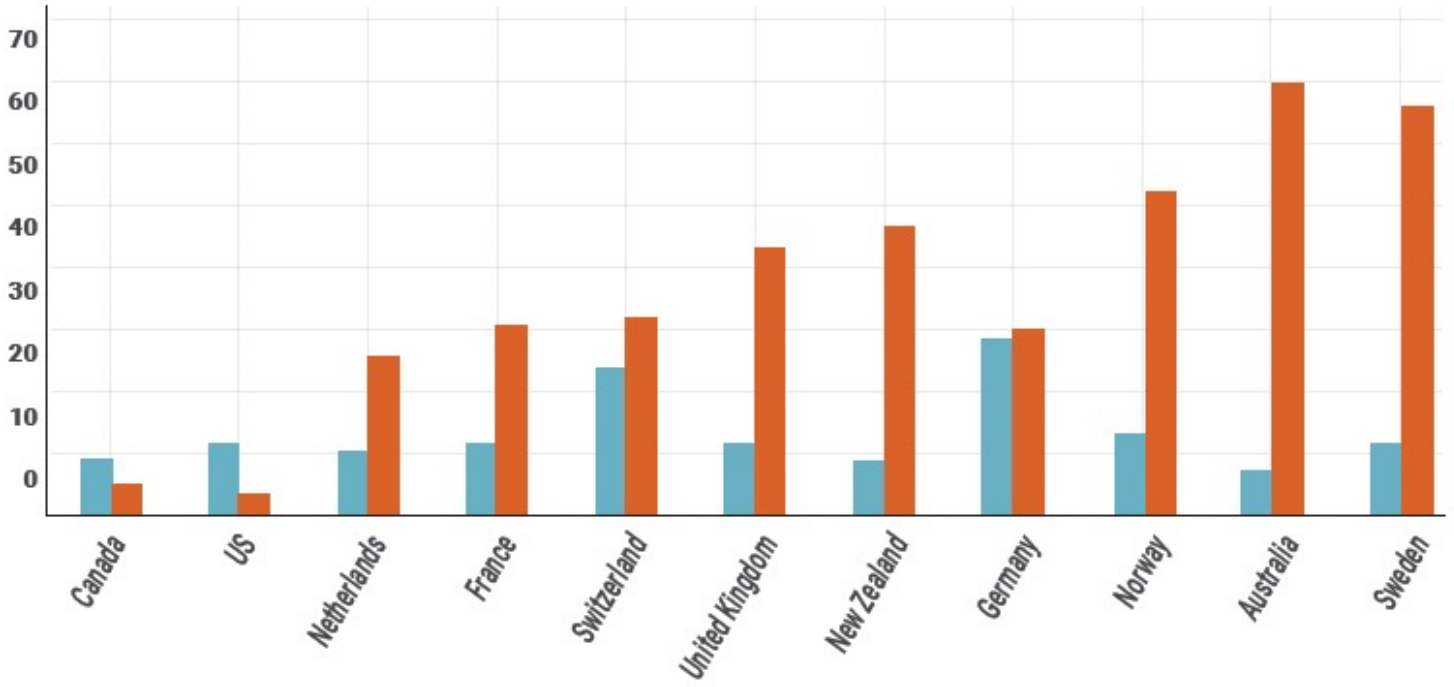
- The midwifery model of care is standard in all countries that have better birth outcomes
- Patient empowerment is a central theme of midwifery care
- “Whole-person” care that considers all the patient’s needs (physical, emotional, SDOH, personal values, cultural needs)

Midwifery is defined as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from prepregnancy, pregnancy, birth, postpartum and the early weeks of life.”

– World Health Organization

Midwifery Care Around the World

Figure 14. Midwifery around the world: Comparison of United States to other Countries



Source: Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal Mortality and Maternity Care in the United States and Developed Countries. 2020 https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries

Midwifery in California

Table 1. Number of Annual Births, by Practitioner, California, 2007-2017

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Doctor of Medicine	501,262	486,714	461,951	443,563	435,221	434,621	421,882	426,326	411,158	405,219	386,646
Doctor of Osteopathy	16,187	16,854	16,423	17,220	18,661	19,575	22,243	23,959	25,027	26,860	27,414
Nurse-Midwife	42,966	42,162	42,239	42,974	41,782	42,510	43,123	45,023	47,642	48,895	49,512
Licensed Midwife	929	1,372	1,447	1,645	1,907	2,168	2,396	2,657	2,849	2,821	2,908
Other (e.g., paramedic)	4,746	4,363	4,626	4,423	4,209	4,489	4,713	4,538	4,755	4,679	4,759
Unknown or not stated	285	270	288	331	313	349	312	332	302	332	394

Source: United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, *Natality Public-Use Data 2007–2017*, on CDC WONDER Online Database, October 2018.

*Slide source: CHCF *California's Midwives: How Scope of Practice Laws Impact Care.* 2019.

Midwives in California: LM vs CNM

HOSPITAL FACILITY

CNM

FREESTANDING BIRTH CENTER

LM

CNM

LM

CNM

Education/Training for California Midwives

Nurse-Midwifery Education program approved by Board of Registered Nursing → American Midwifery Certification Board Exam (AMCB) → CNM certification

3-year Midwifery education program approved by the Medical Board of CA → North American Registry of Midwives Board Exam (NARM) → CPM certification

*CNMs and LMs may also meet equivalent and/or "challenge" processes approved by their respective Boards)

Overview of Birth Settings by California Practitioner 2017

Table 2. Birth Settings, by Practitioner, California, 2017

	DOCTOR OF MEDICINE (MD)	DOCTOR OF OSTEOPATHY (DO)	NURSE-MIDWIFE (NM)	OTHER MIDWIFE
In Hospital	386,581 (99.98%)	27,414 (100.00%)	48,402 (97.76%)	84 (2.89%)
Freestanding Birth Center	0	0	781 (1.58%)	618 (21.25%)
Residence	44 (0.01%)	0	310 (0.63%)	2,157 (74.17%)
Other	21 (0.01%)	0	19 (0.04%)	49 (1.69%)
Unknown	0	0	0	0

Notes: *Other midwife* is the terminology the CDC uses for non-nurse midwives. There may be errors in the data associated with hospital birth attendance. California birth certificates also do not state the planned birth location.

*Slide source: CHCF *California's Midwives: How Scope of Practice Laws Impact Care.* 2019.

Table 40. Resources for Midwifery Educational Requirements, Credential Types, and Scope of Practice

Source	Title	Description
American College of Nurse-Midwives	Comparison of CNMs, CMs, CPMs. Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S.[381]	Compares the three US midwifery credential types in terms of education, scope of practice, certification, and licensure
California Health Care Foundation	California's Midwives: How Scope of Practice Laws Impact Care[356]	Tables 4 and 5 review California-specific information on education, licensing, certification, regulation, and scope of practice for licensed midwives and nurse-midwives
International Confederation of Midwives	ICM Resources: Global standards, Competencies, and Tools[383]	Includes global standards for policy, practice, education, and regulation of midwives

Source: Table 40, Part V, Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: Resources for Midwifery Education, Credentials, and Scope of Practice

Benefits of Midwifery Care

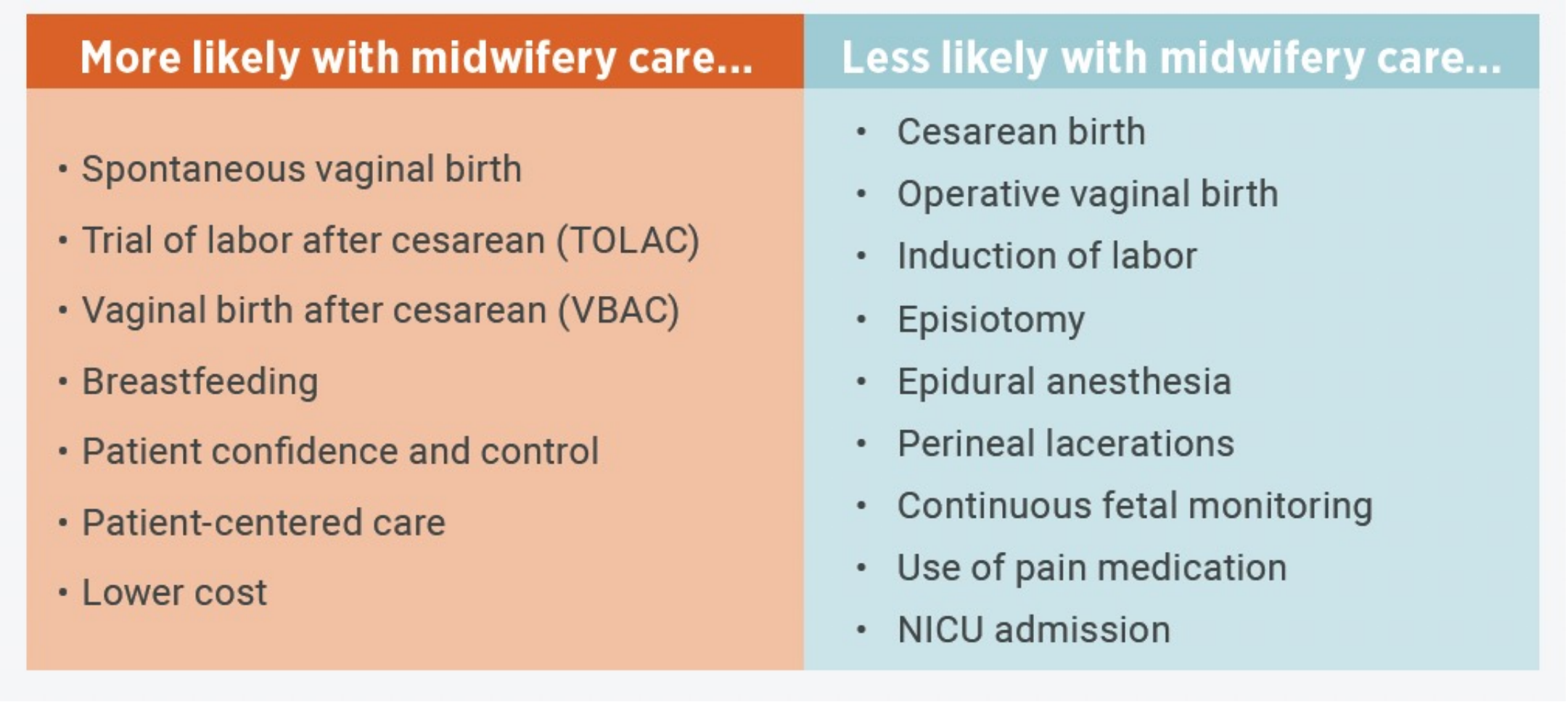


Image Source: CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Midwifery Care

Midwifery philosophy has long preserved three immutable elements:

- ☑ Patient-centeredness
- ☑ "The therapeutic use of the human presence"
- ☑ Nonintervention unless necessary for the health and well-being of the pregnant person and/or fetus

Source: Akileswaran CP, Hutchison MS. Making Room at the Table for Obstetrics, Midwifery, and a Culture of Normalcy Within Maternity Care. Obstet Gynecol. Jul 2016;128(1):176-80. doi:10.1097/aog.0000000000001493

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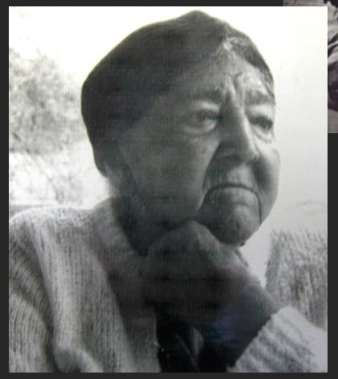
History of Maternity Care and Midwifery in the US

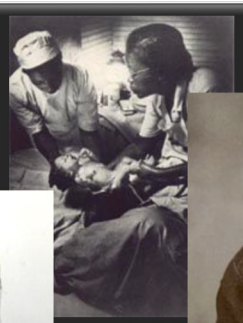
History of Maternity Care and Midwifery in the US

Grand Midwives

- Attended Births
- Provided medical care to enslaved persons (treated lashings and other wounds)
- Often attended both black and white women
- Spiritual Healers



Margaret Charles Smith

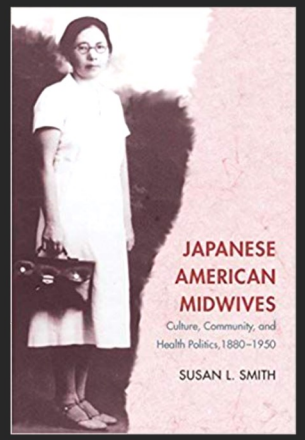


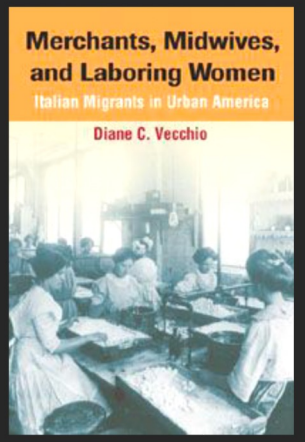
Tempie Avery

Immigrant Midwives

- Parteras (Latin America)
- Sanbas (Japan)
- Ireland
- Italy
- … Everywhere!

(Thompson, 2016)





*Images provided courtesy of Paris Maloof-Bury, CNM
"Marginalization of Black Midwives in America"
CNMA Annual Meeting, 2022

History of Maternity Care and Midwifery in the US

- 1900: less than 5% of births occurred in hospitals
- 1910: Flexner Report published; advocated for the abolition of midwifery and "underperforming" medical schools (which included medical schools for Black physicians)
- 1915: Dr. Joseph Delee – childbirth is a pathologic process, he stated that few escape "damage"
- 1925: Mary Breckenridge founded The Frontier Nursing Service in KY
- 1930: 600-700 maternal deaths per 100,000 live births
- 1939: 50% of births in hospitals
- 1940: American Assoc of Nurse-Midwives did not allow Black members
- 1955: ACNM established

Dr. Joseph Delee:

"It is generally admitted that more women die during confinement in the hands of doctors than of midwives...

The energy directed toward training midwives would bring greater result if spent on doctors…"

– *American Journal of Obstetrics and of Diseases of Women and Children*, Vol 73.

History of Maternity Care and Midwifery in the US

- 1960: 97% of births occurred in the hospital
- 1970s: US military began to train nurse-midwives; only 9% of medical students were women; natural birth movement began
- 1973: ACNM “preferred site of birth is the hospital”
- 1974: CNMs authorized to practice in California
- 1980: ACNM updated its homebirth statement to show approval for community birth
- 1982: MANA established (Midwives Alliance of North America)
- 1993: LMs authorized to practice in California
- 2013: Independent practice established for LMs in California
- 2020: Independent practice established for CNMs in California
- 2023: ***Midwifery care noted to be a key strategy toward reducing maternal mortality and morbidity;*** community birth and hospital midwifery on the rise

Video: “Granny Midwives”– watch at https://timeline.com/granny-midwives-rural-south-87a27ba13dd1

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Midwifery Integration

What Does a System of Integrated Midwifery Care Look Like?

- No universal definition
- We can draw from other definitions – e.g., integrated health care generally and accepted definitions of integrated maternity care
- Other countries serve as a model

Why does Midwifery Integration Matter?

- Improves processes that result in higher quality, safer care
  - *Collaboration and seamless coordination of care = fewer catastrophic intrapartum outcomes and during critical events; prevents critical events before they happen*
  - *Interprofessional disconnect = poor communication, uncenters the patient, unsafe care environment*
- Turns the current culture of doing “too much too soon” into giving the “right care at the right time”
- Reduces health care costs
- Increases access for those who need it most
- Improves choices in pregnancy and childbirth
- Results in a respectful, patient-centered approach to community needs and wants
- Strong step towards reducing disparities in outcomes

PLOS ONE

RESEARCH ARTICLE

Mapping integration of midwives across the United States: Impact on access, equity, and outcomes

Saraswathi Vedam[1,2]*, Kathrin Stoll[1], Marian MacDorman[3], Eugene Declercq[4], Renee Cramer[5], Melissa Cheyney[6], Timothy Fisher[7], Emma Butt[1], Y. Tony Yang[8], Holly Powell Kennedy[9]

Increased **Access To Midwifery Care** Is Correlated With **Improved Outcomes For Families**

=

increased breastfeeding

reduced interventions

increased vaginal delivery and VBAC

lower neonatal death

birth place lab

For more information, visit birthplacelab.org

Video: How Does Access to Midwifery Care Impact Birth Outcomes? – Birth Place Lab – watch at https://youtu.be/6lh77QVw87M

What Does Midwifery Integration Look Like?

Culture of interprofessional partnership (easy access to physician consultation and collaboration); including interprofessional education

Community and hospital midwives are represented in the state perinatal collaborative

Outcomes data are readily accessible

Birth centers are licensed, accredited, or meet equivalent standards

Midwives have admission and discharge privileges

Equal reimbursement; coverage for midwives/birth centers by all payers

State laws allow midwives to practice to the full extent of education & training, including prescribing all drugs and devices in their scope

Guidelines for safe, efficient, respectful transfer exist and are created through a collaborative process

Sustained growth of community midwives,BIPOC providers

Valuing midwifery and physician care as equals (right care at the right time philosophy)

All midwifery credential types recognized in your state and regulated according to the ICM standards

Midwifery Integration HASN'T Been Achieved If….

Policy and practice founded on supervision rather than collaboration among colleagues

Hospitals in your region refuse community birth transfers

CNMs are licensed in your state but not CPMs and CMs

Midwives are privileged at your facility but function as an extension of physicians

Valuing or trusting one midwifery licensure type over another (CNM>CPM)

Hospital midwifery embraced but community birth is disparaged

Midwives in your region have a restricted scope of practice below their actual education and training

Midwives can't prescribe or access the medications they need to provide safe care

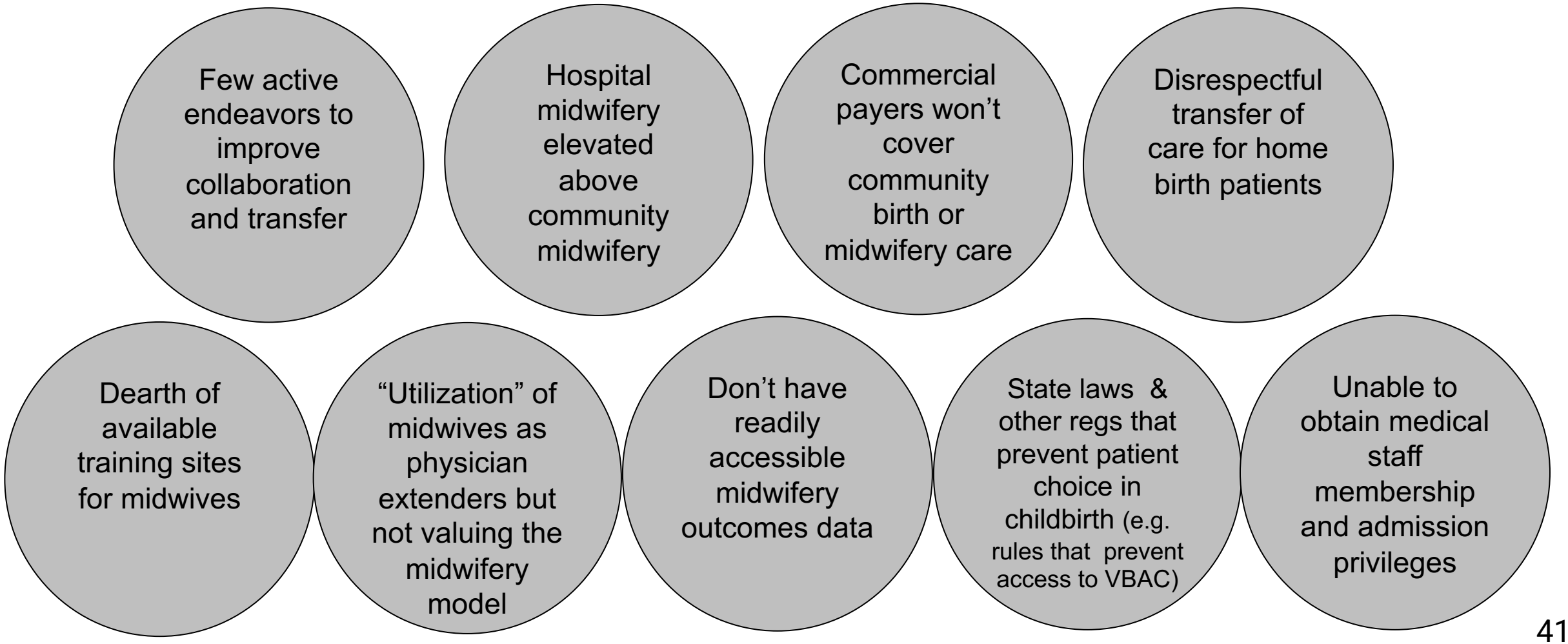
Insurers don't cover community birth (midwives not easily accessible to the public); or otherwise engage in unequal reimbursement

Patients receive disrespectful care or judgment when transferring to hospital from community birth setting

Refusal to believe that diverse care models are critical to addressing the root causes of health care disparities

What's Happening in California – Macro-Level Integration Endeavors

But… this is also happening in California



Which results in…

- Reduced size of California maternity care work force
- Reduced or eliminated patient choice for pregnant & birthing Californians
- Decreases safety and quality of maternity care → poorer outomes
- Increases medical intervention → significant cost to the state and consumers
- Ultimately, the effects are carried mainly by BIPOC patients, SE disadvantaged, and geographically isolated

Zooming in on Micro-level Integration Considerations (clinical and interprofessional levels)

Toolkit Strategies for Midwifery Integration at the Clinical Level

- **Administrative, Educational, and Clinical Strategies** for your hospital

✓Are there midwifery-attended births at your facility or within your group?

✓Do community birth midwives have privileges at your facility?

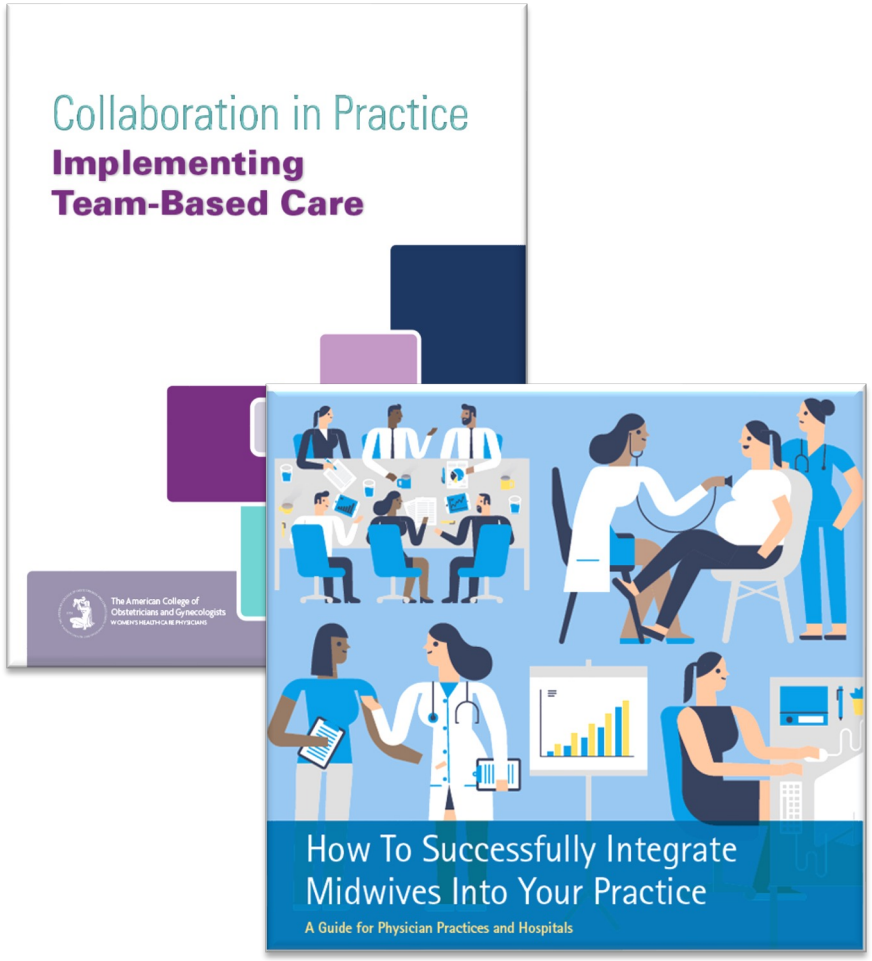
✓Do your policies enhance collaborative partnerships, or do they rely on supervisory relationships?

✓Do midwives lead QI projects at your facility?

✓Is your department engaged in projects that improve safe, patient-centered transfer of care?

✓Are you fostering a departmental culture that values reduced intervention and midwife-led care for low-risk birthing people?

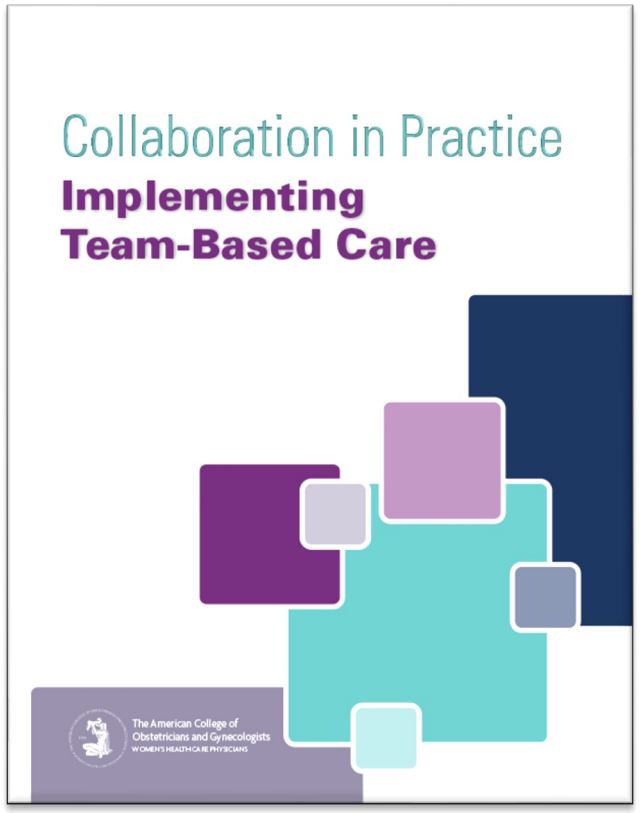
An Integrated Clinical System Implements the Key Principles of Team-Based Care / Collaboration



"Midwife-physician collaboration is a process in which midwives and physicians work together to **enhance and elevate each other's expertise** in pursuit of a common goal: to provide **safe, appropriate, and effective patient-centered care** for women and their families. Commitment to such a successful partnership requires the **integration of both the medical and midwifery models of care**"

(Purchaser Business Group on Health, *How to Successfully Integrate Midwives into Your Practice*)

"Team-Based Care" Webinar Available at CMQCC.org (Feb 3, 2023). You will learn about:



- ✓ The PATIENT is the INTEGRAL CORE of the team
- ✓ The team has a SHARED VISION
- ✓ ROLE CLARITY is essential to optimal team functioning
- ✓ All team members are ACCOUNTABLE for their own practice and to the team
- ✓ Effective COMMUNICATION is key
- ✓ Team LEADERSHIP is SITUATIONAL and DYNAMIC

Toolkit Strategies for Integration and Improved Safety Across Birth Settings

- Do community birth midwives have timely access to consultation, and seamless, respectful transfer?
- Actively working to improve systems that facilitate safe, patient-centered transfer between settings?
- Is there a culture of care that respects patient autonomy and is working to destigmatize the choice to safely give birth in a community setting?
- Does your site implement elements of "Just Culture" when responding to an emergency community birth transfer
- Do you hold joint learning opportunities? (such as debriefs, grand rounds, and meet-and-greets for providers across birth settings)?
- Do community birth midwives have privileges at your facility?

CMQCC clinical leads and data center

Data questions

- datacenter@cmqcc.org

Clinical improvement questions or questions about toolkit

- csakowski@cmqcc.org

Questions about midwifery and team-based care in California or to join the Community Birth Partnership Initiative

- holly@midwiferyrising.org

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