

Giving Birth to Quality Perinatal Care Services: Midwifery Models for FQHCs

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Thanks to...



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Agenda

- US maternity care—where are we?
- The midwifery model
- Midwives and FQHCs
- Models that work



How Are We Doing? A Quick Look at Childbirth Statistics in the US

- 4.2 million births in the US in 2008
- Preterm birth rate is increasing:
 - 10.6% in 1990
 - 12.2% in 2009
- Rate of low birth weight is increasing:
 - 6.7% in 1984
 - 8.2% in 2009



Quality of care



How Are We Doing? A Quick Look at Childbirth Statistics in the US

- U.S. maternal mortality rate has increased:
 - 8/100,000 live births in 1996
 - 17/100,000 live births in 2008
 - *This is the highest maternal mortality rate among developed nations*
- Save the Children Report 2010:
 - Women in 35 of 44 developed nations had a lower lifetime risk of maternal mortality than women in the U.S.
- World Health Statistics 2010
 - 37 nations had lower neonatal mortality rates than the U.S.



***Midwife
means
“With
Woman”***





The Midwifery Model of Care

- **Recognizes the woman as a unique individual in context of her family and community**
- **Supports and protects the normal physiologic process of labor and birth**
- **Establishes the woman as active partner in her own care**



Photo: C Kugel

Rooks 1999

The Midwifery Model of Care



Midwifery is the independent management of women's health care within a system that provides for **consultation, collaborative management or referral** as indicated by the health status of the client

CNM Outcomes



- Lower rates of cesarean birth
- Lower rates of labor induction and augmentation
- Significant reduction in the incidence of third and fourth degree perineal tears
- Lower use of regional anesthesia, and
- Higher rates of breastfeeding.

The Evidence



- Low risk, low income women in CNM/OB collaborative practice vs. traditional care (n=2957)
Collaborative model provided:
 - more spontaneous vaginal births
 - lower utilization of resources
 - no differences in adverse outcomes
- Women in 10 collaborative practices (n=3257):
 - obtained appointments more quickly
 - more time with providers
 - more health information

Jackson 2003, Hankins 1996

Practical Application



Collaborative care models:

- Ideal for diverse patient populations
- Allow women to be matched to the appropriate level of care
- Increase access to care, leading to better health outcomes, lower preterm birth rates
- Greater patient satisfaction
- Better communication among providers

Mvula 1998, Waldman ACOG Presidential Address 2010; ACNM 1997



“What works is not flashy,
not expensive,
but it’s human intensive”

Heidi Rinehart, Amnesty International interview 2008

Source: Amnesty Intl 2010

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Education & Scope of Practice

- **Legal in 50 States**
- **Board of Nursing or Midwifery**
- **Prescriptive Authority**
- **Education: Master's (4 yrs college/2yrs grad)**
- **98% CNM deliveries: hospital**





Midwives in New Mexico

- 2007: New Mexico CNMs delivered 8,662 babies
- CNM attended births in New Mexico more than doubled over the last ten years.
- States with the highest proportion of CNM-attended births in 2007 were once again led by New Mexico (28.5% of all births)
- Total US rate 7.6% in 2009
- Lowest cesarean rate of all 50 states (CDC)

Source: Declercq, J Midwifery Womens Health 2011;56:173–176



New Mexico FQHCs and Midwives

- 15 FQHCs in New Mexico serving 275,748 pts
- 3 with midwives
- 2.5 total FTEs

330 program requirements



Required primary services includes:

- (i) basic health services which, for purposes of this section, shall consist of--
 - (I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and **nurse midwives**;
 - (III) preventive health services, including--
 - (aa) **prenatal and perinatal services**;
 - (bb) **appropriate cancer screening**;
 - (gg) **voluntary family planning services**

Source: Section 330 of the Public Health Service Act (42 USCS § 254b)



Midwives in CHCs

Personnel Category	FTEs	Visits
Certified Nurse-Midwives	520.28	1,255,262

1.1% of medical personnel
2.2% of medical visits



Source: 2010 UDS



NP/PA/CNMs in CHCs

2007

- 2,678 NP
- 1,597 PA
- 418 CNM

Total 4,693 (38%)

2010

- 3,808 NP (60%)
- 2,034 PA (32%)
- 520 CNM (8%)

6,362 (41%)

26.3% increase in 3 years

Sounds like PCMH?



- Maternity care homes
 - continuity of care from a primary clinician who accepts responsibility for providing and/or coordinating all health care and related social services during a woman's pregnancy, childbirth, and postpartum period
 - commitment to continuous quality improvement, patient safety, and evidence-based practice
 - commitment to woman-centeredness and a positive experience of care
 - timely access to appropriate care and information
- Centering Pregnancy
- Childbirth Connection childbirthconnection.org



CNMs Do more than birth babies:

- **Prenatal care**
- **Annual GYN**
- **Family Planning**
- **Preconception Care**
- **Depression Screening**
- **School physicals**





Certified Nurse-Midwives may also be able to do the following procedures:

- **Colposcopy/Biopsies**
- **Limited Ultrasounds**
- **IUD and Implanon Insertions**
- **First Assist at Cesarean Sections**
- **Circumcisions**





Building blocks of an OB model

- Staffing
 - Midwifery, Medical or Shared model
 - Salary & benefit ranges
 - Hospital and/or birth center privileges policies
 - Distance of office/s to delivery facility
 - Provider preferences
- Credentialing, scope, FTCA (of course)



Building blocks of an OB model

- Revenues
 - Expected prenatal visit & birth volume
 - Payer mix, reimbursement & expected collections
 - Vaginal birth vs. C/Section
 - Global billing vs. per-visit fee
 - Uninsured and undocumented women



Clinical Considerations

- Midwifery, Medical or Shared model
- Cross-train staff to assist in OB/GYN
- Walk-in urine pregnancy tests to facilitate access to care
- Add induction, C/Section & breastfeeding rates to quality measures



Let's talk about the margin



Financial Considerations

- OB → pediatrics → family medicine
- Volume is key to sustainability in OB care
- May not make money on OB but it will be a feeder for all other parts of practice
- Consider OB physician vs. CNM salaries



Financial Considerations

- Bill hospital or birth center care fee-for-service
 - pull out of cost calculation on cost report
- Can make money on GYN specialty care
 - Colposcopies, biopsies, etc. in office
 - Surgeries: sterilizations, hysterectomies, robotic surgery
 - Learn OB/GYN billing and coding, especially surgery



Practical Considerations

- Scheduling OB is different than Family Med
- Provide support staff for CNMs like for other clinicians
- OB call is different
 - Avoid scheduling office hours and call together
 - Night call is often all night



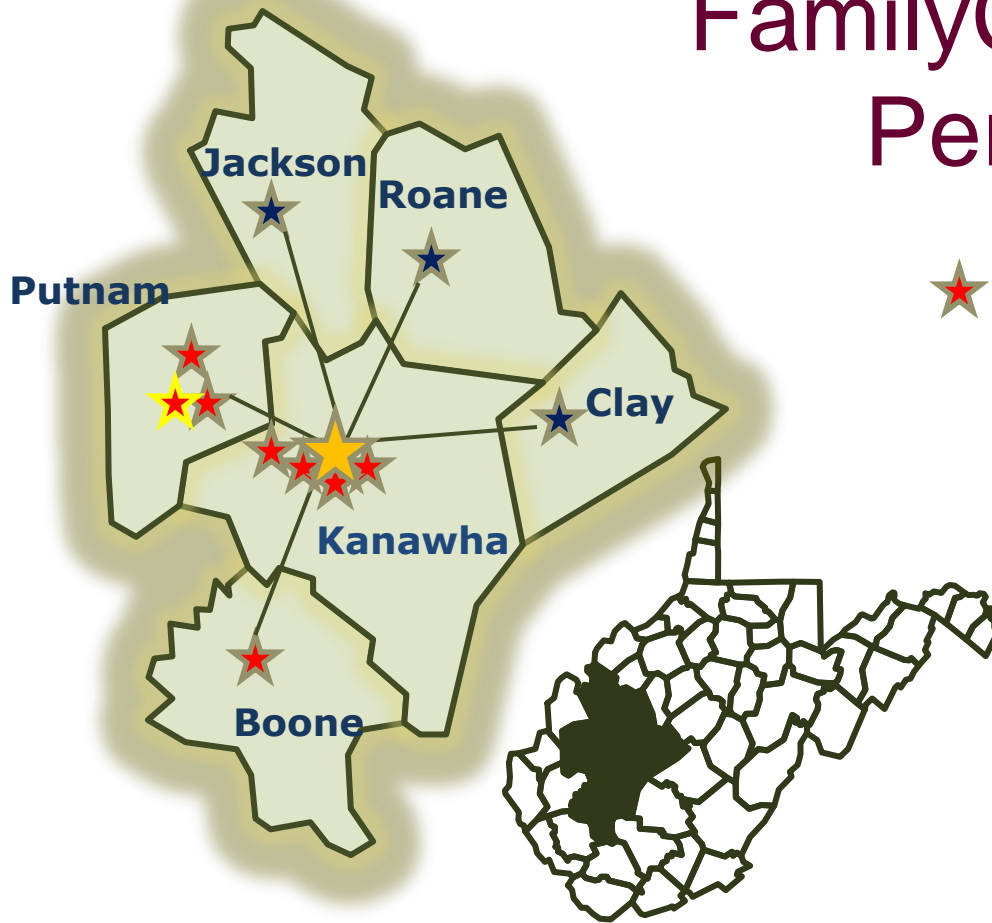
Models that Work



Models that Work



FamilyCare HealthCenter Perinatal Network



- ★ FamilyCare HealthCenter sites
- ★ WomenCare BirthCenter
- ★ Other health center sites
- ★ Tertiary hospital

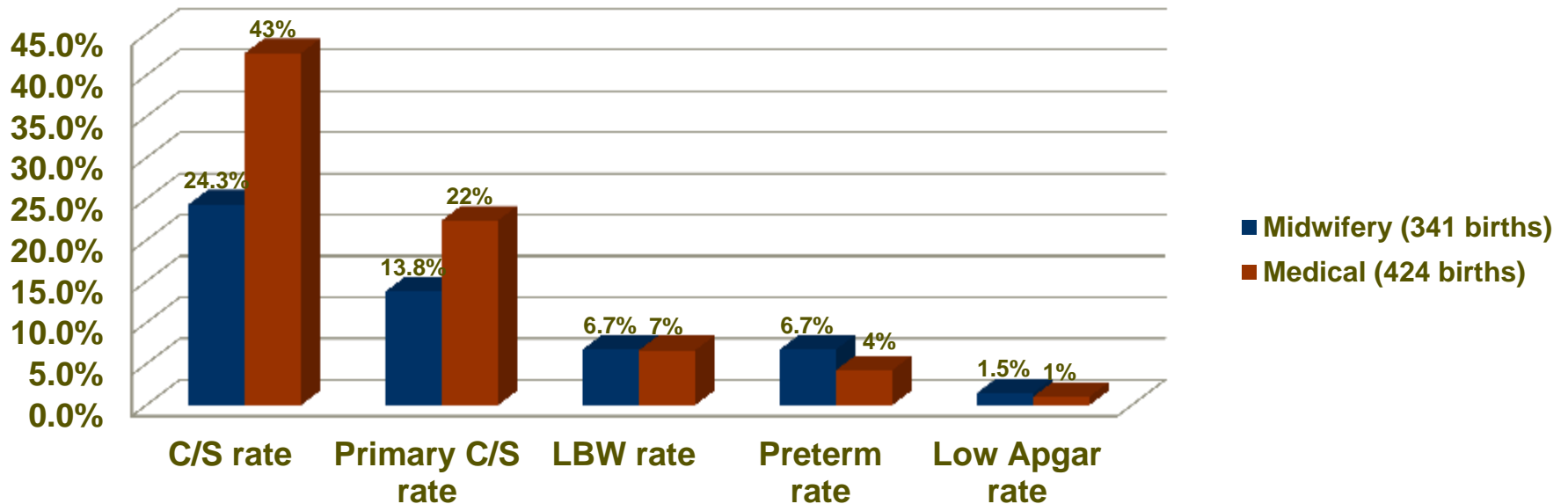


Models that Work



FamilyCare HealthCenter

Midwifery vs. Medical Model
All births CY 2010



Models that Work



CommuniCare Health Centers Yolo County, California

- Established as Free Clinic in 1972
- FQHC Look-Alike 2004
- FQHC 330 2007
- 5 clinic sites in semi-rural county
- 23,280 patients served 2010
- 156 FTE staff



Photo: C Kugel



CommuniCare Midwifery Program

- 580 births/year
- 4.7 FTE Certified Nurse-Midwives
- 0.20 FTE Obstetrician
- Health Education, Breastfeeding Support, Social Work and Nutritionist on Staff



CommuniCare Health Centers

- Contract to a 5 physician group practice for clinic and in-hospital obstetric back-up.
- CommuniCare Midwives form a combined call group with midwives from a private practice.

Models that Work



Cesarean Rate: CCHC

- Primary C/S: 10.3%
- Repeat C/S: 7.3%
- Total C/S rate: **17.6%**
 - National Average: 30.2%

*(Compared to FL FQHC
that sends patients out
to an MD only group for
delivery: **37% C/S rate**)*



Models that Work



Birth Outcomes

- Low Birth Weight: 2.4%

National Rate 8.2%

- Preterm Birth Rate:
3.8%

National Rate 12.2%



Photo: C Kugel
Artwork: RT Freeman



Productivity: CCHC

1.0 FTE CNM had an average of 2,900 visits per year.

Ultrasound , Fetal Testing, Health Education, Social Work and Nutritionist billed at full PPS rate in California.



Questions?



Why we do it



Patient-centered care

“The team I had with me made me feel very empowered when I needed it most. Aided with what we learned in the birthing classes, my husband and I both look back on this with nothing but awe and fondness. It was without a doubt one of the most amazing and positive experiences of our lives.”





***CERTIFIED NURSE-MIDWIVES (CNMs)
and FEDERALLY QUALIFIED HEALTH
CENTERS (FQHCs)***

...a perfect match



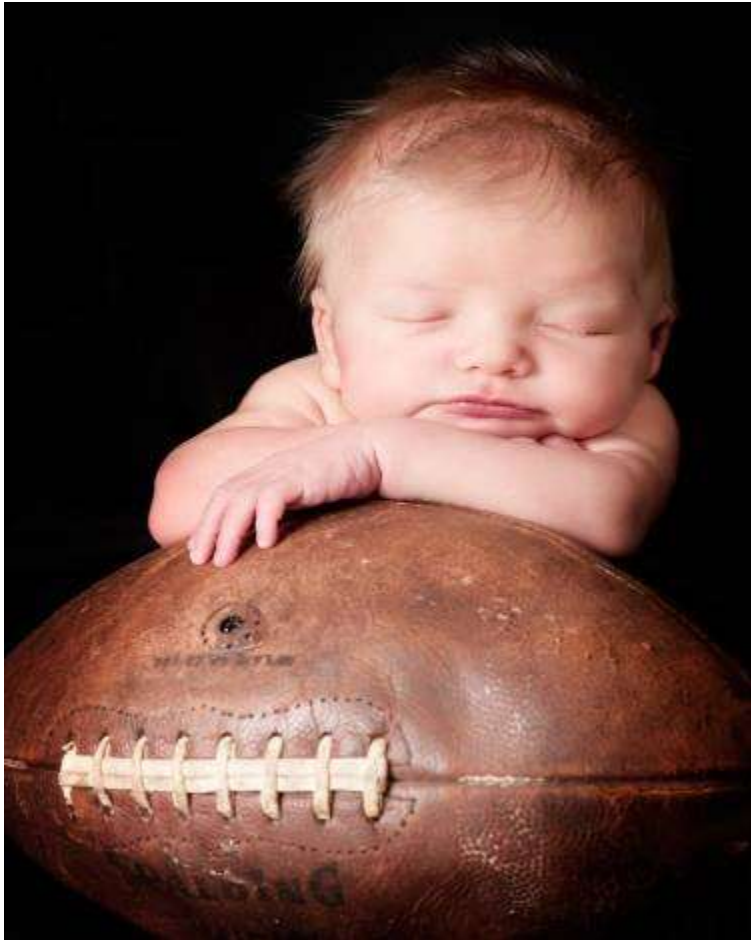
American Academy of Nurse-Midwives www.midwife.org

Resources & References



- **American College of Nurse-Midwives**
<http://www.midwife.org/>
- **Childbirth Connection:** <http://www.childbirthconnection.org/>
 - Transforming Maternity Care: “2020 Vision for a High-Quality, High-Value Maternity Care System” and “Blueprint for Action”
 - Listening to Mothers II
 - Evidence-Based Maternity Care. Milbank Memorial Fund
- **Amnesty International.** Deadly Delivery: The maternal health care crisis in the USA. 2010
<http://www.amnestyusa.org/dignity/pdf/DeadlyDelivery.pdf>
- **The Coalition for Improving Maternity Services (CIMS)**
Mother-Friendly Childbirth Initiative
<http://www.motherfriendly.org/>
- **Cochrane Database of Systematic Reviews.** Midwife-led versus other models of care for childbearing women.
<http://www.thecochranelibrary.com/>

Thank you!



Questions?

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