

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

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# Thanks to...



## **Barbara Boehler, CNM, MSN**

Director of Perinatal Services  
CommuniCare Health Centers  
Davis, CA  
[barbb@communicarehc.org](mailto:barbb@communicarehc.org)

## **Candace Kugel, FNP, CNM**

Migrant Clinicians Network  
HRSA Clinical Consultant  
[ckugel@migrantclinician.org](mailto:ckugel@migrantclinician.org)

## **Denise Henning, CNM**

Clinical Director of Women's Health  
Collier Health Services  
Fort Myers, FL  
President, Midwifery Business Network  
Commissioner, Medicaid and CHIP  
Payment and Access Commission  
[denisecnm@hotmail.com](mailto:denisecnm@hotmail.com)

## **Martha Carter, MBA, CNM**

Chief Executive Officer  
FamilyCare HealthCenter  
Scott Depot, WV  
[martha.cookcarter@familycarewv.org](mailto:martha.cookcarter@familycarewv.org)



# 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

# 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](http://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



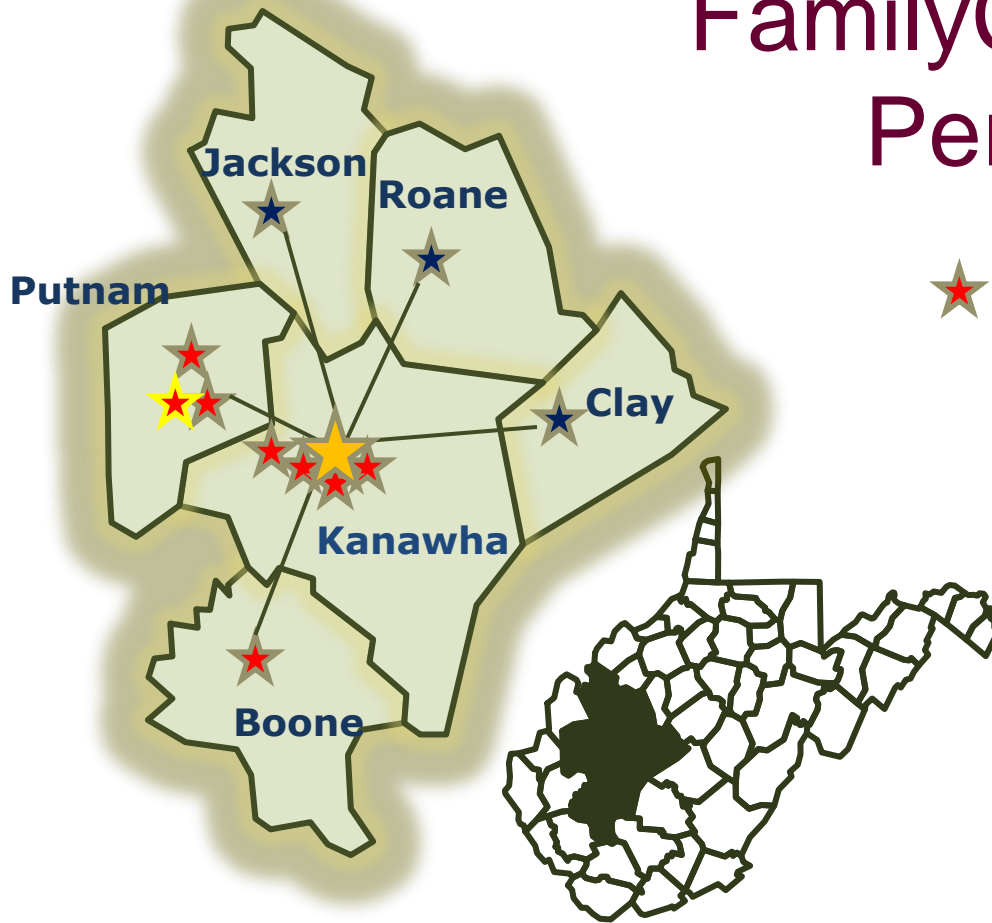
# Models that Work



# Models that Work



## FamilyCare HealthCenter Perinatal Network



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

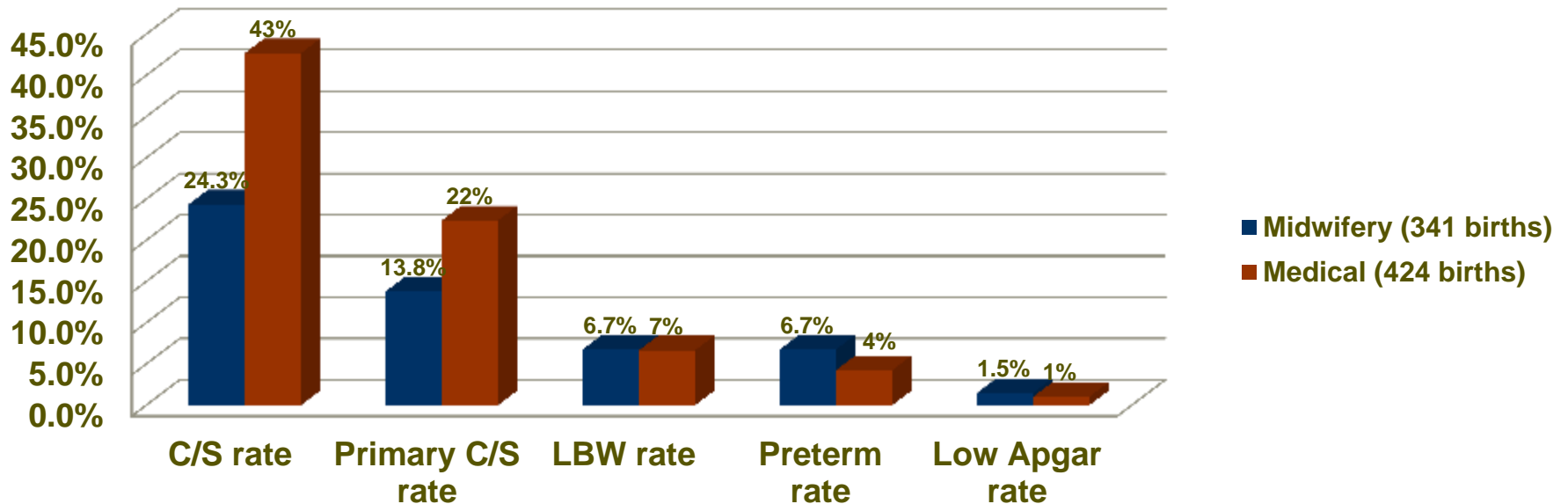


# Models that Work



## 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*



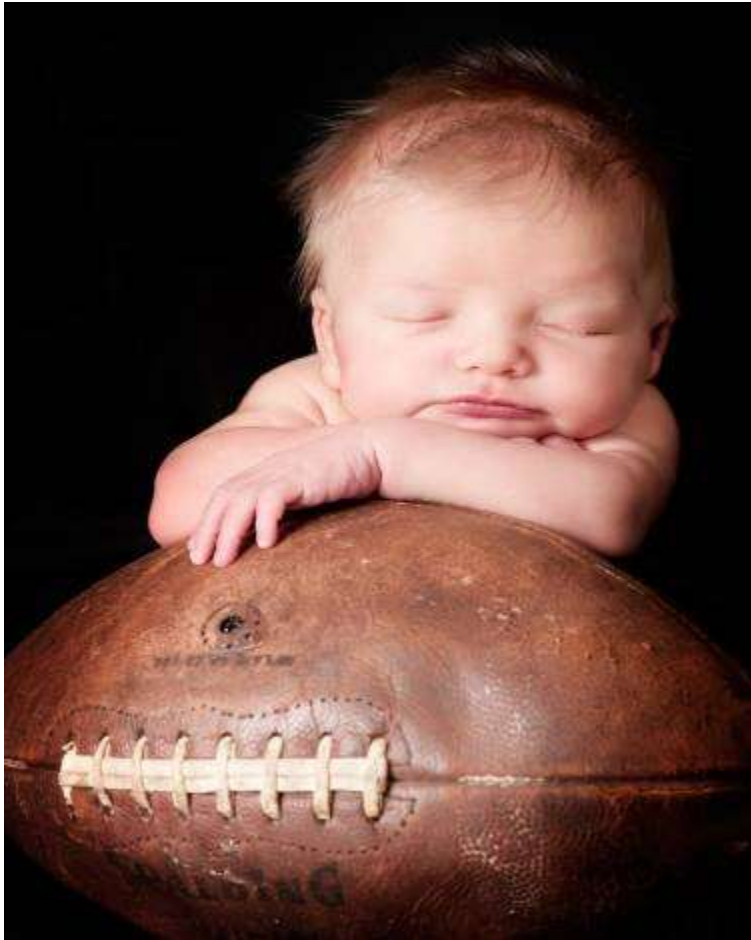
*American Academy of Nurse-Midwives [www.midwife.org](http://www.midwife.org)*

# 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?**

**[ckugel@hrsa.gov](mailto:ckugel@hrsa.gov)**