Session 2:

Value Proposition for Midwifery-Led Care in Medicaid

Panel Transcript

Let's start with the foundation of this conversation---the value of the midwifery model. You represent different key perspectives: birth equity for individuals, health care providers, and health plans. From your unique view, please tell us your thoughts on the value of the midwifery model of care, including how issues around disparities and equity connect to that value and any reflections on where misalignment across stakeholders has presented practical obstacles that folks should anticipate.

Dr. McLemore: Pregnancy is not a disease state to be managed, it is a normal physiological condition that needs to be attended to and witnessed. Birthing is a reverent event that deserves respect and humility. Shepherding new humans to this plane is a process that has for centuries ensured the propagation of our species. This is a radically different way of understanding birth than the risk categorization that dominates obstetrics. So, when I talk about and think about birthing people, this distinction needs to be made.

Next, regardless of age, income, education, insurance and marital status, Black women carry the greatest burden for poor reproductive outcomes across the spectrum. Pregnancy is the condition and there are many outcomes of pregnancy: abortion, birth, miscarriage, surrogacy, stillbirth. Using a life course perspective, we can understand the continuity that is required in care provision for those who carry the greatest burden.

Humans have been birthing since the dawn of time. The midwifery model of care is shown to have superior outcomes around the globe and is the primary model of care in many places. Yet, here in the United States our uptake and scale of the model is hampered by a lack of courage, political will, available workforce, and rampant disrespect for birthing people and the constellation of individuals who surround them.

Dr. George: As an obstetrician, I want to acknowledge Dr. McLemore's remarks. I feel like my specialty has been remiss over the years and needs to right a lot of wrongs. I think that we are acknowledging that and moving forward. From my perspective as an obstetrician who has worked with midwives throughout her career, I would say that there are differences in our perspectives and training. As Dr. McLemore said, midwives see birth as a normal, physiological process, and physicians are trained to see it as an endless list of possible ways that it can go wrong. Labor and delivery units, especially those who serve birthing people enrolled in Medicaid, are often very busy, and are basically set up as intensive care units. There is pressure for efficient through-put, and patients unfortunately get put on a time clock to make room for the incoming. Often, decisions are made because of unit or hospital volume and acuity. In contrast, in my work with midwives over the years, I have found them to really embrace a different viewpoint. They often have fewer patients than physicians and are able to spend more uninterrupted time with their patients. With their focus on normal birth, healthy women are more likely to engage with the process and they practice watchful weighting and often this relates and results into a normal vaginal birth.

From the health policy perspective, midwives have tremendous value, which has been alluded to by Dr. McLemore and in last month's session when Dr. Moore went over the robust evidence to support better outcomes, so we know that midwifery care results in lower cesarean delivery rates, higher VBAC rates, lower utilization of intervention, including epidurals, in low-risk patients who are attended by midwives. Hospitals who employ midwives have lower cesarean rates, and patients are much more satisfied with their outcomes. As we know from the Strong Start study, this carries over into better outcomes for those who are insured with midwives. We are learning more and more that concordant care with providers who share lived experiences improves engagement and outcomes.

Finally, from my perspective as an educator for many years, I have to say I was trained to be a better doctor through my interactions with midwives, and of the 1700 graduating OB/GYNs last year, half of them were trained with midwives. I think that really makes a big difference. Many of them are specifically seeking to build a collaborative practice and have midwifery colleagues.

Mr. Sandwith: I have been in health care for about 35 years. I developed the first perinatal bundles in 1985, did the first mobile maternity engagement app in the state of Wyoming Medicaid population, and now within Tennessee, developed perinatal episodes of care in which we have almost 8,000 births within United. I got into the birthing center aspect when I was approached by TennCare that they had met with a company called Baby&Company who was building birthing centers within the state of Tennessee. When I met with them, I immediately saw the value that they could provide, including providing another side of care for women within the Medicaid program. I immediately built a relationship with them, understood what they were trying to do, and position them within the episode of care program in which they could be participating just as well as any other OB/GYN in the program. It was relatively unheard of, because TennCare asked all the MCOs to do that—as it resolved, we were able to be the first MCO to provide that benefit to any Medicaid women within the state of Tennessee. Unfortunately, Baby&Company was only located within the greater Nashville area. The aspect of providing another side of care for somebody, providing another opportunity to engage with the system allowed us to help with their costs and to develop their quality measures. So, I immediately saw its value, and we implemented it almost two years ago.

Given those perspectives, we would love to hear about your experiences to date with supporting access to midwifery models of care. What type of initiatives have you launched—how do they promote network access, benefit coverage and payment of services? And how have you been able to explicitly incorporate equity into your approaches? Mr. Sandwith tell us about United's approach to supporting access to midwifery services.

Mr. Sandwith: I am an out-of-box person in regard to that. I have been very focused in Tennessee in how we can promote that. The barriers that you are going to find—and I'm going to talk about that, there are a lot of barriers in a health plan to get just about anything done, if you're going to contract with them. I do find it beneficial that in Tennessee and TennCare they worked out a value-based methodology which very easily allowed us to bring in the birthing center as a solution. I had a value-based model, which was episodes. Even as a champion within the health plan, there were numerous barriers. Starting from contracting: what contract paper do I put it on? Is it a provider, is it a facility, all of that to go through? What is going to be their episode of care costs? What are all the components that go into that? I know exactly the model of care because we sat down and did education all the way to delivery about that. That was key. You have to have a champion. If you don't have a champion within the health plan who is going to help you through those barriers, it is going to fall by the wayside. I took it upon myself to be the champion, drive it through with the chief medical officer, with the CFO, with contracting to move that along until they became a participating provider. There are a lot of barriers, and I will talk later about recommendations for that. But I do think you need to first understand, if you are looking at another state, you need to determine if that state is managed Medicaid state, what health plans participate there, are there any value-based programs, what are they doing in perinatal, because Ohio has the same episodes of care program as Tennessee, as does Arkansas, so you can replicate that and understand your position to get toward your solution within that entity.

Dr. George, we would love to get the physician's perspective here. How and why has your hospital-based practice incorporated midwives? What works well and what are the opportunities for the future?

Dr. George: I've worked with midwives since the late 80s, they were part of my training as a resident in New Mexico, and in New Hampshire, where I was for almost 20 years, we had a very busy midwifery practice, and now in D.C. I work with a big midwifery group as well. I have seen a lot of different types of collaborative care along the way. I think that the work the group that I'm with right now has been working with George Washington for over 15 years and since that time we have institutionally seen our cesarean delivery rate decline significantly, in fact we are the lowest in the city, and our midwifery group has won many awards for the care they provide. We are a teaching hospital, so at any given time we have students, both midwifery and medical students, sometimes nursing students. We also have on call two faculty physicians, a faculty midwife, and then some combination of residency students and a midwifery fellow. We work really collaboratively with our midwifery colleagues, and we function very much as a team. They have guidelines on when to consult with us and we are available to them at a moment's notice if they have something they encounter as a complication. Likewise, they are often available to take over for us, if we are stuck in surgery or are unavailable, or honestly if we have a patient who we feel may benefit from some extra TLC. In the last five years--I've been here only three and a half—we've made a very conscious effort to recruit minority midwives into our practice. We have a midwifery fellowship, and in the last five years we have made it a priority to recruit midwifery fellows of color who felt like they needed some additional training or wanted to give them a softer entry into practice, a supportive environment for those folks coming in right out of school, to get a little more experience with extra people around to help make that transition. Sometimes these fellows sub-in for our residents. As a faculty member working with the fellows, I always learn from them, whether its some better way to do counseling or

approach somebody who is super anxious, or a new position to coach a baby out. It's a learning collaborative, and I know we talked about the quadruple aim at the beginning, and I think it really adds a lot of satisfaction to the work I do to have midwifery colleagues. Most of the graduates of the fellowship chose to work in underserved areas and they leave with a lot more confidence and skills to take care of their patients in the future. As we look at opportunities for continued collaboration, we work closely together in terms of quality assurance. We have taken on several QI project including creating better shared medical appointments. Both groups are working together on a safety bundle to lower disparities in our practice. The value add from that satisfaction is tremendous.

Dr. McLemore, recognizing your extensive research and expertise on workforce development, what role can Medicaid agencies, health plans, and providers play in supporting the development of midwifery workforce that supports equitable birth outcomes?

Dr. McLemore: If the last ten months have taught us nothing, it is that we have the opportunity to be as bold as we want to in our thinking. I am going to try and make five points in five minutes, because I could talk about this all day, particularly in the context that California has decided to remove physician supervision from both midwives and nurse practitioners. I have been thinking about this and studying this for a very long time.

Number one, to be provocative, we need midwifery agnosticism. I say this as a tenured professor who is currently on a sabbatical who sits with the midwifery faculty in a nurse midwifery program. Quite frankly, I spend a lot of time with licensed, professional, and lay midwives, and at some point we need to have a discussion about regardless of whatever their educational preparation is, that if they are safe and knowledge providers that they should be able to work wherever we need them.

Number two, there are demonstration projects that doulas, midwives, nurses, and physicians have attempted to put forward that I like to think about as wrap around services, or the essential services we need in order for midwives to be successful. One such project is the Aspiring Black Midwives that Asmara Gebre leads at the University of San Francisco General. She coaches them, she mentors them, she reads through statements to get into school, she allows them to bond as a cohort to really be successful and I think we need more programs like that.

I think we need to talk about racial concordance and really think about teaching the history of why racial concordance is so important. As somebody whose PCORI grant just got rejected for wanting to study, head to head, racial concordance in prenatal care provision in group and as individuals, I think we need to have a frank and honest discussion about what we mean when we talk about racial and cultural concordance. People seem to get this around language, but they don't seem to get it around race and class and social status. At some point, we need a discussion around that.

We also need to have a discussion about our current workforce and our future workforce. One of the first studies I completed after my dissertation was working with recently incarcerated individuals to figure out if they could be successfully trained as birth doulas. Would bringing them back into institutions create harm? Were they actually able to support birthing people? One of the things we found is that not only can they be successfully trained to be birth doulas, but two of them moved forward to advance their education. These were all women of color, low income folks, people who were moms during their carcel experiences. We have to invest in not just the current workforce, but we have to build paths to the future workforce. One thing we could easily do, as folks who serve birthing people, we need to view the people that we serve as our future workforce. At some point, if we had a goal that 20-25% of the people that we serve would ultimately make up our staff—we've done this at homeless prenatal programs here in San Francisco, I know the Preterm Birth Initiative has done this—you make different decisions when you're hiring folks, you make different decisions when you're thinking about staffing, you make different decisions when you think that the people that you serve are penultimately going to become your workforce. I also think team-based care and team-based models are the way to go. I'm really glad to hear Dr. George talk about the co-education with midwifery. We need to bring the nursing students and the psych folks and the pelvic floor folks...we need to be all together in a classroom before we are in a situation where we all have to somehow work together knowing we have different roles and we have common goals for serving people.

The last thing I'll say is that we need to build paths to the workforce. The biggest intervention that we could do as a nation if we wanted to unleash the birthing workforce and have it be racially and culturally concordant is we could cancel student debt and student loans, or create programs like I went through when I was a baccalaureate in nursing in 1988. I agreed to work at the hospital I was born at in Trenton, New Jersey, and they paid my fees at the University where I got my BSN. If I worked for them for two years, then I didn't have any debt when I came out. We need to start thinking about programs like that again if we really optimize workforce towards members.

Mr. Sandwith, please share how your efforts are playing out in terms of promoting access to and use of a midwifery model and achieving the value that you mentioned earlier?

Mr. Sandwith: There is a number of things that position in correctly in the marketplace and I think that the care model, or however it has been developed, needs to be team oriented, needs to have cross-training, and so forth. I learned that by my engagement with that birthing center and those that were working there. What I tried to coach them on is the accumulation of data. I put that out there in the PowerPoint that I presented. How many patients are you seeing? What are the nonmedical transfers, the medical transfers? How many births? What I really found very interesting when I met with a number of them in Tennessee is that they didn't have a marketing plan. If I was going to include this as a benefit, how are we going to make those TennCare members aware of this option, which most people forget about. It doesn't come by divine intervention you really have to develop a plan. I had two interns who were very interested in the birthing center and midwifery, and one of their projects two years ago was to develop a marketing and awareness plan, to learn everything about the birthing center and their capabilities and develop a strategy of how we were going to make members aware of this capability. I'll be glad to share that and send it to you all. It does give you a platform of saying: we all believe in it, we all want to do it, so how are we going to move the needle to make people aware that this is an option. We looked at goals and expectations. In our data, we started to track how many Medicaid women were now coming in there. There was a big push in the birth center where you had a lot of private pays. They didn't really have any contracts with health plans. The majority of those people found that the cost for having that child were far less at the birthing center because they were a cash pay. You need to spend time on what your marketing plan is. You don't have to have unbelievable data, but you have to have certain components of your data that creates accountability and credibility of what you're doing. I've included some of those [on the slides] of what I was able to get. Then, in a value-based program, you've got to start looking at what kind of metrics do you want to track. Statistically, for the perinatal episode in Tennessee, we're below 30%, we're actually 29.8%, and we've done that through the episode of care through educating OB/GYNs that there are other options than a C-section. We've worked hard on that, and the birthing center gave another option. I sat down with the birthing center and identified the metrics that we wanted to track and how the health plan can track that and provide it so that we can move forward to either publish those or expand that. In my mind, I think of bundles or episodes of care because it's value-based, you get into fee-for-service sometimes it gets a little wacky with how they're going to contract with that, but if you got a value-based episode or bundle, you can pretty much put it what's unique for the birthing center: what are the savings going to be? All of those cost categories, I broke down and sat with them, thinking about what it is going to take in an episode of care for you all to be whole as well as get some sort of profitability by doing this episode of care. That took me about two months with them. I took that to contracting and said, here is what the episode of care is going to be with the birthing center. It was one fee, with these metrics tied to it, and the contract took maybe 4 days to get completed and signed because it laid everything out according to the way the health plan was thinking about it. That's the way I kind of approach it.

I will talk very briefly about when you are presenting to a health plan. Do your research on the front end, try to make sure you've got a champion, and when you're doing your presentation, talk about your analytics, your program, how you would like to do pricing and performance. It's really key to at the end tie that to a marketing plan. It's going to take the workload off of that health plan. The health plan has a lot of ways of reaching out to people—newsletters to members and seminars. For me, it was a very exciting process. I got it. I'm a little bit more left than right brained, so I understand the solution, and I went and implemented it for them. I got a lot of complements from TennCare for developing that for their membership.

What works in incorporating midwifery care in hospitals? One huge barrier to the growth of midwifery is the lack of clinical education opportunities. This is often due to perceived competition for residents, unfounded fear of increased liability and lack of funds. What do you think of implementation of broad national programs that encourage (or obligate) institutions that train obstetric residents and receive Graduate Medical Education (GME) funding to simultaneously train midwives?

Dr. George: It's a fabulous idea. I think that that is completely the case, that there is not funding for midwives to receive the training that they need in order to do it, and I think Dr. McLemore can probably speak to this better than I with her expertise in workforce and in nursing. I think we need at least twice as many midwives as we have per doctor. It should be at least a 2:1.

Dr. McLemore: To piggy-back on that comment, because I agree, at the same time we have a strategy problem. If there are 39 currently accredited programs in midwifery in the United States, that's not going to get us to the workforce that we need. When you layer on top of that there are 108 accredited historically black colleges and universities, 39 of which have schools of public health, medicine, and/or nursing, and zero of them have programs in midwifery...Houston, we have a problem. At some point, we will need to have an infusion of funds that will allow for (and I have a ton of ways to think about this) these educational programs to be able to have the capacity. This is why birthing people, this is why doulas, this is why our existing workforce needs to see midwifery as a way of being able to work, as a path. We need to build those paths. We can't just wait for the academic institutions to catch up. Doula work in and of itself is amazing and incredible. I know that for some people, doula work has been an on-ramp to midwifery, and that's one of the reasons why I think we need to build that path. It's another reason why I'm agnostic in terms of education. I know that there are structural barriers and a supremacy of nurse midwifery, but there are other midwives that do really great work. I think that we need to have an honest conversation, if we're going to have a workforce discussion, about where are we going to financially incentivize opportunities for people to become midwives.

How do you recommend identifying champions within health plans? What roles are best positioned to act as champions, and how about folks who do not have C-suite leaders as co-champions? How do you create momentum to shift models of care?

Mr. Sandwith: I think that every health plan you want to start with the business development or business innovation person. I know that at United, every health plan has a business development person, and that's where you want to enter and set up that first meeting. The first meeting should involve the CMO, the clinical team at that health plan, and if possible, any of the contracting people. From that meeting, you are going to figure out quickly who is engaged and who is going to be your champion. From that, then it becomes how do you position that within what offerings that health plan has in terms of value-based programs. Are they doing anything unique in the perinatal side of the business and so forth? If anyone wants more detail, I can lay that out in a lot of detail on how to position it. The last thing I'll say: if you have one meeting, don't forget to set up the next meeting, because if you do, you're out of the loop. All of a sudden, those people can't answer emails for another meeting. When you are in there, you push it and make sure you have a next meeting because the next meeting could be five different people walking you through the process of having your solution implemented.

Dr. McLemore: Is there a role for philanthropy? Is there a way to collectivize this, so that it is not every midwifery group trying to go to a health plan? Is there a collective way we could be thinking about this?

Mr. Sandwith: A lot of health plans are matric organizations, meaning that they have different entities and operate as different companies. What I try to do is a pilot study, and once its successful I push it up to the national contracting people, so then I can get approval to implement it in a broader region. That's been my background. What happens a lot of times is that if you go to the national level, most of those people don't understand what you're talking about, and I mean that in a good way. They are looking at different solutions. But if you started at an individual health plan area, then you've got people who are involved with it more and they're going to be your champions if you want to move it up to national contracting. In most cases that I've done pilot studies, the majority of them have gotten national contract. The pilot study proved the value and had the support from the health plan to move that up the chain.

Access to clinical data, measure development, and reporting, are frequently seen as barriers to success for bundled payment concepts. How is UHC addressing access to clinical data and measure development for maternal bundles of care?

Mr. Sandwith: In Tennessee, every provider is mandated to participate in Medicaid. Every OB/GYN is in the Medicaid has to adhere to the episode of care program. They operate within two thresholds: being commendable and being acceptable. If you are below the commendable you're eligible for outcome payments, if you're above the acceptable you are paying the health plan back for poor performance. It's all tied to quality measures. A technical advisory group set up the metrics and it was mandated that those would be the metrics. We are now looking at those again to see if want to add any other metrics. I have all the data on every OB/GYN for five years in the state of Tennessee, on every procedure that they've done for a Medicaid recipient. In our perinatal program over the last five years we've generated over 8.6 million dollars in savings and we've reduced our C-section rate from high forties down to the low thirties. We've done a lot. You don't need to boil the ocean with your quality metrics or data that you're collecting. Keep it simple and find what is going to provide value in implementing your solution.

Dr. McLemore, you have great expertise as a researcher in meaningfully bringing community voices into research. Based on your experiences, I'd love to hear your advice for how state agencies and health plans can intentionally bring communities of color to the table as full partners in their endeavors, to co-develop initiatives and approaches that meet community needs and expectations. What are some best practices?

Dr. McLemore: As somebody who had to retrofit community engagement on to one of the three pregnancy COVID-19 registries, one of the first things I will say is that community engagement needs to become the standard from the beginning, because the retrofit is very difficult. To try and pull together a community advisory board or national community advisory council when a study has already started or project has already begun, when decisions have already been made, when budget documents have already been determined, it is very difficult to retrofit community engagement. One of the things that my team was trying to establish was the model of how you pull together a national community advisory council such that can be leveraged across different institutions. We are trying to do that through the Clinical Translations Science Institute so that there are standing individuals who are ready to be trained, paid a living wage, and able to represent community voice on projects.

We need to directly fund community doulas and community birth workers. Everyone talks about the mechanism to getting there, but by further institutionalizing them, they lose their secret sauce. There is something that those individuals are doing, and we need to pay that and pay for that. I also think that organizations and institutions need to show up. People talk about building tables and inviting people to the table—sometimes you have to go the community baby shower. Sometimes you have to show up at the community meetings. It's not just them coming to us. We have to prove ourselves trustworthy, so we have to go to where they are meeting. The idea that people serve communities that they don't' live, work, pray, play, or thrive in—we need to have an honest conversation about that at some point. I think it is problematic to not be deeply embedded in the communities in which we serve, and that causes barriers and roadblocks from the beginning. Pay people a living wage from the beginning to opine about how these projects and implementations start, directly fund community-based birth workers, and we have to show up and participate in community events, showing our interest in their health and wellbeing, not just at labor and birth but in the life course.