

Harnessing the Power of Team-Based Care to Improve Maternity Outcomes: Medicine and Midwifery as Partners in Care

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Today's Panelists



Ana Delgado, MS, CNM



Malini Nijagal, MD, MPH



Annette Finberg, MD

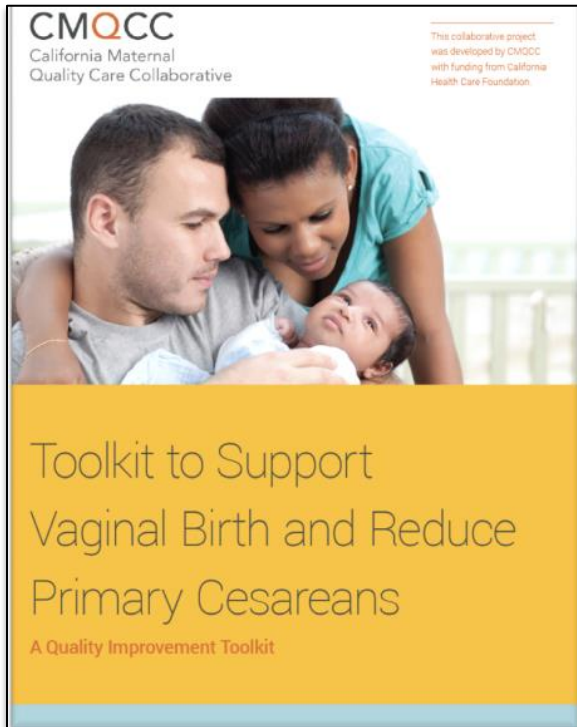


Ana Rapoport, MS, CNM, WHNP

Objectives

- Describe team-based care between midwives, nurses, and physicians and its potential for improving patient experience and birth outcomes
- Appreciate the roles of the care team in providing high-value, high-quality maternity care
- Identify challenges and opportunities for improvement in team-based care at your facility

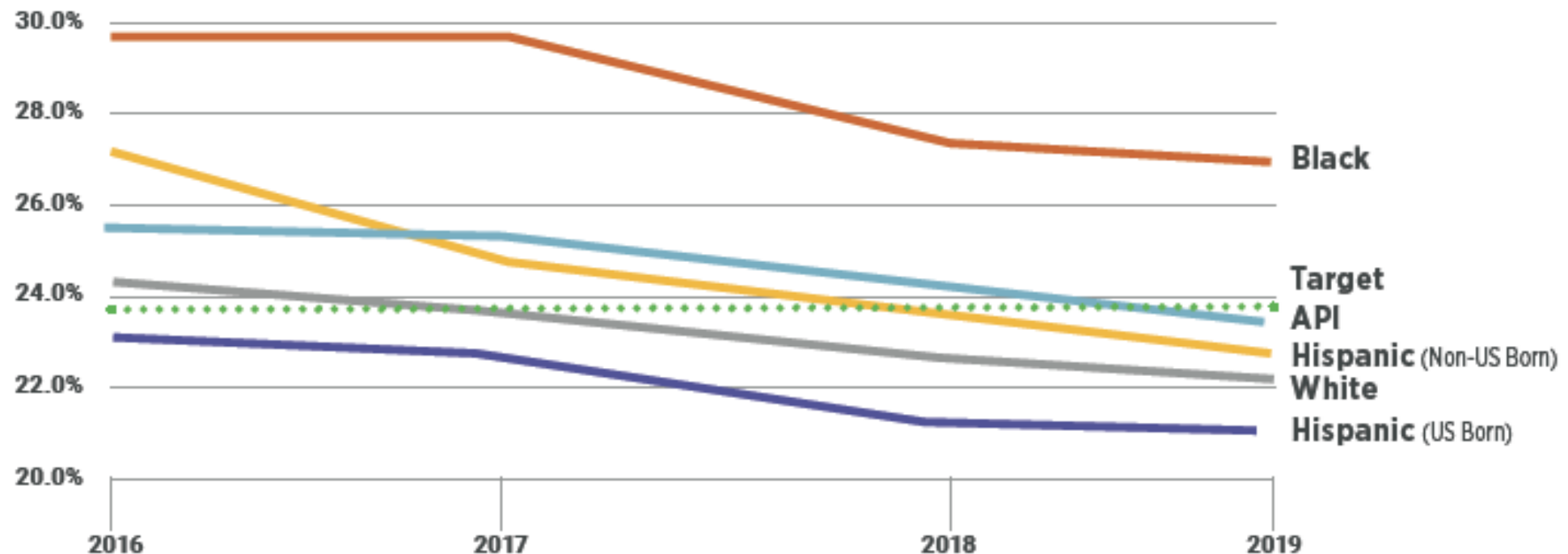
Today's Webinar is Webinar #2 in a Five-Part Series



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)
3. Midwifery Integration – What it Means and Why it's Important for 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

California NTSV Cesarean Rates by Race/Ethnicity



Source: Department of Health Care Access and Information, 2019.

Birth Equity

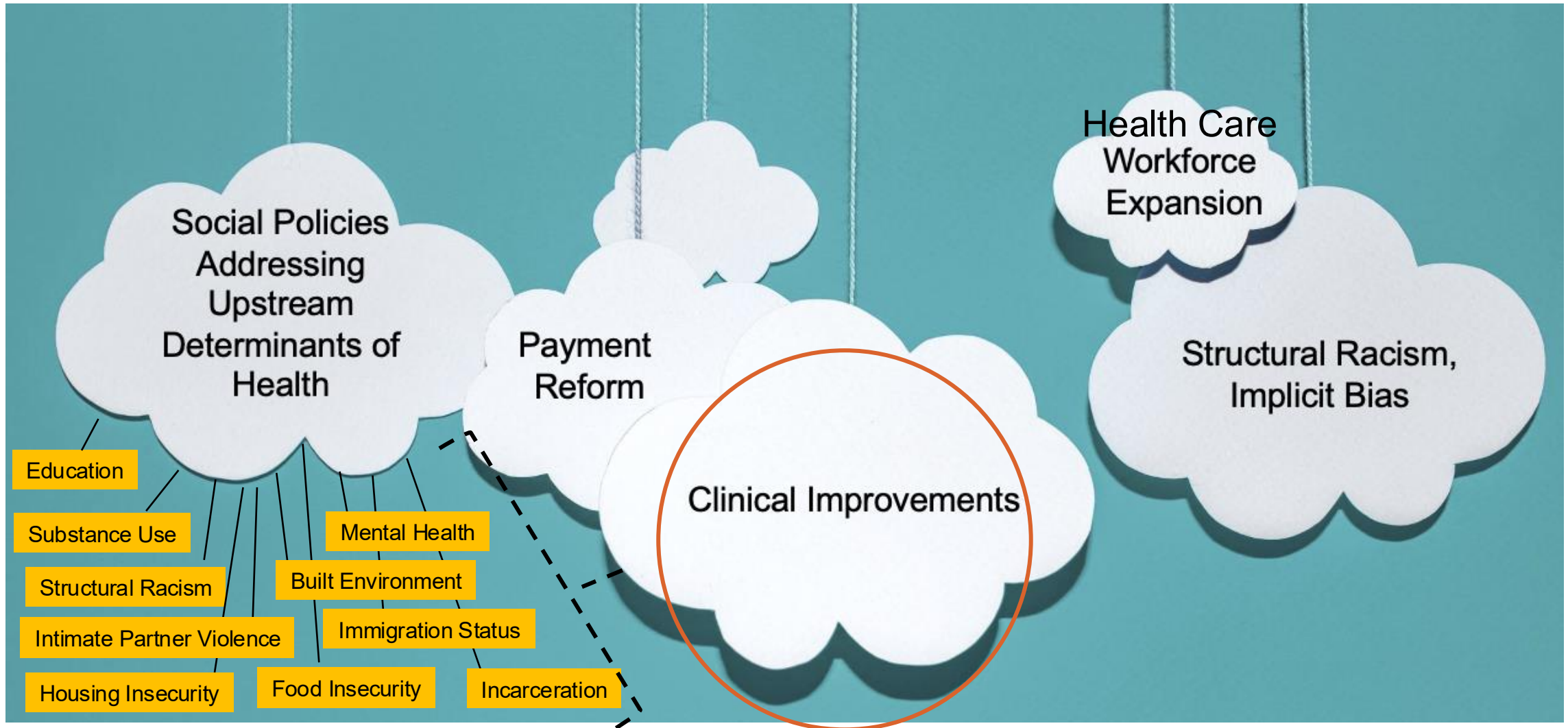
- “The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort.”

– 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



Clinical Strategies that Consider Root Causes of Disparities

- Team-Based Care
- Midwifery Integration
- Improving Partnerships with Community Birth Providers and Improving Community Birth Transfer
- Partnering with Doulas

The Elephant in the Zoom

A values “check-in” around midwives and team-based care

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.^{7,8} 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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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.

Midwifery Care

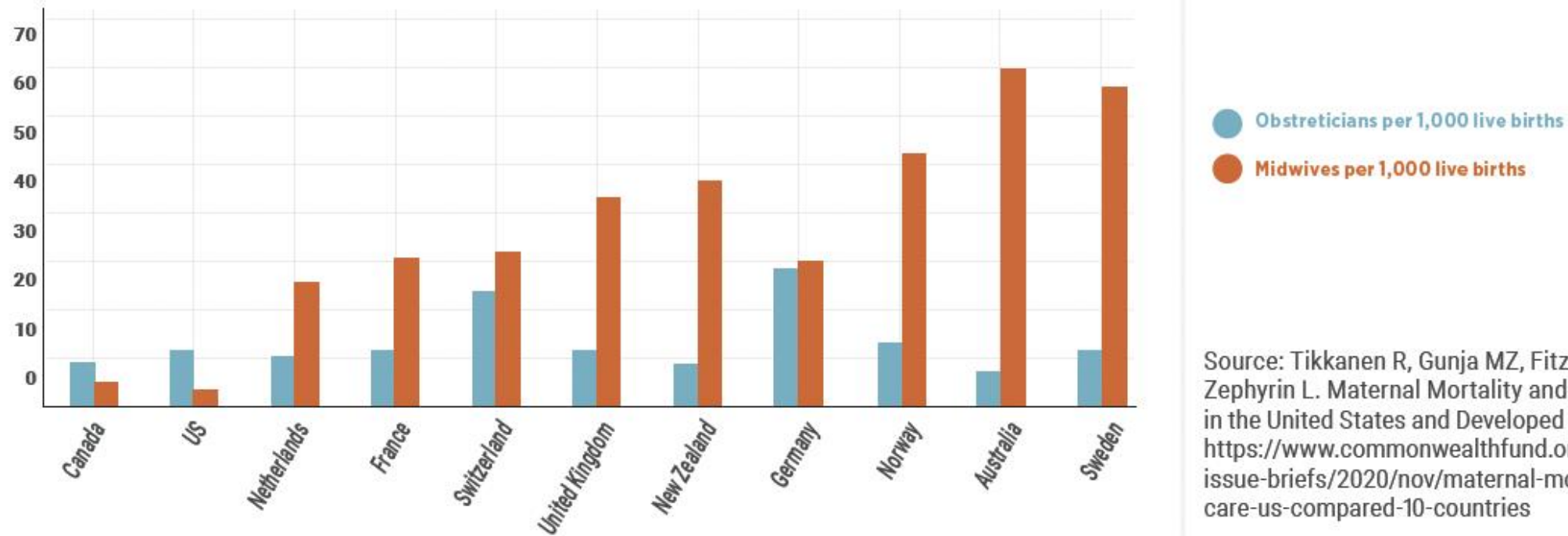
- The midwifery model of care is standard in all countries that have better birth outcomes
- Patient empowerment is a central theme of midwifery care
- “Whole-person” care that considers all the patient’s needs (physical, emotional, SDOH, personal values, cultural needs)

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, *Nativity 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.

Benefits of Midwifery Care

More likely with midwifery care...

- Spontaneous vaginal birth
- Trial of labor after cesarean (TOLAC)
- Vaginal birth after cesarean (VBAC)
- Breastfeeding
- Patient confidence and control
- Patient-centered care
- Lower cost

Less likely with midwifery care...

- Cesarean birth
- Operative vaginal birth
- Induction of labor
- Episiotomy
- Epidural anesthesia
- Perineal lacerations
- Continuous fetal monitoring
- Use of pain medication
- NICU admission

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

Team-Based Care

What is Team-Based Care?

“A team-based model of care is one that strives to meet **patient needs and preferences** by actively engaging patients as full participants in their care while encouraging **all** health care providers to function **to the full extent** of their education, certification, and experience....

Relationships are **governed by negotiated shared norms and visions**...

Each team member has knowledge and skills that contribute to the work, service, and problem solving that are the purpose of the team.”

Terms Used Interchangeably (but inaccurately)

■ Team-Based Care



- Collaboration
- "Right Care at the Right Time"
- Co-Management

ACNM's Definition

“Collaboration is the process whereby health care **professionals jointly manage care**. The goal of collaboration is to **share authority** while providing quality care within each individual's professional scope of practice. Successful collaboration is **a way of thinking and relating** that requires knowledge, open communication, mutual respect, a commitment to providing quality care, trust, and the ability to share responsibility.”

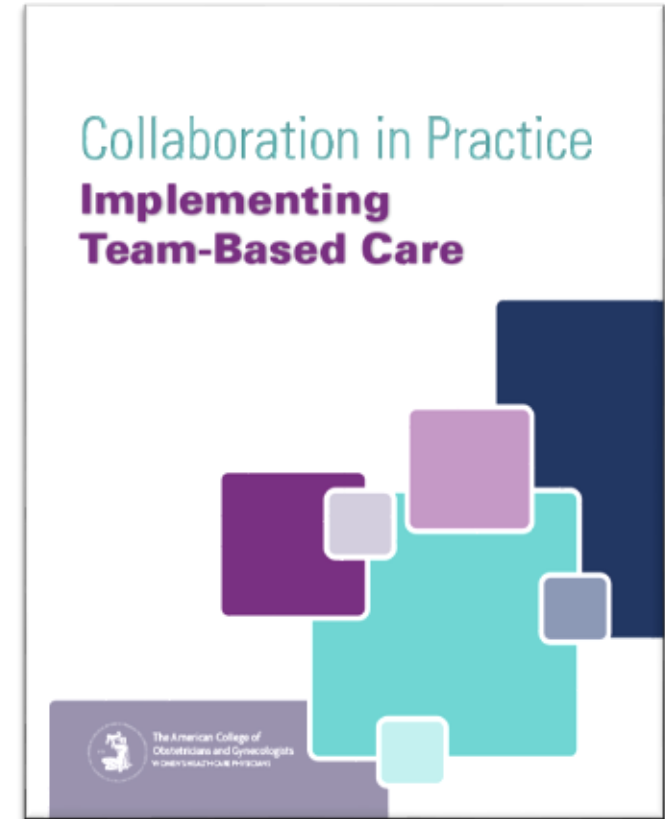
Team-Based Care

- Focus today is on the principles of team-based care and collaboration between **physicians and midwives**
- These principles can inform team-based care between many provider types and other team-members
 - Physicians and community birth midwives
 - CNMs and LMs
 - Nurses, doctors, and midwives
 - Family practice and Ob/Gyn; Family practice and midwives



Key Principles of Team-Based Care

- ✓ The PATIENT is the INTEGRAL CORE of the team
- ✓ The team must have 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



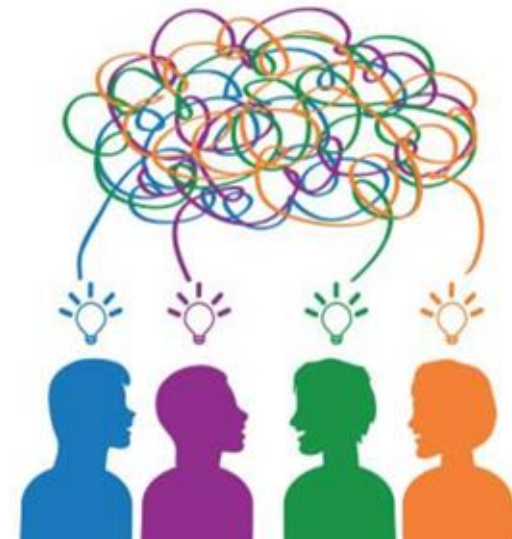
Patients and families are actively engaged as members of the team

- ✓ The team must have common commitment to patient-centered care
 - ✓ “nothing about me without me”
 - ✓ locus of control is with the patient
 - ✓ the patient has choice in all matters, without exception
(Shared Decision Making)

Has created a “disruptive shift in control and power” in health care delivery

The Team Has a Shared Vision

- ✓ Must identify **shared goals**
- ✓ **Collaboratively** create a **roadmap** to guide expectations of “how” things will be done
- ✓ **Unity:** teams are an “**integrated body of knowledge and skills** working together toward a **common goal**” (not individuals practicing in parallel)



Shared Vision: Zuckerberg San Francisco General Hospital

Current Commentary

Great Minds Don't Think Alike

Collaborative Maternity Care at San Francisco General Hospital

Margaret S. Hutchison, CNM, MSN, Linda Ennis, CNM, MSN, Jenna Shaw-Battista, CNM, MS, PhD, Ana Delgado, CNM, MS, Kara Myers, CNM, MS, Leslie Cragin, CNM, MSN, PhD, and Rebecca A. Jackson, MD

For more than 30 years the collaboration between obstetrician-gynecologists and certified nurse-midwives at San Francisco General Hospital has led to the provision of high-quality care to women and families. This enduring partnership has been sustained by shared goals and values, most notably a commitment to excellence in both providing care to the underserved and training the next generation of physicians and nurse-midwives. Success has also depended on a mutual respect for differences that has enabled the collaborative to capitalize on the distinct expertise of each partner. The balance struck between independence and interdependence of the practice groups has led to innovation and successes that might otherwise not have come to being, while also enabling the collaborative to overcome the inevitable conflicts and challenges that arise within this type of long-standing partnership. This model holds promise for replication in other settings and informs broader considerations of health policy and regulation.

(Obstet Gynecol 2011;118:678-82)
DOI: 10.1097/AOG.0b013e3182297d2d

2011 marks the 36th year of collaboration between certified nurse-midwives (CNMs) and obstetricians within the San Francisco General Hospital

See related editorial on page 503 and related articles on pages 603, 673, and 683

From the Department of Obstetrics, Gynecology and Reproductive Science, University of California, San Francisco, San Francisco, California.

Presented at the American College of Nurse-Midwives 56th Annual Meeting and Exposition, May 24-28, 2011, San Antonio, Texas.

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Financial Disclosure

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Division of the Department of Obstetrics, Gynecology, and Reproductive Sciences of the University of California, San Francisco. San Francisco General Hospital serves the culturally diverse indigent and underinsured residents of the city and county of San Francisco and provides a rich clinical training ground for a wide range of health care providers, including obstetricians and CNMs. This article will demonstrate how a strong, enduring, and mutually beneficial collaboration between obstetricians and CNMs can be forged when the partnership is based upon shared goals and values and respect for philosophical differences in the provision of family-centered, cost-effective health care services.

Maternity care arrived at San Francisco General Hospital in 1920 and included prenatal, labor and delivery, and postpartum services. In the early 1970s discussions began between a visionary group of the hospital's obstetricians and local CNMs, motivated by a desire to increase experiences for medical trainees, offer the city its first in-hospital midwifery care, and provide a site for nurse-midwifery training. A nurse-midwifery service was established in 1975 and was followed soon after by a nurse-midwifery education program.¹ Within the first year objectives of the collaborative were met: census was increased overall by 50%, there was access to an in-hospital midwifery model of care for the women of San Francisco, and plans were underway for a nurse-midwifery education program. Currently, there are approximately 1,250 births per year at San Francisco General Hospital, 46% of these to women who have received prenatal care with the nurse-midwifery service.

Despite differences in the medical and midwifery models of care the collaboration between the CNM and obstetric services at San Francisco General Hospital has thrived, in large part because of a mutual respect for differences that is coupled with a dedication to common principles. Cooperation, service to

"a mutual **respect for differences** that is coupled by a **dedication to common principles**. Cooperation, service to the community, and collaboration in the education of the next generation of practitioners **are shared core values**, but respect for distinct approaches to maternity care – **great minds don't think alike** – has been an equally important determinant of the success of this collaboration."



Shared Vision: Sutter West Medical Group + Communicare (FQHC)

Obstetrician and Nurse–Midwife Collaboration

Successful Public Health and Private Practice Partnership

Jenna Shaw-Battista, CNM, PhD, Annette Fineberg, MD, Barbara Boehler, CNM, Blanche Skubic, CNM, Deborah Woolley, CNM, PhD, and Zoe Tilton, MD

OBJECTIVE: To evaluate maternal and neonatal outcomes of collaborative maternity care for a socioeconomically diverse patient population in a California community hospital.

METHODS: Collaborative practice structure and clinical guidelines were analyzed, as were de-identified electronic medical records for all primiparous women who delivered term singletons between 2000 and 2010 (N=4,426). Demographics, care processes, and perinatal outcomes were compared among women seen prenatally in a private collaborative practice compared with a Federally Qualified Health Center prenatal clinic run by nurse-midwives.

RESULTS: Evidence-based practices were used to achieve excellent perinatal outcomes. Three quarters of women received intrapartum nurse-midwifery care (74.4%). Few differences were seen in management or outcomes among women from different prenatal clinics despite significant variation in demographic and clinical characteristics. Private practice patients were older, less likely to be obese, and more likely to speak English compared with counterparts from public health clinics. They were also more likely to use hydrotherapy or

epidural analgesia, or experience severe perineal laceration and repair. Overall, pharmacologic pain relief methods were limited: less than a quarter of primiparous women used narcotics (21.2%), epidural analgesia (23.7%), or warm water immersion (23.2%). Labor induction and augmentation, and cesarean delivery rates (12.5%), were similar among groups and low overall.

CONCLUSION: A collaborative practice of low-tech, high-touch care results in high-quality maternity services. The care model holds promise for replication to address health disparities by limiting obstetric interventions and warrants further investigation with regard to associated costs and resultant outcomes.

(Obstet Gynecol 2011;118:663–72)
DOI: 10.1097/AOG.0b013e31822ac86f

LEVEL OF EVIDENCE: III

A collaborative practice of obstetricians and certified nurse-midwives in Yolo County, California, was founded in 1979 in response to women's requests for natural childbirth and increased participation in their health care. The practice was strengthened by a shared commitment to provide obstetric services to women without means and has evolved into a successful model that provides high-quality, family-centered maternity care. The collaborative practice serves diverse communities through a physician-owned suburban private practice, and a federally qualified health center with primary and prenatal clinics throughout the county. The patient population, collaborative practice, and selected perinatal outcomes have been described previously.^{1–4} Women seen prenatally by members of the collaborative practice give birth at Sutter Davis Hospital, a 45-bed community facility with a level I nursery located in a college town situated between two major metropolitan areas and expansive agricultural areas.

The collaborative practice philosophy includes extensive prenatal education, shared decision-making,

“The collaborative practice philosophy includes **extensive prenatal education, shared decision making, and judicious use of obstetric intervention** in accordance with **evidence-based** clinical guidelines that are developed **collaboratively.**”

See related editorial on page 503 and related articles on pages 673, 678, and 683.

From Sutter West Medical Group, Davis, California.

The authors appreciate the contributions of clinicians at the site of the quality assessment project who provided data, guidance, and editing of this manuscript, including Beth Johnson, MD (Sutter West Medical Group), and Leon Schimmel, MD (CommuniCare Health Centers, Inc.).

Presented at the 2011 annual meeting of the American College of Nurse-Midwives, May 24–28, 2011, San Antonio, Texas.

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Role Clarity is Essential to Team Functioning

- ✓ **Respect** for each member's **expertise**
- ✓ Understanding of each team member's **scope and role**
- ✓ **"Great minds do NOT always think alike"*** – the team values the unique contributions of each member and their differing approaches to maternity care
- ✓ **Maximizes the expertise** of each team member (each team member functions to the full extent of their education and training)
- ✓ **Clinical guidelines** facilitate expectations and communication for consultation/co-management/transfer of care

*Hutchison MS, Ennis L, Shaw-Battista J, et al. Great minds don't think alike: collaborative maternity care at San Francisco General Hospital. *Obstet Gynecol.* Sep 2011;118(3):678-682. doi:10.1097/AOG.0b013e3182297d2d

All team members are accountable for their own practice and to the team

- ✓ Everyone is committed to *consistently practicing within their scope* of practice and appropriate to their training/experience; professional competence
- ✓ Committed to *continuous learning* outside of the clinical situation, and situational learning *within* each encounter
- ✓ Hold each other *accountable* ("situational monitoring")
- ✓ *Mutually agreed-upon* clinical guidelines

All team members are accountable for their own practice and to the team

Requires:

honesty, discipline, reliability, and humility

Effective Communication is Key

- ✓ Skilled **communication with the patient** (Shared Decision Making)
- ✓ Adopt **standard frameworks** for how patient status is communicated
- ✓ **"Trust, honesty, transparency, and timeliness"**
- ✓ Check your assumptions! When in a team, **assume the best** about each person's motives and goals
- ✓ **Active listening**
- ✓ Can share concerns, **without retribution**

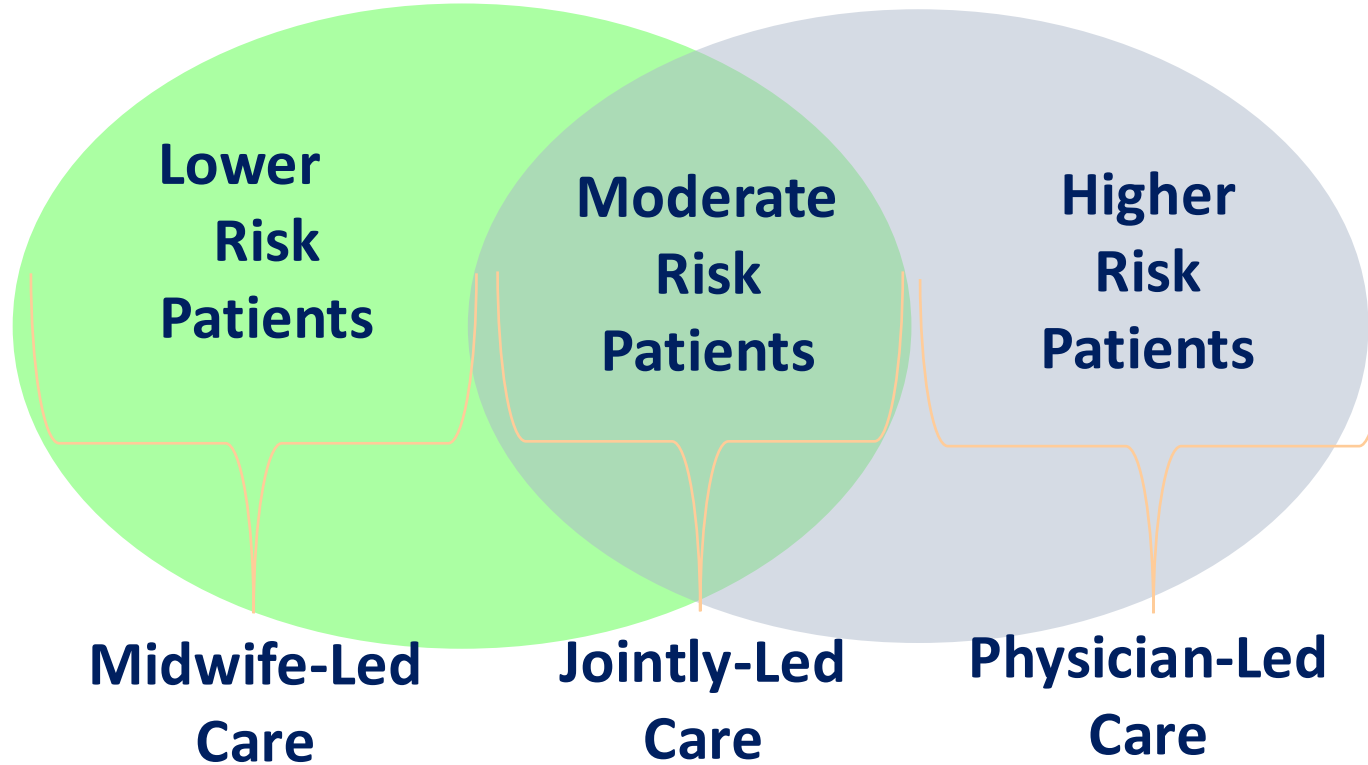
Team Leadership is Situational and Dynamic

- ✓ High-functioning collaborative practices have developed beyond a hierarchical structure
- ✓ The clinician who "can best address the priority needs of the patient assumes the lead health care provider role for the patient." – ACOG
 - ✓ "Shared power"
- ✓ Requires flexibility and fluidity
- ✓ No provider type is superior to the other

Team Leadership is Situational and Dynamic

Requires “experiential learning, building respectful relationships, and time.”

ACOG/ACNM Joint Statement of Practice Relations



“Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.”

Example of situational and dynamic leadership

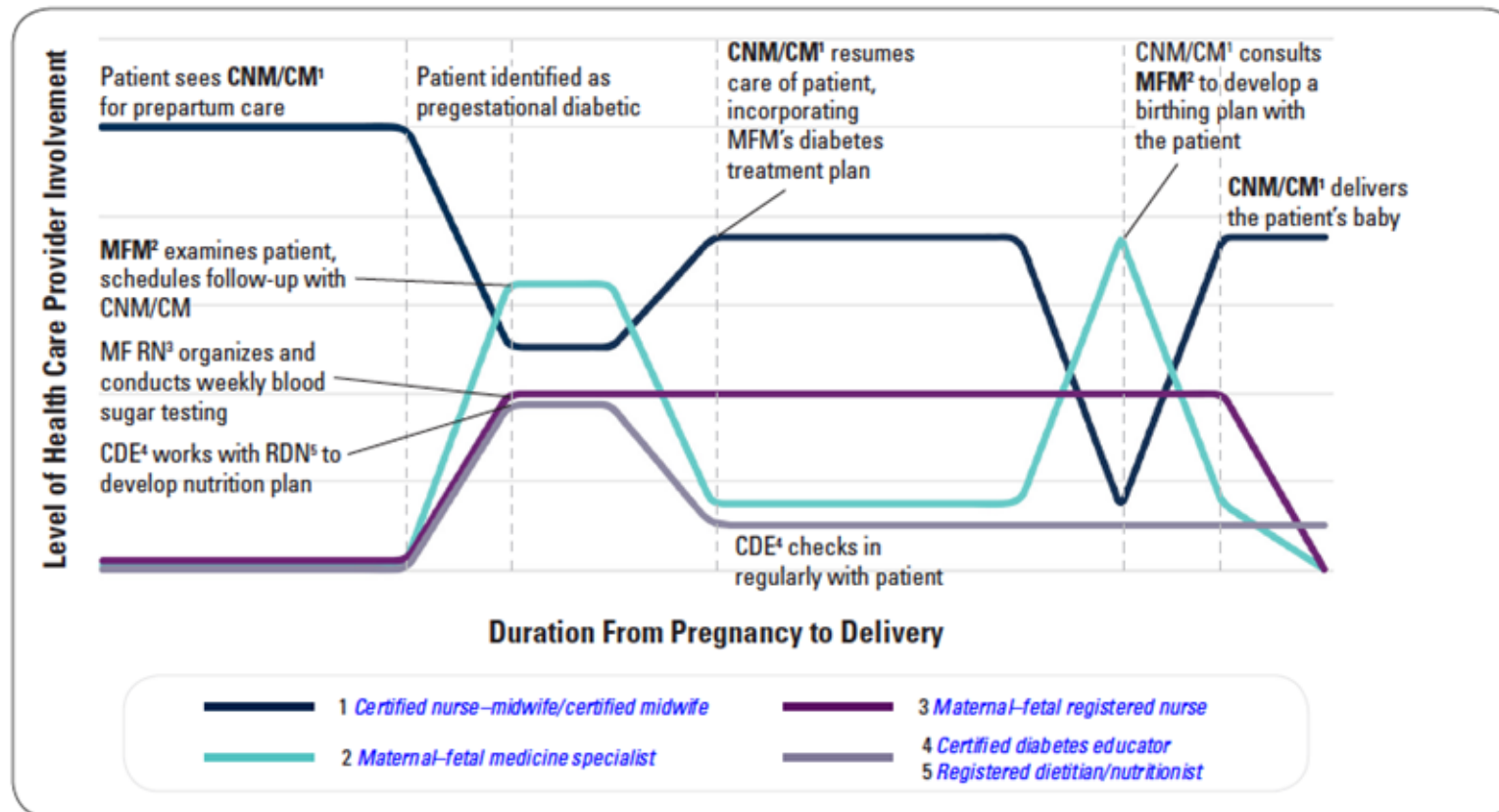


Fig. 2-1. Examples of different levels of health care provider involvement during pregnancy. (Bold font denotes lead health care provider.) ↩

Panelists



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