# How To Successfully Integrate Midwives Into Your Practice

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# Vision

This guide offers the tools and resources required to build a healthy collaborative practice that embraces the midwifery model.

A healthy practice is one that provides superior patient care with excellent clinical outcomes and patient satisfaction, is financially sustainable, and creates a workplace environment where people feel valued and are engaged.

# Contents

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# Executive Summary

The Purchaser Business Group on Health developed "How to Successfully Integrate Midwives into Your Practice: A Guide for Physician Practices and Hospitals" to help increase utilization of midwife led care. Evidence demonstrates that midwives improve maternal and infant outcomes, decrease costs while simultaneously creating more care choices for patients and addressing a growing shortage of perinatal health providers. Midwives are an underutilized resource in this country, delivering only 9% of babies nationally.Nearly all other high-income countries utilize midwives more frequently and experience better or similar outcomes at much lower costs.

This guide is designed to help medical groups and hospitals establish, expand, or strengthen the use of midwives in their organizations. The guide translates the literature and conceptual frameworks on midwife-physician collaboration into straightforward step-by-step actions developed based on real working models. The guide is divided into four sections and flows chronologically. Users, however, can start wherever they see fit.

Part 1, Secure Leadership and Stakeholder Support, focuses on helping an organization make the decision to integrate midwives. This section identifies the critical stakeholders to engage and offers coaching on how to collect, prepare, and present the data and information required to make a compelling business case for the provision of midwifery services. The appendices in part 1 help the reader determine the value midwifery offers to their hospital or medical group and present sample business plans as well as strategic planning activities.

Part 2, Establish the Practice, helps users define roles, select staffing models and build practices that best meet the needs of their organizations. This section also covers marketing and branding as well as the best practices in recruitment, hiring, and onboarding. Appendices in part 2 off er sample meeting templates and recruitment resources.

Part 3, Create a High-Performing Integrated Practice Team, dives into the tasks necessary to create collaborative relationships between physicians, midwives, and practice staff. The section describes the seven core characteristics of collaborative process as described in the literature and evident in all practices interviewed for this guide.

Part 4, Create a Plan to Monitor and Sustain Success, outlines the financial, volume, and quality measurement processes a practice should have in place for a midwifery to be successful in the long term. A practice must be able to communicate its impact to demonstrate its value. Appendices in this section offer data collection templates for use in new practices.

Building a collaborative practice that allows both midwives and physicians to work at the top of their license requires acknowledging that the midwifery model will help a practice meet the diverse needs of patients. Users of this guide should be committed to developing collaborative practices that elevate the expertise of midwives and physicians to offer the benefits of both to patients. That commitment paired with resources and the information in this guide can significantly improve outcomes, increase patient satisfaction, lead to higher-functioning teams, and ultimately, healthier, happier families.

of babies born in the U.S. are delivered by nurse-midwives

# Resources and Methodology

We encourage you to connect with professional organizations such as the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG), which offer many resources for practices. In general, most midwives and physicians are ACNM or ACOG members. Some information is available for public access, and we link to many of those resources in this guide.

**ACNM** Consider becoming an ACNM associate member (open to physicians) as some resources from ACNM are available to members only. Associate members are non-voting members who are "Friends of Midwifery" interested in midwifery and supporting the mission of ACNM. Membership includes a subscription to the bi-monthly Journal of Midwifery & Women's Health, the quarterly newsletter Quickening, and the weekly e-newsletter ACNM Smart Briefs. For more information visit http://www.midwife.org.

**ACOG** Midwives can join ACOG as an educational affiliate for an annual membership fee. Although ACOG does not have an associate member category, an organization can subscribe to various resources through the "Practice Guidelines Online Subscription," which includes access to practice bulletins, committee opinions and other resources. In addition, organizations can subscribe to the Journal of Obstetrics and Gynecology, also referred to as the Green Journal, for a fee. For more information visit the online resource center at http://www.acog.org.

ACOG is a helpful resource for hospitals that are facing quality challenges. Their program, "ACOG Voluntary Review of Quality of Care" (www.acog.org/vrqc) offers extensive exper- tise and provides a multi-disciplinary team to do a site visit, conduct chart audits, and make recommendations. You can add mid- wives to the team if midwives are already part of your organization.
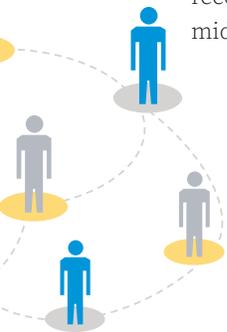
## Methodology

This guide is part of a broader strategy spearheaded by PBGH to increase the number of birth attended by Certified Nurse-Midwives in California. Recognizing that the unrealized gains in quality, safety, and patient experience midwifery-led care could unlock for pregnant patients, PBGH established a nurse-midwifery initiative in 2016. With guidance from expert interviews and its Steering Committee, PBGH identified the most significant barriers impacting midwifery access and developed a Blueprint for Action that outlined five essential strategies to measurably increase access to midwifery services.

As part of this blueprint, PBGH has simultaneously released a white paper and pro forma tool that outlines the financial considerations hospitals and provider groups should take into account when developing the business case for integrating midwives into their organization. Together, the business case tools and this guide serve as a change package that provides physician organizations with the financial argument and clinical tools necessary to establish, expand, or strengthen the use of midwives in their practices.

To develop these tools, PBGH identified 8 hospitals and medical practices with integrated and collaborative midwifery models worthy of replication.‡ Selected sites represented a wide array of care settings, delivery models, and payer populations. PBGH staff as well as clinical and actuarial consultants conducted interviews with physicians, midwives, and financial officers at each of these organizations to collect data on clinical and financial best practices. Actuarial consultants, Milliman, analyzed quantitative data to inform financial tools. PBGH staff analyzed qualitative data for key themes explored throughout this guide.

‡ PBGH developed this criteria with input from national and clinical leaders on its Midwifery Expert Roundtable Committee. Go to www.pbgh.org/midwifery for a full list of criteria used to identify high-performing integrated midwifery practices.

# Introduction

The Midwifery Integration Guide is based on evidence that increased utilization of midwife-led care in the United States will improve maternal and infant outcomes, decrease costs associated with interventions during birth, and create more care choices for patients.[1,2] This guide translates conceptual models of collaborative care between midwives and physicians into straightforward actions that can result in real-life working models.[3] Individuals and health systems should use this guide to build collaborative practices that offer women and their families the benefits and expertise of both midwives and physicians.

Building a collaborative practice that allows both midwives and physicians to work at the top of their license requires trust, communication, and the understanding that midwives serve an essential role in meeting the diverse needs of patients. While this guide will walk you through the nuts and bolts of starting a practice with midwives (sections 1, 2, and 4), the hard work comes in creating an organization that allows the strengths and expertise of midwives to shine and thrive (section 3). For many in health care this will require a change in the obstetric culture to which we are accustomed.

## Why now?

**First, many counties across the U.S. have no obstetrical providers.** The healthcare workforce is changing, and according to ACOG (2017), the country will not have enough OB/GYN physicians to meet the health care needs of women in the coming years. To address this gap, we must "look beyond the individual to more collaborative, team-based care which would improve access to health care while maintaining quality and satisfaction."[4]

**Second, among other high-income countries, the U.S. spends the most on obstetric services but reports the worst maternal-infant outcomes.**[5] (Notably, of the 10 countries analyzed in the Lancet study, the U.S. is also the only country not routinely using midwives). Evidence indicates that midwifery services and interprofessional collaboration can reduce health system and hospitals expenditure[6] while also improving birth outcomes.
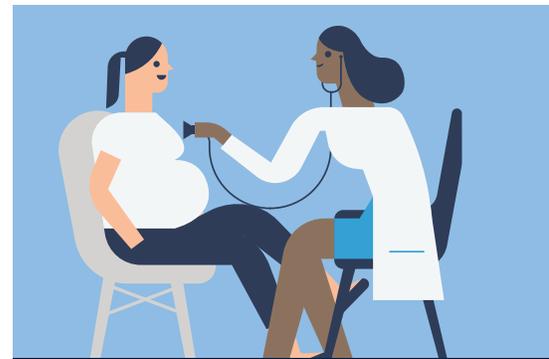


With less than 9 percent of births attended by a midwife, the U.S. has many opportunities to **increase the number of deliveries attended by a midwife.**

This guide intends to help you and your organization integrate midwifery in a way that yields **great outcomes, satisfied patients, high-functioning teams, and healthy, happy families.**

1 Altman, MR., et al. "The cost of nurse-midwifery: Use of interventions, resources, and associated costs in the hospital setting." Women's Health Issues (2017): 434-440. doi: 10.1016/j.whi.2017.01.002 2 Shah, Neel. "A NICE Delivery — The Cross-Atlantic Divide over Treatment Intensity in Childbirth." New England Journal of Medicine, vol 372 iss 23 (2016): 2181-2183. DOI: 10.1056/NEJMp1501461

3 American College of Obstetricians and Gynecologists, Task Force on Collaborative Practice. "Collaboration in Practice: Implementing Team-Based Care." (2016). Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

4 Rayburn, William. "The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications 2017". (American College of Obstetricians and Gynecologists: Washington DC, 2017) Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/The-Ob-Gyn-Workforce

5 Shaw, Dorothy, et al. "Drivers of maternity care in high-income countries: can health systems support woman-centred care?" The Lancet Vol. 388 Iss10057 (2016):2282 – 2295. doi: 10.1016/S0140-6736(16)31527-6

6 Vedam, Saraswathi, et al. Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. Plos One, iss 13 (2018). doi: 10.1371/journal.pone.0192523

## What is a Midwife?

Midwives are trained women's health clinicians with a unique combination of clinical and interpersonal skills that focus on each woman as an individual. Midwives bring the perspective that pregnancy and birth are normal, healthy life events, and they work closely with patients/clients to develop a relationship built on trust and empowerment as partners during the most vulnerable times in a woman's life.

Midwives are important contributors to safe maternity care in today's health care system, providing safe, cost-effective, evidence-based care. Their physiological orientation toward pregnancy and birth typically results in low rates of cesarean sections,

non-indicated labor inductions and augmentations, third and fourth degree perineal tears, regional anesthesia use, and higher breastfeeding rates.[7, 8, 9, 10]

According the American College of Nurse-Midwives (ACNM), a midwife's scope of practice encompasses a full range of primary health care services for women, from adolescence to beyond menopause. These services include the independent provision of primary care, gynecologic, and family planning services; preconception care; care during pregnancy, childbirth, and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. These services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals, and birth centers.

### The value of midwives:

**Quality:** In addition to high rates of spontaneous vaginal births, better integration of midwifery increases the rates of vaginal birth after C-section and breastfeeding while lowering rates of intervention, preterm birth, and adverse neonatal health outcomes.[11]

**Patient satisfaction:** Midwives develop a supportive relationship with patients that increases a patient's sense of control during labor and birth, improves readiness for labor and birth, and increases her sense of respect, compassion, and attentiveness.[12]

**Clinician burnout and retention:** Practices that consciously approached the integration of midwives to help reduce workload burden on physicians found physician workplace satisfaction improved.[13]

**Spend:** With low rates of C-sections, obstetric intervention, and NICU admissions, midwives can help lower costs.[14]

7 Altman, MR., et al. "The cost of nurse-midwifery: Use of interventions, resources, and associated costs in the hospital setting." Women's Health Issues (2017): 434-440. doi: 10.1016/j.whi.2017.01.002

8 Attanasio, Laura., & Kozhimannel, Katy. "Relationship between hospital-level percentage of midwife-attended births and obstetric procedure utilization." Journal of Midwifery & Women's Health. Vol 63 iss 1 (2018): 14-22. doi: 10.1111/jmwh.12702

9 Murfet, Giuliana, Allen, Penny, & Hingston, Tania. Maternal and neonatal health outcomes following the implementation of an innovative model of nurse practitioner-led care for diabetes in pregnancy. Journal of Advanced Practice Nursing. (2013): 1150-1162. DOI: 10.1111/jan.12277

10 Newhouse RP, Stanik-Hutt J, White KM. Advanced practice nursing outcomes 1990–2008: A systematic review. Nurs Econ. 2011;29(5):1–22.

11 Vedam Saraswathi, et al. "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes." PLoS ONE. 2018: 13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523

12 Sandall, Jane et al., "Midwife-led Continuity Models versus Other Models of Care for Childbearing Women," Cochrane Database of Systematic Reviews, April 28, 2016, doi:10.1002/14651858.CD004667.pub5.

13 Philip, S., Govier, D., & Man, A. (2017, December). Certified Nurse-Midwife Integration into a Maternity Care Practice: Financial Considerations for Developing a Business Plan. Milliman, Inc. (prepared for Purchaser Business Group on Health).

14 Altman, MR., et al. "The cost of nurse-midwifery: Use of interventions, resources, and associated costs in the hospital setting." Women's Health Issues (2017): 434-440. doi: 10.1016/j.whi.2017.01.002

* For more information about different types of midwifery licensure, see this ACNM Comparison Chart: https://www.acog.org/About-ACOG/News-Room/News-Releases/2016/ACOG-Releases-Report-on-the-Role-of-Team-Based-Care-in-Practice

## Use of the Term "Midwife"

Across the United States, there are several types of recognized midwifery credentials. This Midwifery Integration Guide is geared toward the incorporation of midwives into hospital-based practices, and we use the term "midwife" to reference midwives recognized by your state's accrediting body and represented by the national standards of the American College of Nurse- Midwives (ACNM). ACNM represents both certified nurse-midwives (CNM) and certified midwives (CM). In California, however, state statute and regulations recognize only the CNM credential.

**Certified Nurse-Midwives (CNMs)**

are educated in two disciplines: midwifery and nursing. They earn graduate degrees, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM.[15] They are credentialed to practice with prescriptive authority in all 50 states.

**Certified Midwives (CMs)**

are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by ACME, and pass the same national certification examination as CNMs to receive the professional designation of CM. CMs, however, are not recognized in all states. At the time of this publication, CMs are licensed in five states.

Other midwifery credentials (e.g. certified professional midwives or licensed midwives) are not included in this guide as their training primarily focuses on delivering the midwifery model of care outside hospitals (home and birth center settings).*



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## What Is the Midwifery Model of Care?

As you read through the guide and link to the many resources and appendices, we often reference the midwifery model of care. The midwifery model is based upon the foundation that pregnancy and birth are normal life events.

**The Midwifery Model >**

**Identify**

Recognizes the woman as a unique individual in the context of her family and community

**Advocate**

Supports and protects the physiologic process of labor and birth

**Empower**

Establishes the woman as an active partner in her own care16
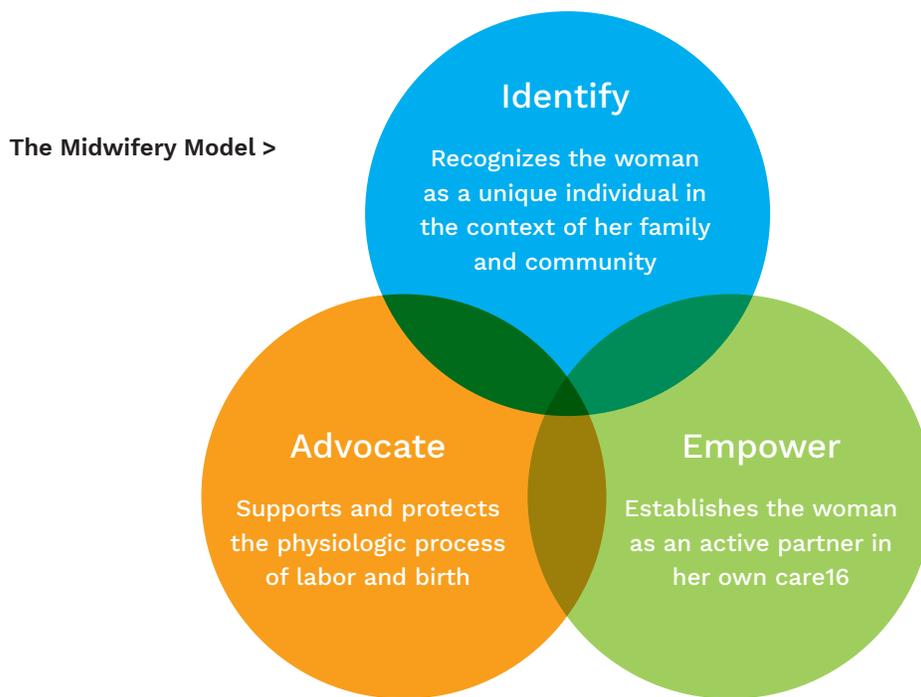
**In a midwifery model, clinicians are able to practice**

| watchful waiting and non-intervention in normal processes; | appropriate use of interventions and technology for current or potential health problems; and | consultation, collaboration, and referral with other members of the healthcare team as needed to provide optimal health care. |
|---|---|---|

Since midwifery is a distinct practice, midwives require their own identity in an organization. This guide is intended to support the integration of midwives in a manner that allows them to practice at the top of the license and will help you maximize the unique skills and expertise that midwives offer patients.

You can find more information about midwifery in this detailed position statement from ACNM. For more information about how to support physiological birth, see ACNM's resource BirthTools.

16 Rooks, JP. The Midwifery Model of Care. Journal of Midwifery & Women's Health. 1999;44(4):370-374.

## Fostering Collaboration

Midwifery and obstetrics are distinct professions with the shared goal of supporting a healthy mother and baby. However, they may differ in their methods to achieve that goal. 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. One midwife describes their collaborative relationship with a consulting physician in action:

The collaborative relationship may look different based on the experience and educational preparation of the midwife, the setting of care, and/or the needs of the patient. In collaborative practices, however, there are certain patients and clinical scenarios where a midwife's scope of practice ends and physician expertise will be necessary. When midwives reach the boundary of their scope of practice, they seek consultation, co-management, or transfer of care to a physician. In these specific situations, the strength of the collaborative relationship, clarity of roles and processes, and effectiveness of communication among providers become essential to patient safety.

"I had a patient this weekend that pushed for three and a half hours. And I really thought she could deliver vaginally. So I asked [my consulting physician] if we could just put the epidural in and maybe see if the baby would rotate. The physician agreed, and it worked! He was impressed and so patient and the whole time was waiting in the wings..."

In our examination of the literature, interviews with successful collaborative practices, and the authors' clinical experiences, healthy collaborative relationships, as described in the vignette above, include these core elements:

1. Shared vision

2. Role clarity

3. Mutual respect

4. Accountability and accessibility

5. Effective communication

6. Influence

7. Flexible and shared leadership of patient care

This guide will describe the steps that you can take to create the organization, processes, relationships, and culture to develop collaborative practice and high performing teams that embody elements above.
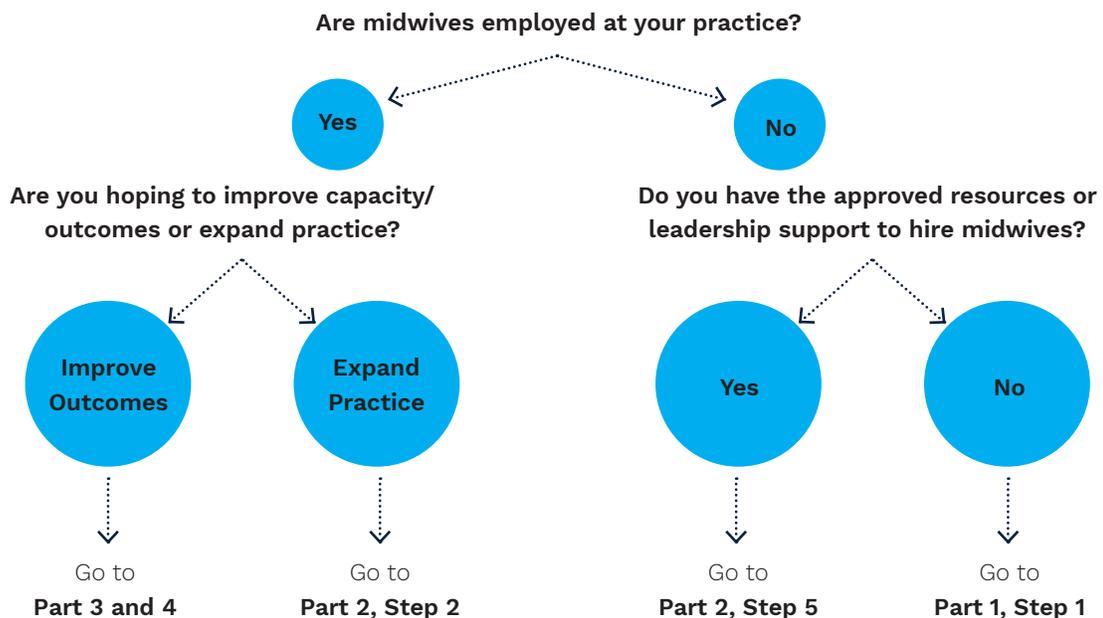
## How to Use the Guide

This guide offers step-by-step guidance for integrating midwives successfully into your physician practice or hospital. The guide provides an overview of the critical steps with links to resources and appendices, where relevant. Appendices contain sample documents that you may use as you develop your practice. Stories and best practices collected from interviews conducted with medical groups and hospitals that have successfully adopted a collaborative midwifery model are woven into the guide.

While this guide is comprehensive, you will likely need additional resources to support implementation. We recommend that you purchase An Administrative Manual for Midwifery Practices, 4th edition, ACNM, 2016, via the ACNM website at https://www.acnmstore.com/product-p/1432.htm. Chapters, page numbers, and appendices are referred to throughout this guide. You may also consider hiring a consultant or partnering with your hospital or health system's "operational excellence" department, if available.

**Where to Start >**
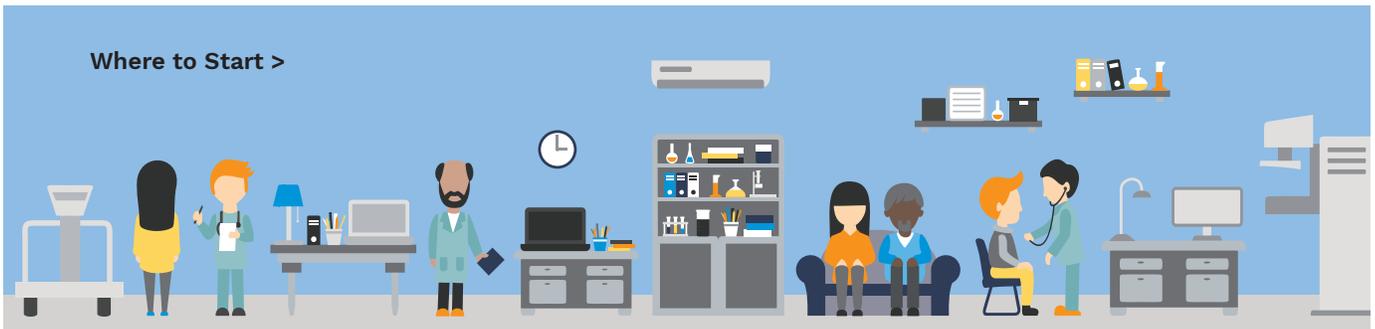
This guide is intended to support physician practices, hospitals, and other organizations in the successful integration of midwives. It also serves as a valuable tool to any midwife interested in starting their own practice. Existing practices with midwives can use this guide to assess their practice and take advantage of its tools to support quality improvement efforts.

**Are midwives employed at your practice?**

**Yes**

**No**

**Are you hoping to improve capacity/ outcomes or expand practice?**

**Do you have the approved resources or leadership support to hire midwives?**

**Improve Outcomes**

**Expand Practice**

**Yes**

**No**

Go to
**Part 3 and 4**

Go to
**Part 2, Step 2**

Go to
**Part 2, Step 5**

Go to
**Part 1, Step 1**

# Secure Leadership And Key Stakeholder Support

STEP 1 > GATHER INFORMATION AND DETERMINE READINESS

STEP 2 > ENGAGE KEY STAKEHOLDERS AND IDENTIFY CHAMPIONS

STEP 3 > MAKE A BUSINESS PLAN

STEP 4 > ASSEMBLE KEY STAKEHOLDERS

STEP 5 > DEVELOP A STRATEGIC PLAN AND IMPLEMENTATION TIMELINE

"It's not just having the right idea, but it's right time" describes the OB/GYN department chair at Providence Medical Group — Everett. When the new CEO (an obstetrician) came on board, integrating midwifery care 'clicked' with him, as well their chief operation officer, who fortuitously, was a midwife. The department chair and a lead midwife developed a pro forma to determine what it would take to integrate midwives into a collaborative practice. The CEO was supportive all along the way, declaring, 'If you guys are committed, I'm committed.'"

## Step 1 Gather Information and Determine Readiness

The decision to integrate midwives into your setting is a tremendous commitment to women and families in your community. Having the right plan in place and set- ting the practice up for clinical and financial success requires research, thoughtful planning, and broad stakeholder engagement. Identify champions from inside the organization and consider working with an outside consultant who understands the business of midwifery to get your organization off to a rapid start. Following are some of the key steps to inform your organization and make the business case for a successful midwifery practice.

**Information to Gather**

Before diving into hiring midwives, review essential resources on midwifery. The information you and your organization need to know before you start includes the following:

- The statutes and regulatory requirements for midwives in your state — You can often find these via your state's Board of Nursing, Board of Medicine, or Midwifery Board. For California requirements, visit http://www.rn.ca.gov/pdfs/regulations/bp2746-r.pdf. If outside of California, contact the ACNM Affiliate leadership in your state for more direction: http://www.midwife.org/affiliates.

- Appendix 19, Key Resources — Midwifery and Collaborative Practice summarizes critical ACNM and ACOG documents to increase knowledge about midwives and collaborative care throughout the organization. Please take the time to review those at the top of the Resources section.

- Various models of midwifery practices — These help you determine which setting best describes your organization. See appendix 1 for an overview of these midwifery practice models:

  - Hospital-Based Practice
  - Midwifery Private Practice
  - Community-Based Practice
  - HMO-Based Practice
  - Physician-Owned Practice
  - Faculty/Academic Practice

# Secure Leadership And Key Stakeholder Support

Determine Readiness Determine readiness through- out the initial discussions with champions and stakeholders by asking questions about capac- ity and culture. Maintaining transparency throughout the process helps keep everyone informed and prepared for

the changes that will come when you introduce midwives into your organization. If you want additional support, many change readiness resources, such as John Kotter's "Steps to Successful Change," are avail- able online and in the literature.

## Step 2 Engage Key Stakeholders and Identify Champions

Introduce the topic at an open meeting (e.g. regular department, leadership, or staffing meeting) to gauge interest of different people in the organization. Then, establish a planning team that includes leaders and operational experts. See appendix 5 for a list of potential key stakeholders and key questions to ask each of them. Having these individuals at the table as you begin to plan for integrating midwives will help ensure that you have all the information you need to make decisions and move the process forward smoothly. Be sure to include these potential stakeholders:

- hospital or practice administration (C-suite, directors and managers)
- IT team
- physicians
- finance team
- medical staff office
- coding/billing team

- HR, as appropriate
- marketing team
- inpatient unit leadership and members of the nursing team
- patients or other community members
- patient safety/quality team

Champions are decision makers who have the ability to engage and recruit others to work on the initiative. This group will be your cheerleaders, evangelists, and

change-makers in the coming months. You should include a member of the senior leadership team at the hospital, a practice administrator, and a physician. A student midwife already on the nursing staff interested in starting a new practice can also help lead the initiative. Clearly define and communicate the role of champions and key stakeholders in the integration plan.

Practices that included physicians in the decision process to integrate midwives also found physician satisfaction improved, whereas practices in which physicians felt they had little control or input in decisions around midwife integration were less satisfied with their practice environments and relationships with midwives.

According to the Institute for Healthcare Improvement (IHI), "improvement teams" should represent the three different kinds of expertise in an organization, including systems leadership, technical expertise, and day-to-day leadership. Try to recruit champions that cover these types of expertise and skillsets, as well as opinion leaders, in the organization.



Champions are decision makers who have the ability to engage and recruit others to work on the initiative.

## **Step 3** Make a Business Plan

In a report commissioned by PBGH, Milliman, an independent actuarial consulting firm, outlines four steps to developing a business plan for integrating midwives into an organization:

**1** Assess the Current and Evolving Payment Landscape

**2** Consider Resource Allocation

**3** Develop a Pro Forma

**4** Develop a Business Plan

For the full white paper and a link to a financial tool, see appendix 2. Although the report contains California specific data, the analysis and themes are relevant to the integration of midwives in all states.

**Assess the Payment Landscape**

Consider all the payment sources, payment models, and payment rates relevant to the maternity practice, and in particular, for midwives. Seek out relationships and contracts that use value-based payment.

**Consider Resource Allocation**

How you allocate midwife and physician ti me in the practice will have impacts on efficiency, productivity, and revenue. Consider these allocations:

• Time dedicated to inpatient and outpatient services

• Level of midwifery experience

• Physician supervision laws specific to your state

**Develop a Pro Forma**

To assist practices in calculating expected revenues, expenses, and financial outcomes associated with hiring a midwife, PBGH developed a "CNM Financial Tool". The tool is intended to estimate the financial value of adding and integrating midwives into maternity care in California based on practice type and practice-specific characteristics. The tool will help you develop a hypothetical pro forma projection for one year showing the revenues and expenses for a CNM practice. It is

intended to support provider organizations' understanding of these impacts:

• Expected patient panel or patient load associated with adding 1 full ti me employee (FTE) CNM

• Revenues generated by adding 1 FTE CNM

• Expenses incurred by adding 1 FTE CNM

• Profit that 1 FTE CNM could generate

**Develop a Business Plan**

A business case is the articulation of the value proposition and rationale for embarking on a new strategic direction or initiating a program. A well-defined business case should outline the following:

• Address why adding a midwife to a maternity practice is the right step

• Clearly state the expected impact to the "bottom line" of the practice

• Articulate the impact on other goals of the maternity practice, including improved population health management, improved quality and access to care, patient experience, provider satisfaction, and efficiency

• Serve as an effective tool for your leadership and practice champions to articulate the rationale for CNM integration

• Explain why this is the ti me to integrate midwifery into your practice or hospital

# Secure Leadership And Key Stakeholder Support

Combine all the above components into a community needs assessment, a business plan, or concept paper, including information about the number of births in the community, current obstetrical providers and hospitals, community-level perinatal outcomes, and potential revenue for the practice. See appendix 3 for a sample concept paper and appendix 4 for a sample business plan template. For additional information, refer to An Administrative Manual for Midwifery Practice, chapter 2, "Developing a Business Plan for a Midwifery Practice."

## Step 4
## Assemble Key Stakeholders

As you begin planning, bring together the key stakeholders identified in step 2. Each stakeholder brings unique information and perspective about the organization and what may be necessary for success. Appendix 5 offers a list potential stakeholders and questions to discuss with each of them. Modify the stakeholders and questions to best meet the needs within your organization. Schedule an initial meeting for key stakeholders. See appendix 6 for a sample agenda and appendix 7 for a sample PowerPoint presentation. In the invitation email, include the list of potential key stakeholders and questions for each.

Appendix 5 provides a basic outline of questions for each stakeholder

**Questions to Ask**

Be transparent about the process, listen to understand the issues and potential concerns surrounding integrating midwives to build trust among stakeholders. When planning the initial stakeholder meeting, consider what information you need each stakeholder to bring to the table. Appendix 5 provides a basic outline of questions for each stakeholder, including questions that will help you determine if physicians and organizational leadership are willing and ready to embrace a midwifery approach to care delivery. Answers to these questions will also help you determine stakeholders' current understanding of the midwifery model. Be sure to tailor background materials to address gaps in knowledge.

**Data to Collect**

See appendix 8, Potential Action Items for Key Stakeholders. This is the perfect time for additional outreach to other providers or administrators to better inform the champions and the planning team.

**Compile Background Information**

Compile a midwifery integration notebook for each stakeholder with the following tabs:

- ACNM standard setting documents

- Joint Statement about Practice Relations between Obstetricians-Gynecologists and Certified Nurse-Midwives/Certified Midwives

- State regulatory information about midwives in California Midwifery Practice Models (see appendix 1)

- Draft of community assessment, business plan, or con- cept paper (see appendix 3 and 4)

- Hospital bylaws regarding midwives

- Credentialing and privileging process for midwives Strategic plan template Communication/marketing plan template Meeting agendas and minutes

## Step 5 Develop a Strategic Plan and Implementation Timeline

A strategic plan will help you build a healthy foundation for integrating midwives into your organization and ensure that all staff involved in the process are working toward the same shared vision. New organizations and businesses that fail to develop a vision, mission, and values statement and a clear strategic plan often fail to thrive. Investing time in this process pays off in the long run.

You should have midwife input in strategic plan development. If you have not yet hired midwives, revisit the strategic plan and obtain midwifery input and buy-in once you have hired midwives. Work with an experienced consultant as needed.

The appendix of this guide offers these sample strategic planning sections:

- Vision, Mission, Values Worksheet (appendix 9)

- Strengths, weaknesses, opportunities and threats (Practice SWOT Analysis) to be completed and compiled into the document (appendix 10)

- Sample Foundational Agreements (appendix 11)

- Sample Midwifery Practice Philosophy of Care (appendix 12)

- Strategic priorities appendices

  - Resources for Recruiting Midwives (appendix 13)

  - Strategies for Fostering Midwife & Physician Relationships (appendix 14)

  - Developing or Revising Written Practice Guidelines (appendix 15)

  - Branding and Marketing Midwives (appendix 16)

  - Building Strategic Partnerships to Enhance Practice Success (appendix 17)

### Create an Implementation Timeline

You can use any commercial project management tool or an excel spreadsheet to develop your implementation timeline.

Depending on the scale of the plan and organizations' readiness, full implementation may take months to years. Include timeline and progress as a standing agenda item for the stakeholder meetings to keep everyone accountable.

**Communicate and celebrate when you reach significant landmarks such as hiring the first midwife, the first birth, the 100th birth.**

Thoughtfully prepare for change and communicate about the change with all staff before and throughout the integration process. ACNM has developed expansive resources for integrating physiologic birth into a hospital. Refer to BirthTOOLS.org to view these resources, including sections about change and unit culture. Remember to keep your stake- holders, the entire team, and your community informed of the changes.

# Establish the Practice

STEP 1 > DEFINE ROLES AND RESPONSIBILITIES

STEP 2 > BUILD THE MODEL

STEP 3 > BUILD THE BRAND AND DEVELOP A COMMUNICATION/MARKETING PLAN

STEP 4 > CONNECT WITH INSURERS AND HEALTH PLANS

STEP 5 > SELECT AND HIRE THE RIGHT CANDIDATE

STEP 6 > PREPARE TO ONBOARD THE NEW MIDWIFE

STEP 7 > ORIENT THE NEW MIDWIFE

Investing in a midwifery practice is a meaningful and patient-focused endeavor. This section will walk you through the steps necessary when establishing a midwife practice, from designing the practice model to orienting a new-hire. An Administrative Manual for Midwifery Practices, chapter 4, "Office Management," addresses many organizational, procedural, and scheduling issues, including a checklist for setting up a new practice. In this section, we highlight some of the essential steps.

## Step 1 Define Roles and Responsibilities

Clearly defining and communicating roles and responsibilities is an important step in establishing a solid foundation for midwifery while building trust among providers to support collaboration. Clarity of roles ensures smooth transition of care among providers and increases patient safety.

Note that hospitals and practices may have different needs as well as credentialing and licensing processes. If relevant, consider both as you define scope and roles.

**Define Midwives' Scope of Practice**

A scope of practice clearly states the conditions and procedures a midwife can treat within the bounds of their state licensure and regulatory bodies. The ACNM Core Competencies "include the fundamental knowledge, skills, and behaviors expected of a new practitioner." Refer to pages 6 and 7 of this guide for additional information.

Depending on your needs, the scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives can expand their practice following the guidelines outlined in Standard VIII of the ACNM Standards for the Practice of Midwifery. Legal authority to perform advanced or "expanded" skills are subject to state law and regulation. Examples may include the following:

- C-Section first assist — depending upon the organization, may require certification or on-the-job training with a physician

- Colposcopy — formal training followed by a number of supervised colposcopies or until the midwife demonstrates competence

- Ultrasound certification — ACNM has recently introduced a new midwife certification program

- Transvaginal cervical length measurement

- Circumcision

# Establish the Practice

**Define Physician Involvement and Role**

Midwives are effective and empathetic caregivers to healthy pregnant women. But what happens if a patient requires treatment beyond the scope of midwifery care? Role clarity and written guidelines are essential to patient safety and the smooth transition of care, if necessary, from a midwife to a physician. Consultation occurs when a midwife seeks the advice of a physician or another member of the health care team while maintaining primary responsibility for the patient. Co-management is the evolving process in which a physician and midwife jointly manage patient care. In some cases, a patient may need to be cared for exclusively by a physician, referred to as "transfer to medical management."

Clearly define the conditions and circumstances that require co-management and transfer to medical management in your written practice guidelines. Poorly or ambiguously defined roles and guidelines can cause confusion and concern about liability and accountability, particularly among consulting physicians. Consulting physicians should be supportive of midwifery and the collaborative process.

**Develop Written Practice Guidelines**

Every midwifery practice should develop written practice guidelines as defined by the ACNM Standards for the Practice of Midwifery, Standard V. ACNM requires written guidelines that include:

- information about the practice model

- state-specific regulatory requirements for midwifery

- hospital requirements for midwifery

- the parameters of service for independent and collaborative midwifery management and transfer of care, when needed

**A midwife at Sutter Davis Hospital describes her organization's approach:**

"We stratify our care to know who can get what type of care and set practice guidelines that define who receives:

1. normal midwifery care (those people can get 100 percent midwifery care)

2. midwifery care with consultation from a doctor

3. midwifery care co-managed with the doctor (the doctor is constantly involved not just consulting)

4. doctor-only care.

All these guidelines are set by collaborative consensus between doctors and midwives. We agree on what is needed and what is not needed for each patient category."



"Developing or Revising Written Practice Guidelines Plan to revisit the guidelines once midwives have been hired and every one to two years."

*See appendix 15*

# Establish the Practice

## **Step 2** Build the Model

There are many ways to staff your practice, and you should thoughtfully consider which structures best fit your organization. If you are a physician practice, you may decide to hire one midwife to determine the fit for your practice, or you may hire a team of midwives. You may start a midwifery practice that provides continuity of care to a caseload of patients and offers a full spectrum of services. Or, you may fully integrate the mid-wives into the practice and share all patients. We define the most common models and staffing structures below.

> Providence Medical Group - Everett chose to put two midwives on call at the hospital at all times in order to allow midwives to have more bedside time with patients. "We decided that, core to the midwives having satisfaction with their job, they needed to provide [labor-sitting]. So, we wanted to really be careful about their load so they were able to provide more bedside care than a physician."



### Staffing Considerations and Structures

Determining your appropriate staffing and model likely requires an assessment of the resources and needs of your organization. Before determining your model, refer to the business plan you developed in part 1, and if you haven't already, engage other physicians and midwives in this process. Keep these considerations in mind:

1. **Rationale for integrating midwives** — What did your stakeholders find to be the most compelling reason or competitive advantage for midwifery integration? Expanded market share? Decreased physician call?

2. **Patient volume** — How many patients do you anticipate midwives will see over the next year? Given midwifery's patient-engagement model (e.g. midwives oft en have longer appointment ti mes and engage in "labor-sitting"), their throughput is different than physicians.

3. **Hospital Call** — Length of call shift s vary among practices. Depending upon the volume, the midwife or physician may take call from outside the hospital or may be re-quired to remain in the hospital. How frequently a provider can take call is inversely proportionate to volume.

4. **Burnout** — Fatigue and sleep deprivation have significant impact on clinician burnout and patient safety. The ACNM recently published a statement on this topic. Although some practices still have 24 to 72 hours of on-call ti me in a row, many practices are transitioning to 12-hour call shifts.

Again, practices determine their model and staffing structure based on unique needs. Midwife and physician roles may vary depending upon the model and staffing structure you chose. Clarity about the structure of the practice will help patients, providers, and office and hospital staff fully understand scheduling and patient flow. Within all models, you can embody the philosophy of collaboration (see part 3).

# Establish the Practice

## *Staffing Models*

Some of the most commonly used staffing models include the following:

**Midwifery Caseload/Separate Call** — Physicians and mid-wives follow their own caseload of patients through the entire maternity cycle. If a midwifery patient develops a clinical condition that requires consultation, collaboration, or referral to medical management, the midwife may or may not continue to provide educational and supportive care. Staffing is determined based upon patient volume.

**Shared Caseload/Shared Call** — Midwives and physicians see all patients and whichever provider is on call at the time attends the delivery. This staffing model cannot guarantee midwifery care for every patient who desires a midwife or, due to clinical circumstances, needs care by a physician.

**Midwifery Laborist** — Midwives offer 24/7 hospital coverage. The midwife manages the labor and delivery unit, caring for all patients within a midwife's scope. Often, the midwife provides care to all women in labor, regardless of who delivered her prenatal care.

**Midwifery First Call** — This is suitable for practices with both midwives and physicians. Midwives admit all patients and perform a patient intake and physical. The midwife assesses the patient's risk status to determine if she is appropriate for midwifery care.

**Obstetric Hospitalist** — Hospitals and medical groups hire physician/s that exclusively work in the hospital to serve women in labor and to address obstetric emergencies The midwife can consult with the hospitalist as needed in the hospital and transfer care to medical management, if it becomes necessary.

## *The following table further explores the staffing variables of these midwifery models:*

| Structural Element | Midwifery Caseload/ Separate Call | Shared Caseload/ Shared Call | Midwifery Laborist | Midwifery First Call |
|---|---|---|---|---|
| Who will patient see for prenatal care? | Midwife as long patient remains within scope | Midwife or physician | Midwife or physician | Midwife or physician |
| Who will attend the birth (vaginal only)? | Midwife (unless patient risks out) | Midwife or physician | Midwife (unless patient risks out) or physician | Midwife (unless patient risk out) |
| Continuity of provider type? | Yes (unless patient risks out) | No | Depends upon the model | Midwifery patients: possibly Physician patients: no |
| What is role of physician? | Consult as needed | Share call shifts | Consult as needed; Deliver own patients | Consult as needed |
| Situated in a practice or hospital-based? | Practice or Hospital | Practice or Hospital | Hospital | Practice |

Whatever staffing model you choose, remember to inform your patients about their care path and which providers they will see for prenatal care and delivery. Provide this information in writing at the initial prenatal visit and reinforce it throughout the pregnancy.

# Establish the Practice

**Determining Staffing Numbers and Hours**

The number of midwives you will need depend on the staffing model selected and the intended birth volume. Some practices start with one or two midwives, then add more as volume increases. In other cases, hospitals will staff an entire midwifery department in the anticipation of an increase of patients due to changes in the community.

**How Many Midwives Do You Need?**

There is a tremendous range in midwife full-time equivalents (FTEs) per number of births per month, anywhere from 5 to 15 (or more), based on other duties and practice model. The ratio is often smaller in a faculty practice where a midwife has other teaching responsibilities. FTE hours allotted to hospital call reduce the midwife's availability for outpatient/prenatal care. A small, call-based practice, for example, may have fewer births per midwife due to the large amount of time on call. CNMs who spend more time providing outpatient services, however, generate less revenue than those who spend more time providing inpatient services.[18]

Once a practice grows to a volume of 50 to 60 births per month, you will need a midwife on call in the hospital at all times. About 4.2 midwife FTEs will cover the hospital 24/7 and additional FTEs are needed to see patients in the outpatient setting for a practice of this size.**

Also consider how the midwife's level of experience may impact productivity. A less experienced midwife will have lower salary requirements but may not be as initially productive or could require more physician consultation. A midwife with experience in a small, low-risk practice may not be as productive when they initially join a high-volume practice that serves patients who are moderate or high-risk. If midwifery is new to you and your organization, consider hiring a more experienced

midwife to support starting the practice. Discuss these options with existing midwives and physicians, and ask interview questions that will help guide you to make the best decision for your practice.

**Full-time, part-time, or per-diem? And, what about locum tenens?**

Some practices only hire full-time midwives and others allow for part-time employees. You should track the total FTEs (full-time and part-time), not the total number of midwives. Part-time midwives may provide some cost savings in benefits, such as health insurance. On the other hand, the liability insurance carrier may still require the same premium, whether the midwife is part-time or full-time. To avoid coverage for paid time off, including vacation and sick time, organizations often hire per-diem (contract) midwives.

If faced with a gap in staffing, consider hiring a locum tenens midwife. Locum tenens agencies maintain contracts with experienced midwives to provide temporary coverage for a medical leave or to fill a vacancy until you hire a permanent midwife. Most agencies provide liability insurance for their midwives and some support credentialing. Overall, locum tenens mid-wives are usually more costly than other hires. Interview all candidates directly to determine skill-level and fit.

**Account for Administrative Time**

In the following section, you will learn more about the importance of having a formal midwifery leader. The percent of FTE that is dedicated to leadership varies widely. A start-up practice may need more protected, non-clinical time to hire staff, do community outreach, and perform other administrative tasks. A growing or large practice may require greater amount of leadership FTE.

If the midwives intend to deliver all patients they see for prenatal care (a continuity model), calculate the amount of office time required based upon the length of visits plus the number of non-obstetric patients the midwives see.

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18  Philip, S., Govier, D., & Man, A. (2017, December). Certified Nurse-Midwife Integration into a Maternity Care Practice: Financial Considerations for Developing a Business Plan. Milliman, Inc. (prepared for Purchaser Business Group on Health).

**  As delivery volume increases, you will eventually hit a threshold when you require a midwife in the hospital 24/7. Monitoring midwifery workload with a focus on inpatient hours will provide you with information to help you  decide when you need to schedule 24/7 in-house coverage. This is often when midwives are doing 50 – 60 births per month and managing triage of their caseload patients.

# Establish the Practice

Also, consider the medical assistant, front-desk staff , and nursing ti me the new-hire will require. Hire and allocate support staff ti me accordingly.

**Be Proactive About Midwifery Leadership**

Regardless of the size of the practice you are planning to integrate, you should develop a formal midwifery leadership role. If you hire a midwifery leader first, you are more likely to have a strong, sustainable team. Some practices designate one individual to be the practice director, manager, coordinator, or lead. The title and responsibilities should align with other departments in the organization. Protected non-clinical ti me helps the leader more effectively attend to administrative details. For examples, see part 3 of this guide.

A formal midwifery leader:

• serves as a primary midwifery contact for key stakeholders;

• streamlines the flow of communication;

• represents the practice in a variety of clinic/hospital meetings and committees;

• spearheads quality improvement initiatives;

• manages day-to-day issues within the practice;

• hires and manages staff  midwives, providing regular feedback, annual performance appraisals, and mentorship; and

• serves as point person around quality and safety, communication, and financial issues that may arise.

In some practices the midwifery leader has a great deal of administrative responsibility and minimal patient-care hours. In other practices, the leader has a heavy clinical schedule and minimal administrative time.

We heard from practices around the country that the absence of a formal midwife leader oft en means that midwives have no avenue to make their voice heard in their practice. This lack of voice can lead to dissatisfaction and turnover while also inhibiting the collaborative process.

Invest in leadership development of midwife staff . Midwives are educated to be highly competent clinicians, but few have had prior leadership experience. Encourage enrollment in an internal leadership development program, local community program, or formal leadership and business classes. The investment will strengthen their leadership skills and benefit the organization.

Refer to An Administrative Manual for Midwifery Practices, 4th edition, chapter 1, "The Role of the Service Director" for detailed information, and appendix 1.1 for a director of nurse-midwifery program position description.

Swedish Midwifery- Ballard established the role of medical director for midwifery. The director has protected 0.4 FTE administrative time to represent the interests and perspectives of midwives at committees and meetings at all three Swedish sites with midwives, serving as a liaison between the broader system leadership and midwives.

Adventist Health Feather River has a supervisor of CNM practices on staff. While the position does not include protected administrative time, Adventist Health provides additional fixed compensation per month for non-clinical duties such as staffing, quality tracking and reporting, and scheduling.

## Step 3 Build the Brand and Develop a Communication/ Marketing Plan

Brand the Practice and Develop Marketing Materials Midwives will likely draw patients from new and diverse populations in your community, so make sure they are visible and that patients can find them. You may want to wait until you have recruited a midwifery leader or the initial midwives before deciding on a practice name and developing a marketing/communication plan. A hospital/ physician group should consider these actions:

- Determine if they will brand midwifery as a new service line or blend midwifery into existing practice

- Add "and midwifery" or "and midwives" into the practice name

- Include information about midwives in all marketing/ communications materials, especially on the website

If you are a hospital you probably have a marketing team that can help with branding and developing a marketing plan. See An Administrative Manual for Midwives, chapter 5. Refer to the sample strategic priority, "Branding and Marketing Midwives" in appendix 16 of this guide. Consider branding your patient education materials by purchasing a book or app that you can customize to meet your patients' needs. Great Expectations is a great example of a patient education tool and is available through Customized Communications, Inc (CCI). You can contact CCI for more information about books and apps for patient education.

### Patient Communication

Every member of your practice is an ambassador for midwifery. Invest in the time to engage and educate your front- and back-office staff about midwifery and the midwifery model of care. Communicating with patients about what they can expect from midwives is very important. If a patient sees a midwife for every prenatal visit, she might assume that she will have that midwife attend her birth. If there is only one midwife, they may not take call 24/7, and the patient may have a physician attend her birth. Setting clear expectations in advance prevents a patient from being surprised or disappointed during one of the most important days of her life.

## Step 4 Connect with Insurers and Health Plans

### Identify a Liability Insurance Carrier

If you are a physician practice and already have a relationship with a liability insurance carrier, check with them about the cost of adding coverage for midwives. Otherwise, there are many commercial options for liability insurance coverage. Be sure you are well-informed about the type of coverage (claims made or occurrence). Plan to pay for a midwife's tail coverage, an extension of malpractice insurance that covers claims made after a provider leaves a practice. As soon as a midwife is hired, file a copy of the certificate of insurance in the office and medical staff office files. Give a copy to the midwife to add to their professional files.

In most cases, the cost of liability insurance for the midwife will be less than the cost of insurance for a physician. Ask the carrier about changes to the costs of insurance for the consulting physician.

If you are a hospital, check with your liability insurance carrier to determine the best option for providing coverage for midwives. Insurance through your general carrier is likely less expensive than for a physician-owned practice. As soon as you hire a midwife, file a copy of the certificate of insurance in the office and medical staff office files. Give a copy to the midwife to their personal files.

> Sutter Davis Hospital has a midwife first-call model. The physician does a dating ultrasound, and a midwife does the physical and orients the patient about her care path. "If [the patient] is not eligible for midwifery care, we tell them. If [the patient is] eligible, we tell them that midwifery-led births are about 60% [in the practice] and they can choose a physician to be present, if desired. It has not been a problem because people come to us for midwifery care."

# Establish the Practice

ACNM has partnered with Contemporary Insurance Services for many years and you can find information about their options for covering midwives at www.cisinsurance.com. An Administrative Manual for Midwifery Practice addresses professional liability insurance in chapter 8, "Legal Issues". See the 2014 ACNM document, "Professional Liability Resource Kit" (members only) or ACOG's professional liability resources (members only).

**Pave the Way for Credentialing with Health Plans**

Every health plan has its own process for credentialing health care providers. Health plans can take three months or longer to credential a provider, so be proactive and start early. Contact the health plans that you plan to contract with as you add midwifery services. Here are some steps to move this process forward:

1.  Contact the health plan as soon as you have decided which midwife to hire and ask about the process for credentialing a midwife.

2.  Ask for a list of documents they require for credentialing on the plan.

3.  If you are hiring midwives who were already credentialed on a health plan, you may simply need to write a letter that will move their provider number from one tax ID number to that of your practice.

4.  Make copies of all the documentation you provide to the credentialing team and consider sending documents by registered mail.

If you wait too long to initiate the process, the new midwife may start before being credentialed and will be unable to bill for services.

## Step 5 Select and Hire the Right Candidate

Now that you have built your model and outlined scope and practice guidelines, you should recruit and select the candidate with skills and strengths that fit the needs and culture of your organization. Making good hires who can develop strong relationships with others will build trust in the quality and safety of your new model. Dedicate time and energy to the process.

> "Be selective enough, and make sure you get the right fit. It pays off in the long run."
> — Medical Director, Providence Medical Group- Everett

**Recruitment**

Now that you have made decisions about FTEs and leadership, develop a job description that integrates this information. This essential document should clearly describe requirements for the job including education, experience, and advanced skills. Your practice may have built-in support to hire a new graduate midwife, or you may need a midwife who is ready to integrate and become fully productive quickly. Based on the scope developed in step 1, consider what additional training and certifications you require (e.g. surgical assist training) and whether you're willing to provide that training on the job or invest in training after hiring.

Refer to An Administrative Manual for Midwifery Practices, chapter 7, "Human Resources."

Recruitment can be as simple as asking around your community to see if there is a midwife looking for a job or it may turn into a months-long endeavor with formal job posting in numerous areas and even hiring a recruiter. It is generally more difficult to recruit for a midwife in a rural location. For that reason, some communities plan years in advance and provide financial support to labor and delivery staff to attend a midwifery education program and become certified.

Some options for posting your position and additional resources can be found in appendix 13, "Resources for Recruiting Midwives."

# Establish the Practice

### Interviewing

Interview for the right fit, focusing on skills and philosophy. Interviewing has become a fine-art and there are many resources available to help you develop an interview guide that will help you find the right candidate. An Administrative Manual for Midwifery Practices, chapter 7, "Human Resources," provides midwifery-specific interviewing guidance. In addition, appendix 7.2 offers a sample interview guide.

> When interviewing midwives, Kaiser Permanente assesses their understanding of collaborative practice and confidence communicating with physicians. Another small physician owned practice looks for friendliness, positive attitude, organizational skills, quick learners, and empathy with coworkers when searching for potential candidates.

Behavioral interviewing is a technique whereby the applicant is asked to describe past behavior to determine whether the applicant is suitable for a position. For example, an interview-er may ask, "Tell me about a time when you faced a conflict with a physician or a peer." More sample behavioral inter-view questions are available online. Modify these to help you find the right fit for your practice or organization.

Thoughtfully consider who should participate in the inter-view process. Depending on the organization, you may need more than one interview for a candidate. All physicians who will be working as a consultant with the midwife, key administrators, the midwife's manager and peers, if any, should meet with the candidate.

Check references by telephone. If possible, talk with a previous manager, physician colleague, and a peer. Some organizations require that reference checks go through the Human Resources department and will only share information about employment dates and whether the individual is eligible for re-hire. The more information you can obtain from references, the better informed you will be about whether the candidate is a good fit for your organization and team. Some large organizations have an additional screening process that has each candidate take an electronic assessment, often referred to as a selection tool. If this exists in your organization, you may want to customize the tool to help you identify the midwife candidate that will be the best fit for your organization.

### Selection

The hiring process depends on your organization. Often, there are pre-employment requirements, including a back-ground check, physical exam with immunization updates, and drug testing.

When making the written offer, include information from the job description such as salary and benefits, responsibilities, reporting structure, and other details. Some organizations use the Human Resources function to process hiring, and the midwife is employed in alignment with organizational standards and state regulations. Other organizations develop a contract with the midwife which may include an end/renewal date, type of liability insurance provided, and options for termination with notice or for cause. See An Administrative Manual for Midwifery Practices, chapter 8, "Legal Issues."

## Step 6 Prepare to Onboard The New Midwife

Now that you have made the decision about who to hire into your practice, there is more work to be done before the midwife can actually start. Note that hires with a malpractice history or out-of-state licenses may have a longer credentialing process.

### Hospital Credentialing

This step often takes several months from the time you submit a complete credentialing packet to the Medical Staff Office to approval from the board of directors. Here are some important steps to help the process proceed smoothly:

- Provide the midwife a list of materials needed for credetialing as soon as they have accepted the job

- Assist the midwife in completing the application accurately and in a timely manner

See An Administrative Manual for Midwifery Practices, chapter 9, "Credentialing and Essential Documents."

# Establish the Practice

## Health Plan Credentialing

A midwife must be a credentialed provider for each health plan they intend to bill. Payers have varying processes for credentialing. In a physician practice, the office manager may be responsible for getting midwives credentialed on health plans. In a larger organization, a department likely manages all provider credentialing. If the midwife has provided care from the same payers in another setting, you may only need to write a letter to the health plan that describes the new practice setting and the Tax ID number associated with the practice.

Here are some suggestions for helping the payer credentialing process proceed smoothly:

- Provide the midwife a list of materials needed for credentialing as soon as they have accepted the job.

- Assist the midwife in completing the application accurately and in a timely manner.

## Develop a Departmental HR File

An Administrative Manual for Midwifery Practices, page 127, has a supporting document checklist for maintaining an HR file for a midwife. All items must remain current, and it is the midwife's responsibility to provide updated licenses, board certification, DEA certificate, and other key documents.

## Prepare an Orientation Process

Communicate to all clinical and administrative staff, as well as leadership, about the newly hired midwife (at staff meetings or via email). Your organization may already have a formal orientation process. If not, now is the perfect ti me to develop one.

An Administrative Manual for Midwifery Practices, 4th Edition, has a detailed sample new employee orientation checklist on page 173. Find more information on organization/clinical orientation on page 90.

## Marketing, Branding, and Communication

Develop an internal and external communication plan about a new midwife joining the organization. Make business cards and add the new midwife's name to signage, website, and brochures. Consider writing an article with a photo for your internal newsletter. Inform the community about the new midwife by placing a welcoming ad in the community news-paper. See appendix 16, Branding and Marketing Midwives.

## Ideally, all of this will be completed before the midwife's

first day. Being prepared makes a new-hire feel welcome. Communicate excitement about the new midwife joining the team. One organization developed a large banner that was placed in the hospital lobby when the midwife was hired. Aft er the first month, the banner was relocated to the hallway outside of her office. (Note: Always work with hospital administration when planning displays or parties in group spaces).
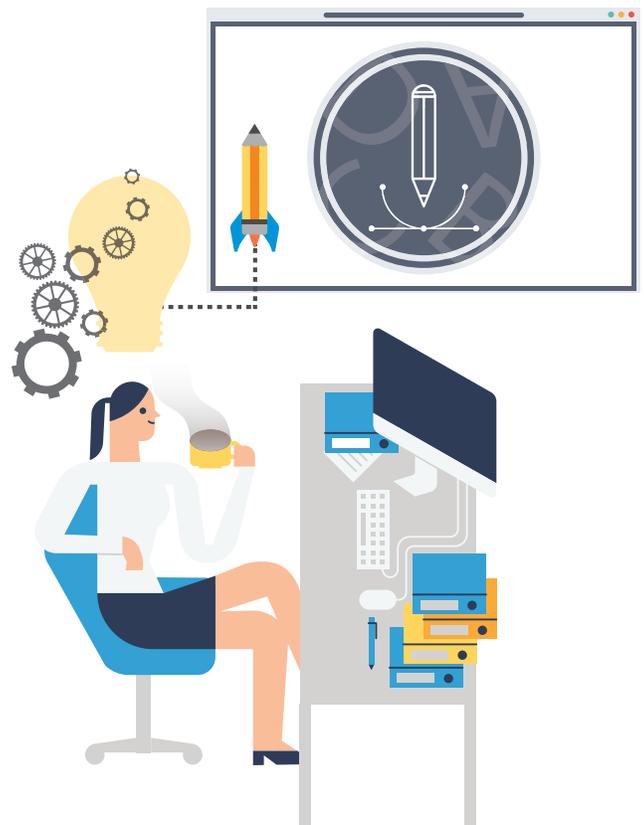
# Establish the Practice

## Step 7 Orient the New Midwife

Now that you have hired a midwife, a thorough orientation to the practice and the hospital will help your organization and the midwife thrive from the start. Orientation should make the midwife feel welcome and fully informed about practice culture, policies, and procedures. Thorough orientation keeps patients safe and protects the clinician and the hospital from liability.

If introducing a midwife into an established practice, schedule a ti me to present the new-hire to the team and create space for staff to get to know each other as colleagues. Ensure that all clinicians and staff understand the midwife's scope and how they will be part of the practice.

> "Learning about each other helps build relationships"Learning about each other helps build relationships and ensure that everyone gets to speak up and help and ensure that everyone gets to speak up and help you hear other people's you hear other people's perspectives."s perspectives."
>
> —Physician, Providence Medical Group - Everett Physician, Providence Medical Group - Everett

If your organization began the strategic planning process before onboarding midwives, schedule a strategic plan launch to add midwifery input. Include physicians and other key stakeholders that were part of the final strategic planning process to align all parties in the shared vision of the practice

### Organizational Orientation

Schedule a practice and/or hospital orientation. Check in with the hospital to learn what they require for orientation. Provide an overview of the orientation process and give the midwife a tour of inpatient and outpatient facilities, introducing them to key contacts in both locations. Chapter 7 in An Administrative Manual for Midwifery Practices can help develop your orientation process.

Schedule meetings between the midwife and these key stakeholder groups during the orientation process:

- Manager or director midwives report to
- Electronic health record staff (also schedule an EHR training)
- Senior leadership
- IT staff
- Medical staff
- Inpatient leadership
- Quality staff
- Outpatient leadership (if in a physician practice)
- HR staff
- Outpatient staff meeting
- Coding/billing staff
- Inpatient staff meetings
- Office staff

Share dates/ti mes of regular meetings that the midwife may be expected to attend:

- Midwifery practice meetings
- Inpatient or outpatient staff meetings
- Provider meetings (to include physicians)
- Perinatal quality meetings
- Department meetings
- Applicable leadership meetings

Share policies and procedures the midwife will be held accountable to include human resources, inpatient and outpatient procedures, and quality reporting.

Remember to explicitly communicate hospital policies for management of preterm labor and labor induction.

# Establish the Practice

**Clinical Orientation**

Assign the midwife to a primary "mentor" to support continuity and walk the new-hire through the orientation checklist. Involve the midwifery leader in the mentor selection and the orientation process. If the midwife is the first to join a practice or hospital, establish a clear plan for who will manage the orientation process.

Schedule observation ti me in both outpatient and inpatient areas. This "shadowing" process will provide an opportunity for the new midwife to become familiar with the settings, paperwork/EHR, processes, and patient flow. Review the written practice guidelines and discuss scope of practice. Observation ti mes provides the opportunity for a mentor to model healthy communication and collaboration with peers, staff , and physicians.

> Sutter Davis Hospital onboards and trains new clinicians to develop a shared understanding of how the collaborative process works in the practice, including scope of practice and "mental buy-in" for the model.

The mentor and/or the practice leader should schedule meetings to discuss how the orientation process is going. The new-hire and the organization should work together to deter-mine when the new midwife can see patients independently. Depending upon the midwife's experience level, the orientation process may last one to three months or longer.

Schedule a meeting at the end of the orientation period to address these priorities:

• Review the orientation process and address any issues or questions

• Determine competence in outpatient and inpatient areas and identify areas that need additional support

• Plan goals for the coming year

• Pave the way for the annual performance appraisal

• Address Continuing Education needs/goals

    • Advanced skills

    • ACNM Annual Meeting

    • ACOG Annual Meeting

    • ACNM Midwifery Works Meeting

    • AMCB Modules

Consider offering the midwifery leader a resource to enhance onboarding such as The First 90 Days: Proven Strategies for Getting Up to Speed Faster and Smarter by Michael D. Watkins (2013) or The New Leader's 100-Day Action Plan: How to Take Charge, Build or Merge Your Team, and Get Immediate Results by George B. Bradt, Jayme A. Check and John A. Lawler (2016).

# Create a High-Performing Integrated Team

STEP 1 >  CULTIVATE THE COLLABORATIVE PROCESS

STEP 2 >  RECRUIT PRACTICE CHAMPIONS

STEP 3 >  INVEST IN ENGAGEMENT AND RETENTION

STEP 4 >  NURTURE THE TEAM

This section focuses on the outlining specific tasks to help you consciously cultivate the collaborative process in your organization. See ACOG's 2016 Report Collaboration in Practice: Implementing Team-Based Care for more information about the conceptual framework behind collaboration among physicians and nurse-midwives in obstetrics.

## Step 1 Cultivate the Collaborative Process

In practice, collaboration among midwives and physicians is a process and an outcome that develops over ti me. In a truly collaborative practice, midwives and physicians work together to bolster each other's expertise to provide safe, appropriate/effective, patient-centered care for women and their families.

Most maternity care providers fall along a spectrum of philosophies that range from the belief that pregnancy/birth is a normal and natural physiologic life event to the belief that pregnancy/birth is only normal aft er nothing has gone wrong. Each individual clinician develops their own philosophy based on their training and professional experiences. A healthy culture of collaboration ensures smooth delivery of care among clinicians along this spectrum while delivering clinically appropriate care to patients. In the absence of collaboration, differing philosophies between midwives and physicians may lead to miscommunication or tension, and in a worst-case scenario, antagonism.

**What Does Collaboration Look Like?**

The structure of effective and successful midwife-physician collaboration can take many forms, as described in section 1 of this guide. Recent research as well as a number of clinical resources extensively explore the characteristics and indicators of effective collaborative practice.  For a complete list of research and resources related to midwife-physician collaboration, see appendix 19.

To better understand the behaviors and best practices that support the collaborative process between physicians and midwives, PBGH interviewed a diverse group of practices and hospitals that embody collaborative practice and embrace the midwifery model. Based on our examination of the literature, interviews with successful collaborative practices, and the authors' clinical experiences, we developed one list of core characteristics present in all healthy midwife-physician collaborations:

1.  **Shared vision** — Interdisciplinary collaborative teams function best when they are working toward a united goal or vision. This vision can be as simple as "delivering woman-centered care."

2.  **Role clarity** — Provider roles within the institution are clearly defined and communicated; written practice guidelines clearly define the conditions that require consultation, co-management, or transfer of care to a physician.

3.  **Mutual respect** — The differences and overlap between midwifery, medical expertise, and clinical management are acknowledged, and each provider's unique skillset, role, and value is appreciated.

4.  **Accountability and accessibility** — Providers work within the agreed upon bounds of their roles/scope and make themselves available and approachable f or both formal and informal consultation.

"In the end we're all essentially hoping for the"In the end we're all essentially hoping for the  same thing, all wanting patient-centered care and same thing, all wanting patient-centered care and  helping to empower women, but we come at it helping to empower women, but we come at it  from different angles."from different angles."

— Midwife, Sutter Davis Hospital Midwife, Sutter Davis Hospital

# Create a High-Performing Integrated Team

5. **Effective communication** — Amicable and frequent communication, both formal and informal, among providers (e.g. during department, provider, and staff meetings; inpatient rounding; case review; or informal chats around the clinic/unit) is fostered.

6. **Influence** — Providers feel equally heard and represented at all levels of the organization. Ideally, a midwife holds a leadership position in the practice.

7. **Flexible and shared leadership of patient care** — Midwives and physicians view each other as partners with co-ownership of patient care. Providers are not territorial or competitive about caseload.

A combination of attitudes and behaviors—core characteristics that function as a practice's values—create a fertile foundation from which trust and effective collaboration can grow.

**Actions to Achieve Collaborative Practice**

The core characteristics of collaboration should exist in inter-personal relationships among clinicians and be embedded in the broader structures of your practice and/or organization. Sowing these core elements like seeds throughout all dimensions of your organization will help develop a collaborative culture and a positive care experience for patients and providers. As you think about how to foster the collaborative process, remember to consider all dimensions[19] of the practice:

• **Organization** — guidelines and structures that govern the joint relationship, including feedback on performance, leadership, and innovation

• **Process** — collective resources, rules, and tasks of the group, including information exchange, establishment of professional boundaries, accountability, and responsibility

• **Relationships** — factors and influences that affect how professionals interact, such as issues of accountability and attitudes

• **Environment** — regulatory, cultural, and political environments that influence the working relationship of professionals

Each practice interviewed sought to realize the core characteristics of collaboration in all dimensions of their organization. Below we explore specific tasks with examples from other practices that can help your organization embody the core characteristics of collaborative practice.

## Shared Vision

| Task | Identify a shared vision and ways to maintain/develop that vision so the work remains meaningful to all. |
|---|---|

*Use appendix 9 to develop vision, mission, and values and tips for who to engage in the process.*

Adventist Health Feather River developed a shared, value-based, mission statement that emphasizes "whole health and wellness."

At a small physician owned practice, collaboration is a value and practice established among the founding providers of the practice: "Our responsibility is to provide patients with relevant information — risks and benefits — and be there for them when they're making decisions; not taking a paternalistic approach. Collaboration isn't with just each other but also with our patients."

A Sutter Davis Hospital physician high-lights how their shared vision serves as the bond between medical and midwifery models of care: "In the end we're all essentially hoping for the same thing, all wanting patient-centered care and helping to empower women, but we definitely come at it from a different angle…"

19 Adapted from DC Smith's Midwife-Physician Collaboration: Conceptual Framework for Interprofessional Collaborative Practice: https://www.ncbi.nlm.nih.gov/pubmed/25297448

# Create a High-Performing Integrated Team

## Role Clarity

| Task | **Develop written practice guidelines with input from both physicians and midwives and the best available evidence. Review guidelines annually.** |
|---|---|

*See part 2, step 1 of this guide, "Define Roles and Responsibilities" and appendix 15, "Developing or Revising Written Practice Guidelines "for definitions and guidance.*

At Sutter Davis Hospital, physicians and midwives documented written practice guidelines to define roles and outline criteria regarding when care requires consultation, co-management, or transfer to a physician. In general, low-risk patients fall under midwifery care and high-risk patients are managed by physicians. "All those guidelines are set by collaborative care between doctors and midwives. We agree on what is needed and what is not needed for each patient category," describes one physician at Sutter Davis Hospital.

The group admits that communication and trust are essential to safely co-manage patients.

| Task | **Build in time for clinical orientation for any new hire to become familiar with written practice guidelines.** |
|---|---|

*See part 2, section 7, "Orient the New Midwife" for detailed steps and information to include.*

Sutter Davis Hospital onboards and trains new clinicians to develop a shared understanding of how the collaborative process works in the practice and acquire clinicians' "mental buy-in" for the model.

| Task | **Review and discuss tough cases at regular team meetings to ensure alignment between written practice guidelines and actual practice.** |
|---|---|

At Sutter Davis Hospital, the opportunity for review comes up at three separate meetings: department, provider, and midwifery meetings. One midwife describes, "a lot of [midwife and physician] conflict …comes from different beliefs and background on pregnancy, labor and delivery. The strength of the group that helps us get past that is the willingness to sit down and ask 'where does evidence land?' and 'where does belief system land?' We really hash out over and over on a clinical theme when we're in disagreement. [It's] frustrating but so beneficial. The willingness to keep having those conversations and seeing the bigger picture…"

# Create a High-Performing Integrated Team

## Mutual Respect

| Task | **Invest in team building as trust among peers serves as the foundation of respect.** |
|---|---|

*Part 3, step 4 of this guide, as well as appendix 14, "Strategies for Fostering Midwife & Physician Relationships" offer more suggestions about how to support team building.*

When Providence Medical Group - Everett switched to a collaborative model, they started hosting all-provider meetings for the first time. Leadership "put everyone in a room and did team-building exercises," explains a physician from Providence. "It's important to communicate with the person next to you. Ask, 'what do you love about what you do?' Learning about each other helps build relationships and ensure that everyone gets to speak up and help you hear other people's perspectives."

| Task | **Hire clinicians that value collaboration and have experience working with physician-midwife teams.** |
|---|---|

*See appendix 14, "Strategies for Fostering Midwife & Physician Relationships," as well as part 2, step 5 "Select and Hire the Right Candidate," and part 3, step 4 "Nurture the Team."*

During the hiring process, Kaiser Permanente screens midwives to ensure they are comfortable approaching and talking with physicians.

Sutter Davis Hospital will only hire physicians who have experience working with midwives.

Many practices recognize the importance of making good hires: As one physician at Providence Medical Group - Everett remarked, "be selective enough and make sure you get the right fit. It pays off in the long run."

| Task | **Explicitly state that conflict is normal and address it as it arises.** |
|---|---|

A small, physician-owned practice that delivers at a larger hospital along with four or five other practices, schedules meetings to address conflict directly with other delivering physicians at the hospital.

| Task | **Create a space at staff or department meetings to discuss challenges or tensions.** |
|---|---|

Sutter Davis Hospital hosts quarterly "collaborative practice" meetings with physicians, midwives, and charge nurses to hash out issues, hear different opinions, and review the evidence.

| Task | **Treat everyone as a competent and credible member of the team and the exchange of differing viewpoints as integral to patient safety.** |
|---|---|

Swedish Midwifery- Ballard named respect between physicians and midwives as the most important factor for building a healthy collaborative practice. One nurse observes that "having respect for each individual's practice is not about having the obstetrician in charge of the midwife. It's treating each other as collegial partners so they feel safe coming to each other when they need help."

| Task | **Express gratitude and publicly acknowledge the strength and contributions team members make to the practice.** |
|---|---|

Overwhelmingly, all providers interviewed expressed deep gratitude and appreciation for their physician/midwife counterparts. One midwife explains that "physicians [in our practice] honor the midwives hugely and vice versa!"

# Create a High-Performing Integrated Team

## Accessibility and Accountability

| Task | **Set up a shared office space (e.g. team pods) or situate physician and midwife clinics close to one another to promote effective communication and collaboration.** |

Providence Medical Group- Everett found that co-locating midwives and physicians into one clinic fostered a natural building of trust and collaboration among the team. As one physician describes, "once you're working side by side, you tend to communicate more cordially together. It's much easier to do a curbside consult — walk down the hall and ask, 'Hey I'm seeing your patient, what do you think I should do with them?' Being able to coordinate care that way has made a big difference to build trust."

| Task | **Develop quality improvement initiatives with joint physician and midwife leadership.** |

Establish an inter-professional quality improvement committee and joint "morbidity and mortality" reviews.

| Task | **Define responsibilities and accountability systems in order to establish trust in each other's knowledge, skills, and follow-through.** |

*See appendix 18 for sample midwife and physician meeting agenda.*

As a midwife at Swedish Midwifery- Ballard describes "I feel so supported here. Knowing that RNs and OBs have your back and are not antagonistic or working against you has contributed to all of us moving calmly in the same direction."

## Effective Communication

| Task | **Establish regular meetings and other feedback loops (e.g. huddles or debriefs, monthly midwifery and midwife-physician meetings) to address concerns and show appreciation.** |

*See appendix 18 for a sample midwife and physician meeting agenda.*

Constant communication is the norm on call shifts at Sutter Davis Hospital where one midwife and one physician are always present, and midwives notify physicians of any "pink flags" — issues with patient cases or their condition — as they con-verse throughout the day. This helps to make sure those patients are on the physicians' radar.

A nurse from Swedish Midwifery- Ballard explains, "We've worked a lot on the feedback loop between nurses and physicians. When there's an issue between a provider and nursing staff...the charge nurse is responsible for helping facilitate that conversation. We try to deal with things in the moment. At any time, any staff member can call a huddle or debrief to discuss what went well or what didn't go well and create the opportunity for both sides to give feedback."

| Task | **Provide opportunities for team communication training.** |

Several practices noted the Agency for Health Care Research's TEAM STEPPS training as a critical opportunity to build trust among providers. TEAM STEPPS includes multiple evidence-based tools for developing effective team communication in a variety of scenarios.

# Create a High-Performing Integrated Team

**Task** →

### Build trust among providers, as it is essential to good communication.

Work together to develop written practice guidelines and develop clear roles and responsibilities.

Learn a new skill together.

Invest in team building to build rapport.

**Task** →

### Create scripts for all staff about the role of midwives in the practice.
*See part 2, step 3 "Build the Brand and Develop a Communication/Marketing Plan."*

Providence Medical Group - Everett created scripts for their front desk and patient-facing staff in order to educate new patients about the benefits of midwifery, group prenatal care, and the care pathways available to them.

**Task** →

### Model open and free-flowing communication that empowers all staff. Craft messaging to staff that reflects a collaborative and supportive environment.

When hiring midwives, Kaiser Permanente assesses their understanding of collaborative practice and knowledge of how to talk to physicians. When introducing midwives, they focus on communication that "flattens the hierarchy." As the Director of Midwifery notes, "having meetings, especially together as a group, not just as midwives, but with the physicians we work with help address issues as they arise."

## Influence

**Task** →

### Carve out a distinct leadership position for midwifery (e.g. Chief Midwifery Officer) and attribute administrative FTE to the role.
*See part 2, section 2 "Build the Model" for more information about the role of a midwifery leader.*

When Swedish Midwifery- Ballard expanded midwifery from one campus to more than 40 midwives across three campuses, they established a new leadership role—medical director of midwifery. The director has protected administrative time to represent the interests and voices of midwives in various Swedish committees and meetings.

**Task** →

### Define decision-making processes and consider decision-making by consensus

At Sutter Davis Hospital, midwives are directly involved in department meetings and high-risk meetings regarding operation changes in clinical management (e.g. the final decision of how to manage patients with gestational diabetes).

According to the Director of Women's Health at Kaiser Permanente, "Midwives need to have a voice at the table, need to be heard, and need to have a leadership role."

# Create a High-Performing Integrated Team

**Task**

### Define and communicate the process for proposing and implementing practice innovations.

In all practices, midwives spearheaded innovations in practice protocol by presenting the proposed changes with sufficient evidence at designated provider or staff meetings. Innovations championed varied from staffing schedules to clinical practice changes and helped create a sense of ownership and trust.

**Task**

### Encourage attendance to all-staff meetings.

Sutter holds a department-wide meeting with staff and providers once a quarter to continue to create the space to hear different perspectives on bigger topics. According to one physician, "It's a very dynamic model, and everyone usually feels like they are empowered to make changes in what our general practice is and provide input at the point of care as well."

## Flexible and Shared Leadership of Patient Care

**Task**

### Implement similar financial awards and advantages and access to resources to prevent competition among providers.

A small physician owned practice describes their reimbursement philosophy: "Our practice is unique, as we take our entire income and divide evenly three ways. We don't do bonuses at the end of the year based on productivity. We divide everything equally among providers. Some providers are doing more than others in different months but we have a general understanding that no one is slacking…"

**Task**

### Promote behaviors and/or initiatives that increase inclusivity and belonging.

One midwife at Sutter Davis Hospital noted that she feels "able to seek my colleague's opinion at will—whether nurse or physician—and have a reasoned discussion and come up with a plan…We work very hard as a team, both in the office and on call. When it works, it works well, and everyone is very collegial."

# Create a High-Performing Integrated Team



## Step 2
### Recruit Practice Champions

Identify on-the-ground physician champions for midwifery care; they may be different people than the champions involved in the decision making and strategic development. You need people who are respected clinically and are practice "influencers" to lead and motivate staff in the development and maintenance of the collaborative process.

## Step 3 Invest in Engagement and Retention

A hospital in a rural community had a midwifery practice with 11 midwives and a very strong reputation. They had excellent outcomes and won the ACNM Gold Commendation Award. But the hospital administration changed, and the midwives were no longer welcome at the table. As a result, eight midwives left the practice. Women in the community were outraged and wrote letters to the hospital administrators and letters to the editor of the local newspaper. Even when the hospital recruited additional midwives, many didn't stay for long. Today, the practice still only has a few midwives, much to patients' disappointment.

Plan to measure employee engagement in your organization every one to two years and develop a plan for retention of midwives with a specific focus on the areas we have identified in step 1. An effective retention plan starts in the recruitment process and needs leadership involvement. Highly engaged midwives are less likely to leave and are more likely to be productive. In the story above, the cost of turnover has been tremendous.

## Step 4 Nurture the Team

For collaboration to succeed, all midwives and physicians must support and believe in the process. Consulting physicians should be supportive of midwifery and the collaborative process and be willing to model healthy communication habits.

From practice interviews, we learned physicians with positive, trusting relationships with midwives spend less ti me on super-vision activities. Clinician attitude is essential to the success of healthy collaboration, and you may have to educate physicians and nurses in an existing practice about how to practice and communicate collaboratively with midwives. For physicians who have never worked with midwives, team- and relation-ship-building exercises are particularly important in building trust and familiarity (see step 1 of this guide). If hiring new clinicians, physicians most prepared and interested in practicing with midwives have generally worked with them previously in a residency program or another practice. Many universities have midwives on faculty who teach medical students and residents about normal prenatal care, labor, and birth.

"The midwives were part of integrating OBs as they were first coming on and making sure physicians don't just feel comfortable supporting midwives but really believe that midwives offer a different type of service that adds value."

— Midwifery Director at Swedish Midwifery- Ballard

# Create a High-Performing Integrated Team

Consider creating ti me for a staff retreat to reinforce relationships, build trust, and work on communication. Use retreats as an opportunity to revisit your vision, mission, and values and other foundational agreements; explore strengths-based leadership models; and engage staff in the success of the practice.

As discussed in step 1 of this guide, good communication is important for patient safety and satisfaction as well as provider fulfilment. Research suggests the effective communication is "respectful, clear, direct, and explicit."[20] Create ti me and space for relationships to develop among col-leagues and for opportunities to address conflicts.

All of the above tasks increase the likelihood that each member of the team feels safe to communicate directly with one another. Refer to appendix 14, "Strategies for Fostering Midwife & Physician Relationships" and appendix 18,

"Sample Midwife or Provider Meeting Agenda Template" for additional information.

One practice describes all the meetings and opportunities for providers and staff to hash out conflict. These could include the following:

- A hospital performance improvement committee that meets once a month to review any issues from patients who had a bad/unexpected outcome or for anyone who wants to bring up an issue with what another provider has done

- Department meetings where just the physician and midwives can bring up issues

- Collaborative practice meetings where all staff get together and bring up issues

- A hospital call once a month that focuses on just birthing center issues

Practices that provided specific activities and frameworks to structure the midwife-physician relationship found greater physician satisfaction than those practices who did not strategically cultivate the midwife-physician relationship.

20 Audrey Lyndon, Marya G. Zlatnik, and Robert M. Wachter, "Effective Physician-nurse Communication: A Patient Safety Essential for Labor and Delivery," American Journal of Obstetrics and Gynecology, 2016: 205(2), 91-96. doi:10.1016/j.ajog.2011.04.021.

# Create a Plan to Monitor and Sustain Success

**STEP 1 >** ENSURE FINANCIAL SUCCESS

**STEP 2 >** MONITOR OUTCOMES AND QUALITY INDICATORS

**STEP 3 >** INTEGRATE LEARNERS INTO YOUR PRACTICE

**STEP 4 >** RECOGNIZE AND CELEBRATE SUCCESS

*You should be able to assign value to midwives' work and impact on the practice in a way that resonates with practice clinicians, leadership, and financial officers. This section will take you through the steps to monitor and report on financial and clinical outcomes.*

## Step 1 Ensure Financial Success

To accurately track financial data, have a separate cost center for midwifery. Whether you name the practice and use the brand to define the entity or call it "the midwifery department" or "midwifery division," tracking expenses, income, and volume will help you evaluate the success of the practice.

Include the coding/billing team and the finance team right from the start as key stakeholders (see part 1) to build a solid foundation for financial success.

### Coding and Billing

Sound financial practices, such as these, are key to the suc-cess and sustainability of a midwifery practice:

• Coding or billing accurately and effectively

• Tracking midwifery-specific billing and collections

• Having a mechanism to account for fixed and variable expenses

• Monitoring downstream revenue

In a physician office, monitoring downstream revenue may include tracking referrals for ultrasounds, consultations, cesarean sections, and gynecological procedures. In a hospital-based practice, downstream revenue may include prenatal testing such as laboratory and ultrasound, facility fees for triage or emergency department visits, and facility fees for hospital admissions, including delivery.

### Invest in Midwifery Coding Abilities

Midwives will come to your organization with varying levels of understanding about coding for the services they deliver. Since coding is not among the core competencies for basic midwifery practice, most midwifery education programs put little focus on the finer details of coding. Start by administering an assessment of coding knowledge to determine what support your new-hire needs to code effectively. Although many electronic health records (EHRs) link documentation with coding, midwives should understand the value of coding correctly and coding compliance issues.

To support midwives coding and billing abilities, consider the following:

• Providing a basic coding orientation from your coding/billing team. Include ACNM coding resources.

• Providing EHR education about appropriate documentation required for coding in inpatient and outpatient settings.

• Identifying a midwife "coding partner" to serve as a resource when questions arise. Timely feedback can rein-force good coding habits.

• Providing access to coding and billing education opportunities offered by ACNM and ACOG. The ACNM Annual Meeting or Midwifery Works Conference offer resources. ACOG offers in person education as well as online resources.

# Create a Plan to Monitor and Sustain Success

- Offering a formal coding assessment or site-specific coding training by a certified professional coder. Contact ACNM for a referral.

- Creating a standing agenda item about coding and billing in practice meetings to introduce new learning or reinforce good coding habits.

Refer to An Administrative Manual for Midwifery Practices, step 6 and the ACNM document, "Getting Paid."

**Tracking Volume and Productivity**

Practices vary in the ways they track productivity. Tracking volume indicators will help you monitor the financial details of your practice. Some monitor volume while others col-lect Relative Value Units (RVUs). Refer to An Administrative Manual for Midwifery Practices, step 6 for more information. Assessing the productivity of a midwifery practice helps you understand the value they contribute to the organization.

If you do not have a mechanism in place to track data, appendices 23-27 provide guidance and tools you can use. Save and share these documents in a "shared folder" that all midwives can access. These resources include the following:

- Overview of Data Collection Tools for Midwifery Practices (appendix 20)

- New OB Log (appendix 21)

- Patients Due Log (appendix 22)

- Delivery Log (appendix 23)

- Practice Statistics Spreadsheet (appendix 24)

Use these templates to prepare for participation in the ACNM Benchmarking Project (discussed in step 2).

In California, the California Maternal Quality Care Collaborative's Maternal Data Center makes tracking quality and outcomes data easy by linking patient discharge data hospitals already collect with birth to certificate data to de-liver real-time performance metrics. Currently they only offer services to hospitals.

**Midwifery Practice Volume Indicators**

Appendices 21-24 outline volume and outcome indicators you can track in detail. The list below highlights what you might consider tracking. When feasible, ask your IT department to hardwire your EHR or billing system to set up automatic tracking of these indicators:

- New obstetric visits

- Return obstetric visits

- Number of patients due each month

- Loss rate (percent of patients who started with the practice

- but moved or switched providers)

- Deliveries:
  - Total deliveries
  - Nulliparous Term Singleton Vertex (NTSV) deliveries
  - NTSV cesarean sections
  - Total vaginal deliveries
  - Operative vaginal deliveries
  - Total cesarean section deliveries
  - Total primary cesarean section deliveries
  - Total trial of labor after cesarean (TOLAC)
  - Successful TOLAC

- Hospital length of stay (LOS)

- NICU admissions

- Number of patients transferred to medical management

- Number and percent of patients attending their postpartum visits

- Number of problem-focused visits

- General practice no-show rate

- Relative Value Units (RVUs) (see An Administrative Manual for Midwifery Practices, page 79)

This information will help you set and monitor practice volume goals. Keep current with data collection and share key volume metrics at your monthly midwifery practice meetings or with senior leadership. Consider a monthly report card or annual report that includes both volume and outcome data. See appendix 25 for a sample annual report.

# Create a Plan to Monitor and Sustain Success

**Prepare and Share Financial Reports Monthly or Quarterly**

Develop an initial budget for the midwifery practice. You can use the pro forma developed in part 1 of this guide. Collect input and feedback from midwives, once onboard. Not every member of the team will be interested in budget development on an ongoing basis, but every midwife should understand the budget process and how they contribute to the financial success of the organization.

Next, develop a report that summarizes the financial picture. Once your organization has a mechanism to track midwifery specific revenue and expenses, you need a mechanism to report this information. Some organizations already have complex monthly reports that the finance team compiles for each department. Otherwise create a simple revenue and expenses report. An Administrative Manual for Midwifery Practices has samples of a pro forma income statement, pro forma cash flow statement, and balance sheet on pages 34-35.

Be sure to introduce and educate all midwives about these reports. Often, only the practice leader has access to these reports. Transparency and the opportunity to learn and give feedback about the financial reports empowers midwives to be involved and more engaged in increasing revenue and cost savings.

Finally, develop a standing meeting agenda item about the financial reports monthly or quarterly. Often, volume and outcome indicators are discussed, but not the financials. Some midwifery practices have found themselves blindsided when they suddenly learn that their practice is deeply in the red. Regular review of these reports helps keep every member of the team informed. You can discuss questions such as "When can we add the next midwife?" more realistically when everyone is better aware of the impact that adding a midwife will have on the practice's finances.

## Step 2 Monitor Outcomes and Quality Indicators

The midwifery model can help a practice and hospital achieve high-quality outcomes commonly measured and reported (e.g. episiotomy rates, NTSV C-section rates). Every midwife should understand and engage in data collection to help the practice remain focused on excellence. Refer to An Administrative Manual for Midwifery Practices, step 10, "Quality Improvement and Data Collection."

The ACNM Standards for the Practice of Midwifery, Standard VII states, "Midwifery care is evaluated according to an established program for quality management that includes a plan to identify and resolve problems. The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.

2. Provides for a systematic collection of practice data as part of a program of quality management.

3. Seeks consultation to review problems, including peer review of care.

4. Acts to resolve problems identified."

Participating in a comprehensive quality management process at the practice or organizational level is every mid-wife's responsibility. Quality management includes quality improvement (QI), quality assurance (QA), and peer review. Collaborate with the hospital's quality department and inpatient leadership team to familiarize yourself with current QI projects. Midwives can serve as effective leaders of QI initiatives in the practice, so it is important to identify opportunities for their participation. An Administrative Manual for Midwifery Practices, pages 132-137, provides an overview to the quality management process.

Transparency and the opportunity to learn and give feedback about the financial reports empowers midwives to be involved and more engaged in increasing revenue and cost savings.

# Create a Plan to Monitor and Sustain Success

**Clinical Outcomes and Quality Data**

Data collection and reporting is the foundation of all quality improvement efforts. Tracking and reviewing data is an essential and ongoing component in delivering excellent, high-quality care.

If you are a physician practice preparing to integrate mid-wives, you may already have a mechanism for tracking quality measures for each provider. Many physician practices leave that work to the hospital quality department. Seek greater understanding of what quality measures health plans monitor and what data is publicly reported in your state. Note that value-based payment, or connecting reimbursement to quality and outcomes, efforts are growing.

**Inpatient Outcome and Quality Measures**

Every hospital quality department has a set of perinatal core measures that they monitor and report. Perinatal providers should know these measures and how they individually con-tribute to a safe perinatal environment.

The Joint Commission requires most hospitals to report NTSV C-section rates. Leapfrog collects and publishes self-reported hospital quality data on NTSV C-section rates, early elective deliveries, and episiotomies. Check out Leapfrog for rankings from reporting hospitals in your community.

California publishes annual hospital quality data on NTSV C-section rates, episiotomy rates, breastfeeding rates, and the availability of vaginal birth after C-section (VBAC) on www.calhospitalcompare.org.

**Outpatient Outcome and Quality Measures**

All health plans report data annually through the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) program. HEDIS general measures and physician specific measures are relevant to midwives. Prenatal and Postpartum indicators require that a new obstetric visit within 42 days of patient request and that a postpartum visit occurs 21 to 56 days after birth. Consumers can access NCQA data through Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, a public/private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

The California Value Based Pay for Performance (VBP4P) program is the largest alternative payment model in the U.S. http://www.ncqa.org/hedis-quality-measurement/pay-for-per-formance. Providers should know what data they need to collect for payment and, if possible, modify the EHR to assist in the process.

**ACNM Benchmarking Project**

Every practice should participate in the ACNM Benchmarking Project. Developed with sponsorship from the Service Director's Network (now the Midwifery Business Network Caucus), the ACNM Benchmarking Project provides a mechanism for organizations to share volume and outcome data from their midwifery practices which are benchmarked against similar practices nationally. ACNM benchmarking allows the user to enter anywhere between six data points to over 50 data points about their practice thus creating tracking and reporting consistency among all midwifery practices. The six mandatory questions for participation include:

- Total number of vaginal births

- Number of primary cesarean births

- Number of repeat cesarean sections

- Number of midwifery FTEs

- Practice name and mailing address

- Contact person, phone number and email address

ACNM benchmarking participants who meet certain quality criteria are eligible for acknowledgment for the ACNM Triple Aim Best Practices and Four Core Best Practices awards. Participation is a valuable way to track and communicate about the amazing quality your midwifery practice provides. Refer to An Administrative Manual for Midwifery Practices, page 137, for more information.

# Create a Plan to Monitor and Sustain Success

**Patient Satisfaction and Experience**

Midwives build close, trusting relationships with women during one of the most vulnerable ti mes of their lives, and you should track their impact on patient experience. Most hospitals formally measure patient satisfaction using a nationally standardized tool, the Hospital Consumer Assessment of Provider and Systems (HCAHPS), which is also referred to as CAHPS® Hospital Survey. The HCAHPS Survey contains 32 questions and 21 patient perspectives on care and patient rating items that encompass key topics ranging from communication with providers to responsiveness of hospital staff. The survey also includes patient demographic items for adjusting the patient mix across hospitals.

Consumers can access patient satisfaction data about local hospitals, and for many women, these results influence the decision they make about where to give birth. Go online for more information about HCAHPS.

HCAPHS survey items that midwives can positively impact include nurse and physician communication (highlighted by the collaborative relationships between midwives and physicians), staff  responsiveness, pain management, and discharge information.

Consumers interested in publicly reported quality data can compare hospitals in their community by visiting: https://hospitalrating.org/. Click on your state and see what patients are saying about your facility.

**Develop a Peer Review Process**

According to ACNM, "participating in peer review is considered a professional responsibility." ACNM has developed a list of tools to assist you in developing an affiliate peer review program. See also An Administrative Manual for Midwifery Practices, page 132, "ACNM Standards for the Practice of Midwifery."

Including a midwife in the practice and/or hospital's peer review committee ensures that the midwife's perspective and philosophy are represented in the review of any obstetrical or gynecological peer review cases. Midwives can serve as effective leaders of QI initiatives in the practice or hospital.
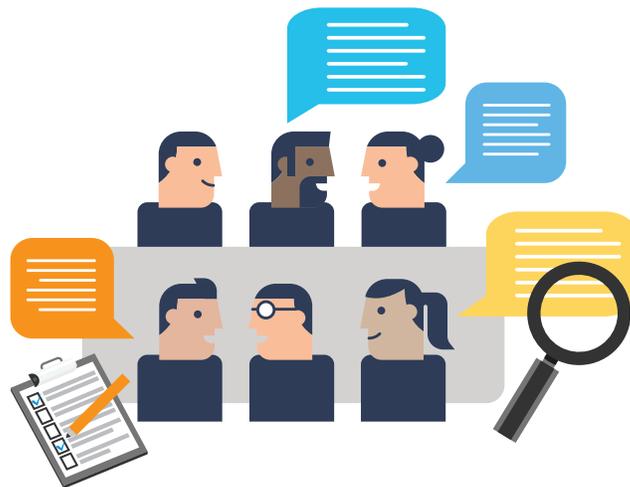
According to ACNM, "participating in peer review is considered a professional responsibility." ACNM has developed a list of tools to assist you in developing an affiliate peer review program.

# Create a Plan to Monitor and Sustain Success

## Step 3 Integrate Learners into Your Practice

We know that there are challenging women's health care workforce issues in our future. As part of our commitment to growing future maternal health clinicians, we should be thoughtful about providing opportunities for precepting midwifery students, medical students and residents.

In general, a practice must be well-established and stable before opening the door to learners. Once you think you're ready, initiate a discussion with midwives, physicians and administrators about next steps. You may decide to work with a local university midwifery education program or a distance learning program to precept midwifery students. An Administrative Manual for Midwifery Practices, step 11, provides detailed information about clinical precepting for students. In addition, appendix 11.1 offers a checklist for CNM/CM students and appendix 11.2 provides a clinical evaluation tool form. Additional resources about clinical teaching are available on the ACNM website at http://midwife.org/Preceptors.

Midwives have also long been successful as a part of training for medical providers. The ACNM Medical Education Caucus is a network of midwives who teach medical students and residents and can off er additional resources. Investing in the education/precepting of medical students and residents helps midwives teach the value of midwifery care, model collaborative practice, and develop the next generation of consultants.

Ideally, all practices will participate in interprofessional education, where medical trainees and midwifery students learn side-by-side in the clinical setting. Teaching the culture of collaboration from the start of a student's training will more successfully prepare them to practice collaboration through-out their careers.

## Step 4 Recognize and Celebrate Success

It has taken a lot of work to get here and you should make ti me to appreciate the fruits of your labor. Recognize opportunities to celebrate success. Celebrate achieving and maintaining high quality outcomes and growth with the whole staff . Call out particularly good work at staff meetings. Celebrating success fosters camaraderie and supports a positive work environment.

When the Swedish Midwifery- Ballard practice was recently recognized for quality through ACNM, the midwives acknowledged nursing staff as well saying, "We could not have achieved this without you."

# Conclusion

Successfully integrating midwives into your physician or hospital practice involves many key stakeholders and thoughtful planning. Throughout this guide, numerous links, and extensive appendices, you will find valuable recommendations and resources. Case studies of best practices and challenges give you additional information how to increase the likelihood of success. As with many endeavors, having an experienced consultant or coach can help you keep the initiative moving and anticipate and remove potential barriers to success. We wish you the very best on your journey to integrate midwives into your organization.

# Acknowledgements

## About Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health (PBGH) is a non-profit coalition representing nearly 70 member organizations from the public and private sector member organizations. PBGH's mission is to be a change agent creating increased value in the healthcare system through purchaser collaboration, innovation, and action, and through the spread of best practices. They leverage the purchaser voice to trans-form the delivery of healthcare and promote policies that advance value-based care at the federal and state level. Current initiatives focus on high cost high need patients, better maternity care, care coordination and primary care access, and payment reform.

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# Acknowledgements

# Glossary of Common Terms

**ACNM**
American College of Nurse-Midwives, the professional association for Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs)

**ACOG**
American College of Obstetricians, the professional association for Obstetricians and Gynecologists (OB/GYNs)

**Call**
Provider availability to patients for telephone calls and inpatient services. Call may be provided in the hospital or out of the hospital. If a provider is on call from home, they must be able to get to the hospital within a timely fashion

**Caseload**
Patients who are assigned to a practice, a midwife, or a physician. In some practices the patients are shared by all providers (shared caseload), while in others there is a separate midwifery caseload and physician caseload.

**Collaboration**
A process involving mutually beneficial active participation between autonomous individuals whose relationships are governed by negotiated shared norms and visions. (ACOG 2016)

**Co-management**
The process whereby a CNM or CM and physician jointly manage the care of a woman with medical, gynecologic, or obstetric complications or a newborn. (ACNM 2014)

**Consultation**
The process whereby a CNM or CM who maintains primary management responsibility for the woman's care seeks the advice or opinion of a physician or another member of the health care team. (ACNM 2014)

**Credentialing**
The process by which a hospital or health plan reviews and validates a provider's qualifications and career history including their education, training, licenses, and specialty certificates. Once a provider's credentialing is approved, they can apply for privileges to practice or be paid by a health plan.

**Gynecological services**
The provision of annual exams, health screenings, and treatment involving women's reproductive care outside of the maternity cycle.

**Inpatient services**
Services that are provided in a hospital setting. For a mid-wife, this may include triage, labor management, delivery, postpartum, and newborn care.

**Medical management**
The process whereby the midwife directs or refers the woman to a physician or another health care professional for management of a particular condition or aspect of care.

**Midwife**
For the purposes of this guide, a women's health practitioner with certification recognized by a state's accrediting body. In California, they are Certified Nurse-Midwives.

**Midwifery model of care**
A model of care based upon the foundation that pregnancy and birth are physiologic life events.

**Obstetric services**
A term for pregnancy and delivery services, also referred to as maternity care.

**Outpatient services**
Services that are provided in an outpatient setting such as an office or clinic. Outpatient services can include ultrasound and laboratory services.

**Physician oversight/supervision**
A requirement by either a state, hospital, or health plan that a physician has the responsibility to oversee or supervise a mid-wife. There is no federal requirement for physician oversight/supervision. In California, this requirement is present yet there is no clear definition of what time or activities are required.

**Practice**
A group of providers and support staff that provide care to patients. The practice can provide care in both outpatient and inpatient settings.

**Practice model**
A way to describe the caseload and staffing structure of a practice. For example, if a practice has a defined set of patients that midwives are responsible for, this may be referred to as a midwifery caseload model. If midwives provide inpatient care as 1st call for every patient, regardless of who sees the patient for prenatal care, this may be referred to as a shared caseload, midwifery 1st call model. There is no consistent use of definitions for "practice models," and in this document, we have attempted to provide some structure to the concept.

**Practice setting**
A way to describe the employment structure of a practice. For example, if midwives are employed by a hospital we refer to this as a hospital-based practice. If a midwife is employed by a Federally Qualified Health Center (FQHC) we refer to this as a community-based practice.

**Scope of practice**
The types of care provided by a midwife in a practice setting. Midwifery as practiced by certified nurse-midwives (CNMs®) and certified midwives (CMs®) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include the independent provision of primary care, gynecologic, and family planning services; preconception care; care during pregnancy, child-birth, and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. (ACNM 2012). The scope of practice of a midwife may vary depending on her experience, physician relationships, and organizational requirements.

**Top of license**
Refers to a midwife being able to provide care at the highest level that her certification, education, experience, and state regulatory requirements allow. According to federal law, midwives are independent practitioners. Some states, such as California, require physician oversight/supervision.

**Written practice guidelines**
Written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.

# List of Appendices

Appendix 1. Midwifery Practice Models

Appendix 2. CNM Practice Financial Tool

Appendix 3. Sample Concept Paper

Appendix 4. Business Plan Template

Appendix 5. Critical Questions for Key Stakeholders

Appendix 6. Sample Agenda for Initial Key Stakeholder Meeting for Integrating Midwifery into your Organization

Appendix 7. Sample PPT for Key Stakeholder Initial Meeting

Appendix 8. Potential Action Items for Key Stakeholders

Appendix 9. Vision, Mission and Values Worksheet

Appendix 10. SWOT Analysis

Appendix 11. Sample Foundational Agreements

Appendix 12. Sample Midwifery Practice Philosophy of Care

Appendix 13. Resources for Recruiting Midwives

Appendix 14. Strategies for Fostering Midwife & Physician Relationships

Appendix 15. Developing or Revising Written Practice Guidelines

Appendix 16. Branding and Marketing Midwives

Appendix 17. Building Strategic Partnerships to Enhance Practice Success

Appendix 18. Sample Midwife or Provider Meeting Agenda Template

Appendix 19. Key Resources - Midwifery and Collaborative Practice

Appendix 20. Overview of Data Collection Tools for Midwifery Practices

Appendix 21. New OB Log

Appendix 22. Patients Due Log

Appendix 23. Delivery Log

Appendix 24. Practice Statistics Spreadsheet

Appendix 25. Sample Annual Report

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