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AN INTRODUCTION TO MIDWIFERY CARE AND OUT-OF-HOSPITAL BIRTH IN WASHINGTON STATE

By
Kristin Eggleston, LM, CPM, Sunrise Widwifery. **ViviAnne Fischer**, MA, CPM, LM, Instructor, Department of Human Development, WSU. **Gina Ord**, MS, OTR/L, Assistant Professor, WSU Extension. **Elizabeth Soliday**, PhD, Associate Professor, Human Development, WSU Vancouver

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Abstract

Having up-to-date information on available options for birth care helps women and their families make decisions that suit them best. In this article, we aim to inform families, family support professionals, educators, and health policy makers on midwife-attended, out-of-hospital (OOH) birth care, because little reliable information is available to the public. In recent years, the numbers of OOH births have been increasing, and in 2012, about 1.4% of U.S. women planned OOH births, with more than twice that percentage in Washington State, at 3.4% (MacDorman et al. 2014). U.S.-based studies have shown that midwife-attended, OOH birth is safe and effective for low-risk women, and families appreciate receiving personalized care in a familiar setting. We discuss additional considerations, including costs, to help families and others as they make this important life decision.

Midwives and Out-of-Hospital Births

Midwives are women's health care clinicians who provide holistic and comprehensive prenatal, birth, and postpartum care for women with healthy low-risk pregnancies. Some midwives practice in obstetric clinics and hospitals. Others practice independently, and they assist women in planned out-of-hospital (OOH) births exclusively. Although all midwives share the same general care philosophy, this publication focuses on those with OOH practices.

Care by midwives is *holistic,* focusing on physical, emotional, and spiritual health in the context of culture and family. Midwives offer all the same screenings, tests, and monitoring one would receive from a physician. Clients often have 24-7 direct access to their midwife via cell phone or pager when labor begins or if any concerns arise.

Generally, midwives aim to build trusting, respectful relationships with their clients, and value open communication. This begins with involving women in deciding on any screening, test, or intervention the midwife can offer. Through informed consent, midwives inform women of the known risks and benefits of any tests or treatments they may undergo. Clients are encouraged to consider how their beliefs, values, and preferences factor into the treatments they may accept.

The midwife supports the birthing woman throughout the process in making decisions for her and her baby's health, and in listening to her body and instincts.

Midwives provide care throughout pregnancy, during birth, and in the early weeks postpartum. Prenatal visits with an OOH midwife often last 30 minutes to an hour. In those visits, clients receive routine prenatal and postpartum care, which may include any or all of the tests or procedures in Table 1.

Table 1: Screenings and Procedures Routinely Provided by Midwives

- Mother's vital signs
- Fetal growth
- Fetal heart rate
- Protein/glucose screening (urine test)
- Blood chemistry
- Sexually transmitted infection screening
- Fetal genetic disorder screening
- Gestational diabetes screening
- Group B strep test
- Full physical exams
- Referrals for ultrasounds, including dating, anatomy scans, and follow-up scans
- Referral to other providers as needed
- Pap smear

In labor and delivery, midwives aim to provide an optimal environment for normal physiologic (often called "natural") birth. Supporting physiologic birth involves creating the conditions that allow women to access their own inborn capacities to give birth (Buckley 2015). This involves:

- Minimizing intrusions
- Providing continuous, one-on-one care and support
- Minimizing interventions
- Allowing women to move freely
- Allowing food and fluid intake as desired
- Allowing women to move in or out of water (showers, baths)
- Granting freedom to find effective birthing positions

Research studies involving large numbers of women have indicated that physiologic birth supported by licensed midwives is associated with lower use of procedures such as labor induction, episiotomy, and cesarean birth. Lower use of birth procedures is correlated with fewer maternal and newborn complications (Buckley 2015; Sakala and Corry 2008).

In a home birth, the midwife monitors the mother and baby's well-being throughout labor. Midwives bring routine birth care and emergency supplies, such as oxygen, neonatal resuscitation equipment, IV fluids, antibiotics, anti-hemorrhagic medications, sterile instruments, and tools for a full newborn exam. Upon arrival, the newborn stays with the mother to bond for at least an hour, uninterrupted. Before the midwife leaves the home, she does a full newborn exam and makes sure the mother and baby are stable.

Postpartum care for the mother and newborn occurs in the comfort of the mother's home. Midwives check on a mother's and baby's general well-being and perform routine newborn screenings (hearing, pulse oximetry for congenital heart defects, metabolic screens). They also assist with breastfeeding as needed. Newborns delivered by midwives had initial breastfeeding rates of 99.6% in a study of almost 17,000 planned home births that occurred between the years 2004 to 2009. At six weeks post-partum, 97.7% of newborns were at least partially breastfed, and 86.0% were exclusively breastfed (Cheyney et al. 2014).

In Washington State, licensed midwives are required to submit hospital transport plans for births that may become complicated or change from low- to high-risk and share these plans with their clients (WDOH 2016). Hospital transport involves taking a mother to the nearest hospital where the on-call obstetrician assumes care. Two recent studies have shown that the vast majority of women planning OOH birth succeed in doing so. Cheyney et al. (2014) reported that 89.1% of women who planned home birth gave birth at home. Women who transferred generally did so during labor, and they transferred for non-emergency reasons including prolonged labor, desire for pain relief beyond what the midwife could provide, and exhaustion. Birth center statistics look much the same: in 15,574 U.S. birth center births, 87.6% of women delivered at the center. Less than 1% transferred for emergencies, with most transfers for non-emergencies such as prolonged labor (Stapleton et al. 2013).

As has been discussed, OOH birth is suited for healthy women and pregnancies free of significant complications. As a matter of course, midwives interview new patients about their health history to correctly assess safety for OOH birth.

If the midwife determines that OOH is not an appropriate option, then the midwife will refer the woman to the correct type of provider or facility. *Pre-existing conditions* that would preclude OOH birth include seizure disorder, HIV infection, Type 1 diabetes, or significant social or other disability that would warrant the specialized services available only in a hospital. Other concerns precluding OOH birth may arise during pregnancy, such as pre-eclampsia (a type of high blood pressure), placenta previa (placenta covering the opening of the uterus), or abnormal fetal development.

On occasion, complications may develop during labor or just after birth. Some complications occur with little warning, and others are linked to risk factors that can be seen during pregnancy or around the time of labor onset. For this reason, midwives assess their patients throughout pregnancy and birth for any concerning developments, and they have detailed plans for transporting patients to the hospital. Common complications that may require hospitalization for birth include thick meconium (baby stool) in the amniotic fluid, a long labor with the baby staying high or getting stuck in the birth canal, or an abnormal fetal heart rate. Should these or other risk situations arise, the midwife explains the problem and treatment plan to the parent(s), she initiates and facilitates transport to the hospital, and the birth or postpartum care takes place in the hospital. In Washington State, licensed midwives are required to submit hospital transport plans to ensure safe, efficient, and professional transfer of care should it become necessary.

Education Requirements for Midwives

In the U.S., there are two main pathways to becoming a midwife—either by completing nursing training followed by specialized midwifery training or focusing solely on midwifery (Table 2).

Table 2: Nursing and Non-Nursing Routes to Becoming a Midwife

Nursing Route (CNM)	Non-nursing Route (CPM, LM)
• Nursing degree (RN, BSN) + additional midwifery training • 90% work in hospitals • Have full prescriptive rights • Care for women across the life cycle	• Midwifery training only or naturopathic doctor (ND) + midwifery • Have education, supervised clinical experience, and rigorous exams • Provide care throughout pregnancy and up to 6 weeks after birth • Able to administer certain drugs and devices appropriate for OOH care

Abbreviations: CNM – certified nurse-midwife; RN – registered nurse; BSN – Bachelor of Science in nursing; CPM – certified professional midwife; LM – licensed midwife

Washington State's Department of Health maintains the highest level of education and credentialing requirements for midwifery in the country, including (WDOH 2016):

- Graduation from an accredited three-year school
- Participation in $\geq$ 100 births
- Providing primary prenatal care for $\geq$ 50 women during all stages of pregnancy
- Earning passing grades on national and state examinations
- Submitting written plans to transport OOH births to hospital if birth becomes complicated
- Receiving continuing education units yearly after initial licensing

Figure 1 shows the distribution of birth centers, LMs, and CNMs in Washington State.

In contrast, *lay midwives* are uncertified or unlicensed midwives who are educated through informal routes such as self-study or apprenticeship. Lay midwives are not licensed and cannot advertise, accept compensation for midwifery services, or bill medical insurance companies.

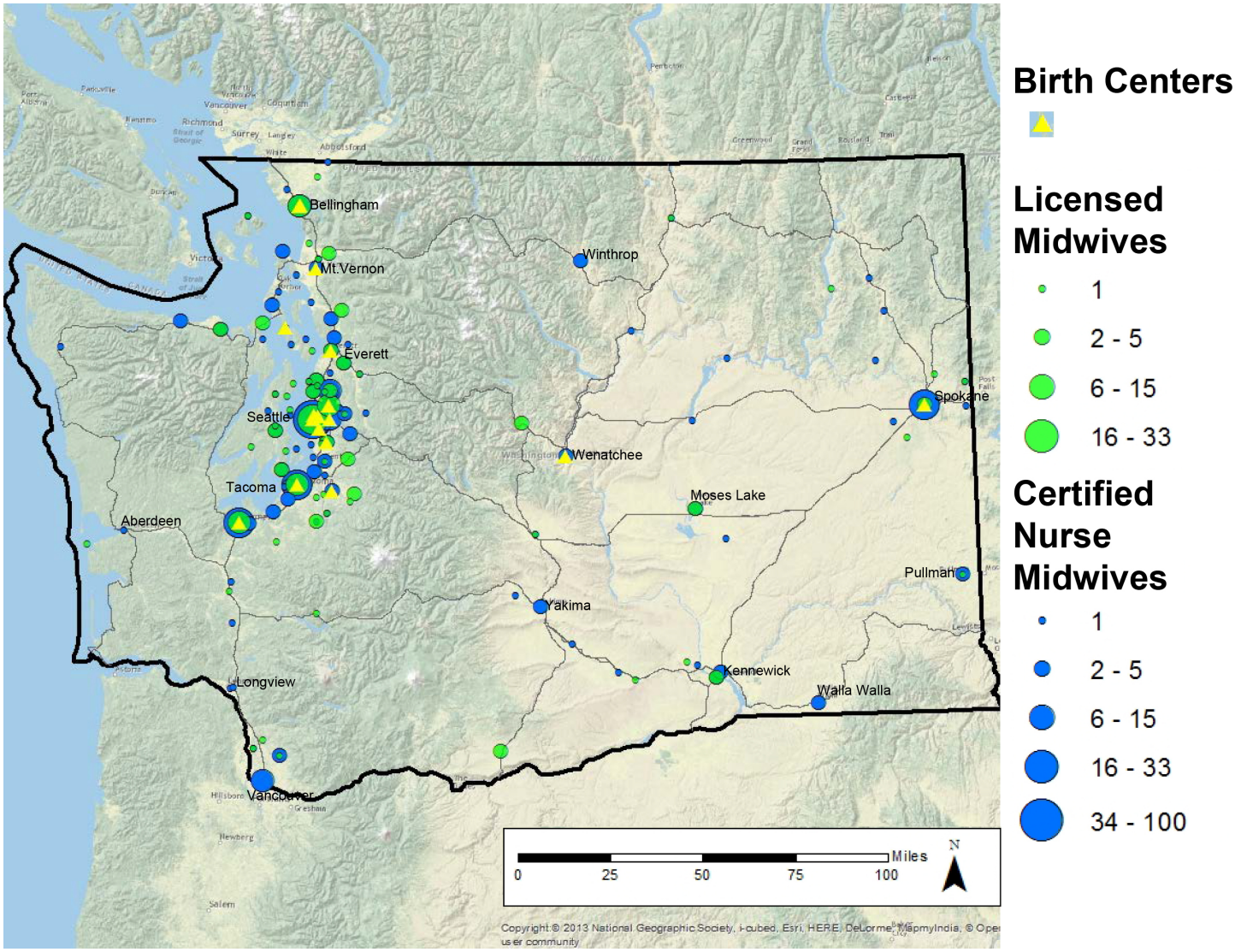

Figure 1: Distribution of Birth Centers, Licensed Midwives, and Certified Nurse Midwives in Washington State; Data Sources: PSMBC 2014, WDOH 2017

Actual Costs and Insurance Coverage for Midwife Care in WA State

Both Medicaid and private insurers are required to reimburse for midwifery care and for birth center facility charges. The Affordable Care Act (U.S. Office of the Legislative Counsel 2010) contained provisions to expand access to midwife-led birth care by requiring that Medicaid (Apple Health in Washington State) reimburse midwives the same as physicians. Legislation has also mandated that private insurers allow midwives to participate in their networks just as physicians (U.S. Office of the Legislative Counsel 2010). Though these provisions were designed to expand access to care, a midwife who wishes to be reimbursed by Medicaid or private insurance must be willing to submit required documentation, so it is essential to check with individual midwives and insurers about their participation in specific programs or plans.

Medicaid pays for about half the births in the U.S. (Markus et al. 2013). A 2007 study through the Health Management Associates (HMA) of Washington State Medicaid-covered birth costs from 2001 to 2004 and showed significant cost savings for pregnancy and birth care by midwives in homes and in birth centers (Figure 2).

These figures do *not* include birth center or hospital facility charges, which would be in addition to the provider charges shown in the figure. The HMA (2007) study reported that expanding Medicaid to support midwife-led birth care resulted in an estimated $2.7 million cost savings to Washington State over a 3-year period. This does not include costs savings for private insurers.

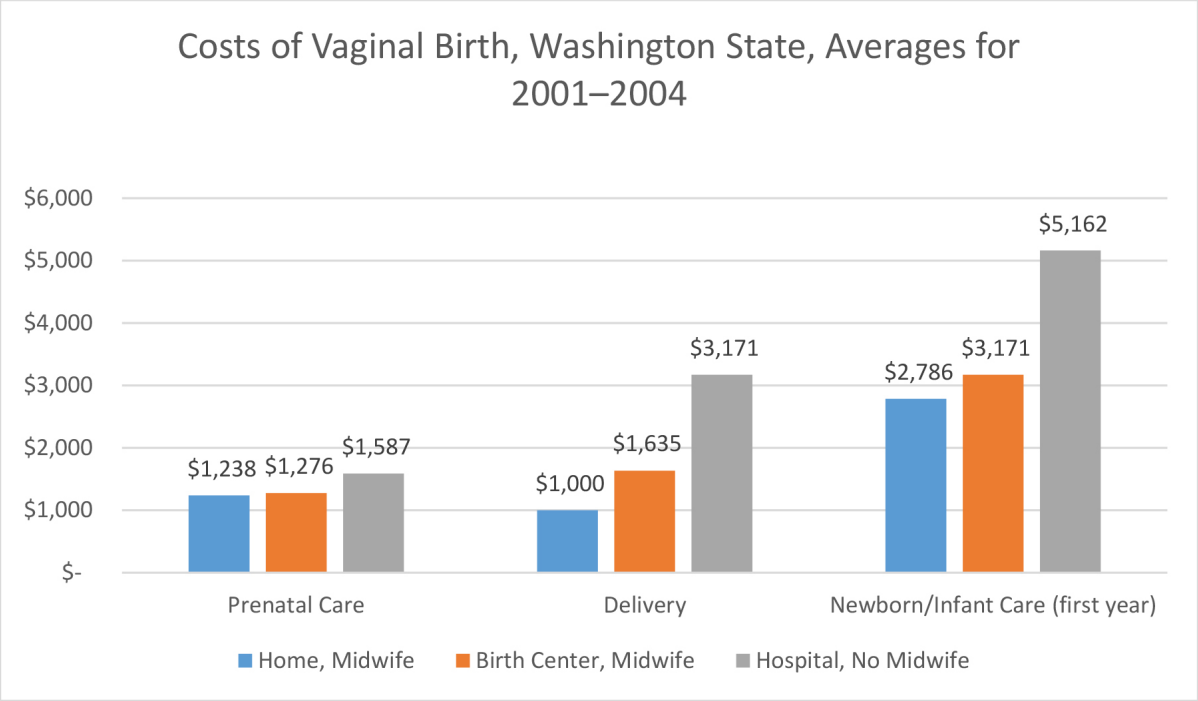

Figure 2: Medicaid Payments for Home, Center, and Hospital Care for Vaginal Births in Washington State, from 2001 to 2004; Source: HMA 2007

In the years since this 2007 study, health care costs have increased significantly. However, the pattern of cost savings with midwife-attended OOH birth has held over time. A 2014 national study of birth costs found that even when midwives attended births in hospitals, cost savings resulted because cesarean birth rates were nearly 10% lower among women who had midwives (Howell et al. 2014). Overall, available studies on pregnancy and birth care costs indicate that care with licensed midwives can save families and the health care system money. Evidence further indicates that lower-cost midwife-led care is *not* associated with increased risk to maternal or newborn health. In contrast, well-conducted studies indicate that planned OOH birth results in fewer interventions and complications for newborns, even for births that require hospital transport (Cheyney et al. 2014; Howell et al. 2014; Johnson and Daviss 2005). To compare the current cost of having a baby in the 39 counties in Washington State, visit: http://www.wahospitalpricing.org/Basic_INP.aspx and contact a local licensed midwife.

A Brief History of Midwifery Practice and OOH Birth in Washington State

Up until the early 20th century, most U.S. births took place in homes with the support of midwives or experienced mothers. Then birth shifted to hospitals, and in the early years of obstetric medicine, practices such as “twilight birth” (birth under general anesthesia), forceps use, enemas, and pubic hair shaving were routinely used (Wertz and Wertz 1995) By 1940, the percentage of home births fell to 44%, continued decreasing from there, and hovered around the 1% mark until it began steadily ticking upward in 2010 (MacDorman et al. 2014).

As the U.S. medical establishment grew, professional and cultural acceptance of midwifery practice declined (Starr 2008). This cultural shift has contributed to low OOH birth rates across the nation and difficulty for midwives to achieve licensure in all 50 states. Despite the challenges, advanced midwifery training and high-quality care have persisted over the decades. Documented OOH birth rates have increased alongside growing evidence for OOH birth safety and women’s satisfaction with it. From 2004 to 2012, planned OOH birth rates steadily ticked upward for *all* racial and ethnic groups. OOH birth rates increased the most for non-Hispanic white women, nearly doubling from 1.2% in 2004 to 2.1% in 2012 (MacDorman et al. 2014).

The events listed in Table 3 show how Washington State holds a unique place in the history of midwifery and OOH birth in the United States.

Table 3: Historical Events Surrounding Midwifery in Washington State

Year	Event
1978	At the urging of state officials, women's health advocates created the Seattle Midwifery School, Washington State's first
1981	WA State legislature approved licensure for midwives
1983	Midwives Association of Washington State (MAWS) formed, began working on formal credentialing, licensing, and professional advocacy
1999	Medicaid began reimbursing LMs in Washington State following evidence of positive results
2004	MAWS created quality assurance program. Includes peer and incident review.
2007	WA State DSHS released study findings showing $3.5 M annual savings from LM care associated with reduced use of medical procedures (epidurals, cesareans)
2008	WA State legislature voted to limit licensing fees for licensed midwives (LMs) to help stabilize the profession
2014	WA State legislature passed HB 1773 to expand license eligibility and to mandate data collection and continuing education for continued licensure.

At about 3.4% (some OOH births are not planned), Washington State OOH birth rates are among the highest in the nation (MacDorman et al. 2014). In addition to progressive health care regulations and education for midwives, evidence on safety and economic benefits of planned OOH birth are likely factors in Washington State's high rates.

Overall, Washington State has created a culture of safe, effective, high quality care by midwives. From 2014 to 2016, Washington State saw the number of LMs grow from about 110 to over 150 active practitioners. This was largely due to house bill 1773 (Table 3) and the higher number of newly-graduated midwives. Eastern Washington has a much lower concentration of LMs and CNMs due to the population density. As midwives grow in visibility, so do their numbers across the state.

The map in Figure 1 shows the birth center distribution in Washington State for LMs and CNMs. There are currently 16 birth centers in Washington State with more being developed. Note that a birth center is, by law, independent from a hospital. All these are currently run by midwives.

How Midwives are Integrated into the Medical System

To maintain their philosophy of highly personalized, person-centered care, midwives have historically worked at a distance from the hospital obstetric care system most familiar in the U.S. today.

However, midwives are trained to screen for appropriate OOH candidates, to use common medical procedures, and to obtain more specialized care for their clients when needed. Thanks to the work of midwives, physicians, and Washington State health agencies, midwives have better collaborative arrangements, emergency transfer protocols, and outcome data than other states in the U.S.

Effective collaboration between U.S. midwives and hospital obstetrics relies on good faith efforts to establish respectful professional relations, which can be difficult to achieve. As the number of families choosing OOH birth continues to grow, the need to establish formal communication and support mechanisms between OOH birth and hospital obstetric professionals intensifies. As one essential step in this very important process, WDOH worked with licensed midwives to develop guidelines and formal licensure requirements for OOH birth hospital transport plans (WDOH 2016).

Links between the planned OOH birth and hospital obstetric communities will likely improve as reliable scientific evidence on the safety of OOH birth accumulates. Perhaps most valuable in this effort is the "MANAStats" database, a large-scale research effort spearheaded by the Midwives' Alliance of North America (MANA). Data collection is ongoing, and as of 2016, the database contained statistics on OOH births from over 100,000 U.S. women of varying income and cultural backgrounds who were followed from pregnancy to postpartum (MANA 2016).

Among key findings from a MANAStats analysis of 16,924 planned home births was an overall cesarean birth rate of 5.2% (Cheyney et al. 2014). This is about one-sixth of the U.S. national rate of 32.2% (Hamilton et al. 2015). In the same study, the rate of episiotomy, a cut used to enlarge the vaginal opening to allow the baby to pass through, was 1.4%. This is one-tenth of the national average (Friedman et al. 2015).

Large-scale, high-quality, expert-driven research efforts like MANAStats are relatively recent compared to the longstanding tradition of well-funded hospital obstetric research. Additional, high quality studies in both OOH birth and hospital obstetrics are needed to address research problems such as how place of birth, birth procedures, and birth complications are recorded on birth certificates and in medical payment systems (Ananth 2005; Cahill and Macones 2006). Only with continued research can some of the outstanding and most controversial questions on OOH birth, such as neonatal death rates, be answered with full confidence.

Additionally, Washington has its own database on obstetrical outcomes called OB-COAP in which multiple hospitals, and now MAWS members, participate. These statistics are being used to build bridges between the OOH and hospital obstetrics communities. Recently passed legislation was designed to help the hospital obstetrics community value midwives' training and roles by requiring midwives to participate in ongoing quality improvement training and to submit standard birth outcome data to state research agencies (Washington State Legislature, Second Substitute HB 1773, 2014).

Today in Washington State, multiple groups and agencies have helped make midwifery care an integrated and respected choice in maternity care. First, birthing women and midwifery consumers have driven the demand for quality midwifery care. Second, individual midwives around the state have established evidence-based care protocols and collaborative care ethics that inspire confidence in midwifery care. MAWS has worked with midwives and physicians to establish evidence-based practice guidelines and quality assurance, to provide continuing education, and to obtain equitable insurance reimbursement (MAWS 2016). This has led to more physician support, both statewide and locally, as physicians recognize the validity of midwifery care and the positive role midwives play in an over-burdened medical system. The Washington State DOH has long recognized the positive financial and health impact of midwifery care on maternal and newborn outcomes (HMA 2007).

Costs aside, women generally find benefit in the personalized approach that midwives take to their care, the time that midwives spend discussing care decisions with them, and their relative control over the birth experience (Boucher et al. 2009; Soliday 2012). The lower costs of midwife-led OOH birth are compelling, and we wish to emphasize that women and families seeking birth care should base their decisions on the quality of care rather than on costs alone.

Resources for Locating a Midwife

The Midwives Association of Washington State (MAWS)

The National Association of Certified Professional Midwives

The American College of Nurse Midwives

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