All-State Awardee Meeting
Understanding Midwives
October 19, 2017

Yvonne: So we are right at the top of the hour. I'm going to go ahead and start us, just because I think we have a lot to cover and a very little period of time. So, I have, for those of you that are on the phone, we strongly, strongly recommend that you join on by computer. If you can join by computer that'd be helpful, so that you can jump in with questions, and if you're on the computer.

So, we've got you on mute, If you hit a part where you want to talk, you should certainly unmute yourself and talk, but we've got a great presentation. Our guest today is Courtney Emerson, and I'll introduce her in just a second, but she's going to present, and then she has some of your questions, and so she's going to try and answer those questions, but then at the end we'll have time for more questions, but she has a lot to cover so I want to make sure that we can give her enough time.

I had the pleasure of meeting Courtney, actually I've met her a couple of times now. She works, She's the director of research and education, wait. She's the academic faculty and James graduate studies at the midwives cause of Utah, which is how I got to meet her. She has her doctorate in medical anthropology, and as you can see from the screen, she's very well connected to a lot of national organizations and so, we've been talking a lot about newborn screening and midwifery. This is the beginning of a partnership. We have a lot of ways that we want to work together to help move this along, and to really reach to a group that we don't get as connected to all the time in newborn screening, and I think as we hit our low-hanging monkeys, the next step is kind of to bring on those midwives, and so I'm very, very excited to have Courtney talk to us.

I'm going to stop sharing, so that she can start sharing, and just going to turn it over to Courtney, so that you so much.

Courtney: Thank you very much, Yvonne. Let me go ahead and begin this presentation. It should be showing for all of you. Thank you so much for having me here. I am excited to be with all of you, and I really just want to say thank you for the invitation here this afternoon.

So, just a couple of housekeeping items. We do have a lot to cover. So, in advance of the presentation we asked for your questions, and I'll be interweaving those throughout the presentation, and then in addition, we'll try to save a little bit of time at the end for some more questions as well as some discussion. I'll be hopping off a little bit early, I teach class right at the next top of the hour, so I'll leave you with Yvonne at the end, but I'll stay with you as long as I can.

In addition, since we have a lot to cover, I have made my slides available, and those can be disseminated to you alongside the recording. That way you can just sit back, relax,

enjoy the show and get all the little information and resources after today. So, I think with that we'll go ahead and jump right in.

The purpose of our time today is to really lay a foundation of understanding, consideration, and resources, for establishing effective relations between staff and members of the newborn screening program, and midwives who are going to be working in what we call community birth settings, in common commitment to optimal neo-natal health. So, community birth settings encompass what we understand to be home birth, and free-standing birth centers. So these will be areas that are unconnected from the hospital. So, to accomplish our purpose today, we're really going to take the framework of interprofessional collaboration, and education. Some fast facts about understanding midwives, and you'll see why I start with that in a moment. Then go specifically into, how do we educate midwives, and their clients around newborn screening programs? How do we integrate this as part in parcel midwifery daily practice? So it becomes habit, and not a barrier to overcome, and, how do we ultimately engage in communication that allows us to have crucial conversations for crucial times? Then we'll end with some closing words and discussion.

So, I really conceive of today's talk, as part in parcel of this larger framework and discipline of interprofessional collaboration and education. Many of you are probably familiar with this as an umbrella concept, but in a nutshell, when we think about the ways midwives will work with the newborn screening program, we can talk about coming together as professionals. A really great definition of interprofessional collaboration, comes from the Canadian interprofessional health network, who said, that interprofessional collaboration is simply the process of developing and maintaining effective interprofessional working relationships with learners, with practitioners, with patient's client's families, and with communities to enable optimal health outcomes. Elements of this collaboration include, respect, trust, shared decision making, and partnership. For me this encapsulates exactly what we are trying to accomplish here today, and in our ongoing efforts.

So, when we think about what's the end game, right, of interprofessional collaboration with midwives, we understand it to be a partnership between a team of health providers and a client, or patient in a participatory collaborative and coordinated approach to both shared decision making, and ultimate decision on health and social issues. So, I think this framework will become very useful as we see kind of where we need to start in establishing effective relationships with midwives. A key mechanism for creating interprofessional collaboration is, interprofessional education. These are kind of different sides of the same coin, and this really involves fostering our own knowledge base of the professional that we are working with. It's very had to establish a relationship with someone if you don't know anything about them, because you fall into the pitfalls of maybe using incorrect of inaccurate terminology. You don't know where to locate them. You don't know what's going to hit them and get them into your circle.

So, for me as a medical anthropologist, this really means exploring culture and systems, including system level constraints, and opportunities. I'm going to kind of model the principles of IPC, and IPE here today as we go throughout the presentation. Here's our local healthcare needs, you see this diagram right. We've identified in our case newborn

screening being one of the healthcare needs, and we see that we often engage in a fragmented healthcare system. What can we do to improve that? Interprofessional education at the center here, and then that ultimately leads us to collaborative practice, and then those optimal health services and and health outcomes that we are all striving for in this case, on behalf of newborns everywhere.

So, lets start with fostering our understanding of the midwives. So, in the United states there are two main types of midwives. The first is direct entry midwives, and the second is certified nurse midwives. Certified nurse midwives, or CNM, are legal in all fifty states, they primarily practice in the hospital, and they are usually the ones you're most likely to understand if I say, what's a midwife, right? That may be what people's first introduction is, is the CNM. In our case here today, we're talking about direct entry midwives, or DEM's. DEM's bypass nursing school and go directly into midwifery training. It's more a proletary European route, where as certified nurse midwives become nurses first, and then go on for advance training in midwifery. Direct entry midwives, they start their training first and foremost as a midwife. The national certifying credential for certified entry midwives is called the certified professional midwife credential or, CPM, and DEM's or CPM's primarily work in community birth settings, so this is your home birth and free standing birth center. For the rest of the presentation when I'm talking about understanding midwives, realize we are talking about direct entry midwives working in those community birth settings.

So, in addition to the national certification and achievement of the certified professional midwife credential, that direct entry midwives can achieve, direct entry midwives are also legally recognized and able to be state-licensed or regulated in thirty-three states. This graphic says thirty-two, but Alabama was added a few short months ago, and it received legislation that passed through for additional licensing terms. So, this is a challenge right, some of you have encountered. If you're in a green state, you might have some challenges with enacting relationships with midwives, and if you're in a yellow state. The yellow states are the ones where midwives aren't legally recognized, and regulated. So we might understand them to be quote "underground" and that makes it even more difficult to reach them and integrated them into this healthcare system.

So, when we think about effective relationships with midwives, we need to realize that one of the key challenges that we face around equity and access for neo-natal health, is going to be the fact that certified professional midwives aren't always recognized in all of your states, and yet despite the barriers that direct entry midwives face on a system's integration level, the outcomes of their care model are overwhelmingly positive. So, here I just pulled out some quick points from one of the articles that myself and my colleagues published in twenty fourteen. This remains the largest home birth study to date. Looking at midwife care in a home birth setting, and we see very high rates of spontaneous vaginal delivery, of physiologic birth, very low rates of intervention. High positive rates of breastfeeding, and overall low morbidity and mortality alongside positive, wholistic neo-natal and maternal health.

So, we see really good outcomes despite some of the misnomers and structural barriers that direct entry midwives are facing. What helps midwives achieve these great

outcomes? The answer is, their care model. So, direct entry midwives are guided by the midwives model of care, and there's actually a specific trademark definition for this, and this is a very key piece of understanding, as we ask how to maintain effective relationships. So, the midwife model of care is based on the fact that pregnancy and birth are normal physiologic wife pocticies, that don't inherently need medical intervention unless a problem arises. So the midwives model of care includes several elements including monitoring the physical, psychosocial and social wellbeing of the mother throughout the childbearing cycle, providing the client with individualized education, counseling and prenatal care, minimizing technological interventions. Keep that one in your mind, that's going to come up a little later when we talk about some barriers with newborn screening in particular. Identifying and referring individuals who require higher levels of attention, whether it be by obstetrics, or paranatalogists, or in our case, others who may be working with the neonate. The application of this model as I said has overwhelmingly positive outcomes.

It's really important for you all to know where direct entry midwives are coming from. They aren't inherently approaching their care as something that needs medical intervention. Their seeing it as, how do I support a physiologic birth process? And when we can trust that to the medical model of care, we can see some stark difference on how we might work with or approach midwives and their clients. So this particular graphic I've adapted from the work of sociologist and anthropologist, Pat Rahman, and Davis wade, who years and years ago, outlined what they called the medical or technocratic model of care, and then the midwifery or [inaudible 00:12:59] model of care.

So, here we see some key elements, right? In the medical model of care it's been documented more provider centered, in the midwifery care it's more person centered. In medical models we call them patients, in midwifery models we call them clients. We often see a more top down decision making approach in conventional medicine compared to shared decision making that has always been at the heart of midwifery models. We se social support often being regarded as secondary, whereas family, and partners and other people in the social network are super key to midwives and their clients, so when they are making a decision about something like newborn screening, they're not making it isolation, they have this larger social network. They are treated as active agents, we see home as nurturing, the mother-baby dyad, they're inseparable, and that's compared to often time in medical models where hospitals kind of like equivalent in many writings to a factory and the baby is a product, and there is a disconnect there. We value multiple forms of knowledge, not just scientific knowledge, but experiential knowledge, emotional knowledge. Again, childbirth is a physiologic process not one of pathology. How do we do that then? We support it by what we call low tech, high tach techniques, rather than try and control with intervention.

So the midwife becomes this skillful guide, rather than a manager, and all of this really leads us to tip number one which is, language matters. Inclusive language and imagery is extremely powerful. So, I kind of put this into a, who? What? When? Where? Why? Kind of framework for you, there's two who's in our case. The who's of course are the providers, so in this case CPM's or physicians, OBGYN's, CNM's. Call them clients, if you could approach a midwife and say, how is your patient going to do this newborn

screening? They'll be like, I don't know I don't have a patient, I have a client. Realize that their facilities they are working at are home and birth centers. They aren't usually part of a larger institution that provides them that structural support, they're autonomous practices. They provide a continuity of care model, whereas in the hospitals its often shift base. You come on for a shift, you go on, you come back on. For midwives, direct entry midwives, it's ongoing, and they hold a different model of care in everything they do.

So, one of the important questions that we got from all of you was, what are some ways to help facilitate a relationship between lay midwives and providers? I was like great, let's start this presentation talking about language and how powerful it can be, and then use this particular question as a case study that we can break down, right, to show why this is important. So, there's a couple of things we can pull out from this question.

The first, is that midwives are providers, so setting it up as a dichotomy of lay midwives or providers, inherently will insult your midwives because in their mind they're like, well, I am a provider also. So we have to remember they too are well trained, well educated providers. And, in most circles, not every circle, but most circles throughout the United States lay midwives at this point is considered a derogatory term. There's been a real move around professionalism to move toward calling it what it is, which is either I'm a midwife, just like the next person, or I'm a direct entry midwife. So I always say, when in doubt, either just use midwife. Don't give them a special label, or call them whatever their credentialing is, maybe they're a certified professional midwife, or they're a licensed midwife in your state, or registered midwife in your state, but when in doubt always lean toward using midwife or Direct entry midwife. Unless the midwife has specifically said, oh no I prefer to be called a lay midwife.

If they told you that, go with whatever they say, but most of the time people take pretty deep offense to lay midwives. So, it's a really good example of creating effecting relationships starts with respect and understanding. Language can help us do that. What else do we need to know? We need to know that midwives are autonomous providers in autonomous practices, but they are not without professional organizations, they don't exist in a vacuum. They are part and parcel of something larger. In our case for direct entry midwifery we have something called the allied midwifery organizations. So, the allied midwifery organizations is a coalition of different associations that work together to advance the profession and address pressing issues, such as, newborn screening. So, here on the screen you see their logos, I'll just briefly review these. We have the midwife reliance of north america, they are the umbrella professional organization. We have NACPM, they're our secondary professional association that are an association for specifically certified professional midwives. So, MANA will cover not just CPM's, but we have many people in MANA that are also CNM's that are community midwives, or traditional midwives, or church midwives. They might not have any credentialing.

NACPM is specifically for the national credential. MEAC is the midwifery education accreditation counsel, this is the accrediting body for direct entry midwifery schools and programs recognized by the US department of education. We have NARM, that's the North American Registry of midwives, they are the national credentialing entity that provides the CPM credential. We have the international center for traditional

childbearing or ICTC, they're specifically dedicated to supporting the professionalization and communities of color, midwives of color that are working to serve clients of color where we all know there are massive inequities within childbirth for communities of color, and then we have the association of midwifery educators who are the professional association specifically for educators.

So, in addition to these umbrella national organizations, we also have state level organizations, and everyone of you probably come from a different state, and so rather than going through almost every state, I'm just going to provide you some resources here. So, the first one I want to provide you, and this is one of the reasons I'm giving you my slides, so you can have all these links is a resource coming from the midwives alliance. We actually have a state by state guide where you can click on any state as you can see here on my screenshot, and then pull up a record on each state, I pulled up Utah as our example. Up top it'll tell you what's the legal status of both direct entry midwives and CNM's. It'll tell you, are they legal, are they not. If they are legal, what's their licensing agency? What is the consumer organization that supports midwives? What is the professional organization for midwives? So you can quickly know who you can contact, on the whole, to get to all the midwives at once.

My second resource comes from the national association of certified professional midwives, or NACPM. NACPM, has started a new initiative in recent years doing something called chapters, and chapters are meant to really support exactly the reason we're all in this virtual room together, pressing issues in the field, how to reach an otherwise decentralized profession. So they have more and more chapters being added all the time, you can go to their website, click on the link and get chapter contact information for a variety of states.

The other thing I want to add here is around CEU's. So, the professional associations and organizations commonly create conferences, quarterly, maybe bi-annually, annually. Their educational conferences, new and upcoming things in the field. This is an amazing opportunity for you all to become guest speakers, and present at one these state professional associations on newborn screening. Come to their space beyond their terms and make sure you apply for the proper CEU's because midwives love CEU's. That and food is how I get them in a room to do anything, and it really allows them the opportunity to meet their own national credentialing requirements, they have to show CEU's just like any other profession for their CPM's certification and renewal. There's state licensing agency, if they are licensed, require it. And for direct entry midwives the number one CEU's that they will want is MEAC CEU's. So, the midwifery education accreditation counsel, if you offer them medical CEU's they're going to be like kinda useful not one hundred percent because that's not what we're being asked to provide for our own renewal [inaudible 00:21:56].

So, knowing who to apply to, I provided that link on the screen. Super important. This brings us to tip number two, which is understand midwifery nationally and in your state and use the midwifery organizations to reach midwives on the whole. One of your questions from all of you, what is the best way to educate midwives? And you're really talking here about educating the whole midwife community, not just midwife by

midwife cause that's exhausting. So, use these professional organizations, apply for the appropriate CEU's, it will go a really long way.

Both tips number one and two kind of culminate to tip number three. Which is kind of a simple one, and yet profoundly important for relationships, and that is, respect midwives. Do our due diligence to understand midwives as professional providers, with opportunities and challenges like any other provider, and when we can recognize that and not treat them as separate, but just unique in their own right we're better able to see, what are our opportunities for integration and where might we have something to overcome? So, I encourage you to sit down with a cup of tea one afternoon and go to this resource I'm linking to on the website, and go check out what's up with CPM's. What's their education like? What's their training requirements? Let me know a little bit about who I am about to approach.

So, with those little fast facts about direct entry midwives, lets go to a specific question around newborn screening, midwifery, and how we educate these midwives and clients about the importance of newborn screening. So, there's kind of four tips that I thought I would depart here when we're looking at our two target audiences. These, are four guiding principles that you will want to think about when you're creating educational materials. So, the first principle is, be inclusive. Be inclusive in your language, we've gone over that. Be inclusive in your imagery. So, if your imagery is like, some doctor in a white coat poking a newborn's heel in a hospital with some crazy resuscitation equipment behind him, that doesn't appeal to midwives. Midwives are like, not for me, moving right along in the world. If you show them something sweet at home, much different, and we'll look at some examples of that in just a moment.

Principle two, make sure your materials are evidence-informed, but at the same time make sure that research is accessible, to both midwives and especially clients. Those of us that are researches, we have a tendency to know the scientific literature so well, we forget that not everybody talks like we talk, and we need to find a way to make that accessible. Principle three, be comprehensive. Show midwives and clients the benefits of the newborn screening, the risks that they could be avoiding. The reasons that we're doing it. Their options if they have any. The consequences of doing it or not doing it. in frame that within the midwife model of care. Find a way to speak their language. Finally the fourth principle is, be supportive. We have a tendency sometimes in health education work to use fear tactics. If you don't get this test your baby might go undiagnosed and then something horrible could happen. That only goes so far, especially in this community, they see pretty much right through fear tactics.

So, if we were to look at examples of each of these. Here's an example of midwife doing a basic newborn exam right after a home birth with the parent side by side. You see a very different imagery here than you would maybe in the hospital. This is what we mean by being inclusive. Accessible data, using knowledge translation techniques. There is a fantastic article I can also send to you by Van Wagner, that was published in twenty sixteen, that looked exactly at this. How do we communicate ideas, especially around risk? Which midwives and their clients avoid at all costs. In a way that feels supportive so they actually can hear it. So she talks about techniques like using words instead of numbers, this says a lot about health communication and literacy.

We also want to think about being comprehensive. Remember I said frame your materials within the midwifery model of care, well this is another chart that comes out of Van Wagner, and what we see here is there's a way to talk about comparing risk to everyday risk using visual aids. Accounting for not just risk, but benefits and alternatives, building confidence, understanding limitations. All of that really helps us to make sure that what we are departing in education and knowledge is really effective for the people we're trying to reach. We also see benefits, such as, instead of just talking about why it's so important for newborn screening to avoid something. Talk about benefits that make sense to midwives and their clients. So three that I just pulled off the top of my head were, prevention, if you talk about newborn screening as an intervention, it doesn't fit with their model of care. If you talk about it as preventative measure, totally fits with what midwives believe in. Midwives believe one hundred percent in prevention. What about wellness? How do we talk about this as supporting wellness in a wholistic sense? In arguably, we can even say that the newborn screening provides support for parent and infant bonding, because if we know, that there is no underlying struggles or concerns, and we can really just ensure we protect the parents, we'll have that opportunity to support their bonding which they also love.

What else do we have here? Finally we have avoiding fear, and for midwives and their clients, that fear piece comes twofold. The first is fear of failure, and the second if fear of intervention. So, the fear of failure could be, I did something wring as a parent. I'm feeling like something is wrong with my baby, I didn't do good enough for them, or it could be I feel maybe nature failed me, because this model of care is trusts physiology. So what happens if the newborn screening test comes back and says hey your physiology is whack? A little off. They might take that as like , I'm fearful of getting this test cause I don't want it to come back and say that, and of course there's fear of intervention. So, we really have to think about how we ensure that we are avoiding fear tactics and making our materials supportive.

So, as an example of this I pulled this little flyer that you might be familiar with from baby's first test. There's several things wrong with this campaign from a midwifery perspective. The first, of crouse is that it talks all about hospitals. What do you need to do? Nothing, the hospitals will do it for you. Not gonna work for your community birth setting. Its standard there, not going to work for informed choice. We'll get back to that. It's called a test, okay, that's not going to work so well within this model of care either, and so we have to think about other ways. The word screening is actually really good in this model of care. We like screenings, as long as they don't inherently lead to bad interventions, screenings are a preventative measure. Tests, sound like something that's an intervention and that I could fail, and so that could be problematic from this model's perspective. Now, even if we enacted the four principles I just went over, we still have to recognize something else, and that is, every midwife is still different and every client is still different. These are themes and patterns we see throughout the model of care but they're not everything ever.

And perhaps most importantly, clients have a right to autonomy and decision making. So, you're probably all familiar with the four internationally recognized ethical principles for health and medicine. Midwives also abide by those, they're here on your screen. Autonomy, non maleficence, or do no harm, beneficence and justice. And for midwives

and midwifery clients, autonomy is the first and foremost one that's invoked. I have often experienced this in several states where I've seen people from the newborn screening program come to midwives, and they're like, but you have to do this. You and your client have to do this, it is mandated by the state, you have to do this. They think they're being convincing, it's mandated by the state, but in the minds of the midwives and the clients, they're thinking, I'm sorry are you trying to tell me what autonomy I have in decision making? Are you trying to tell me I have to do the screen? Cause I don't. I have this thing called autonomy behind me.

So, we have to find ways to not only respect that very real ethical principle, but recognize in our educational materials and approached, that we have to make room for clients and midwives to ultimately engage in shared decision making, and that means that sometimes they're going to decline the test, and we need to be okay with the fact that we need to minimize that percentage. We know we don't want anybody to decline, but if we focus on that one percent, we're going to miss the ability educate everyone else. So, we need to acknowledge that autonomy is important and most of the time you can get people to make strong positive decisions around newborn screening, as in accept it, as long as you don't threaten their autonomy. If you threaten their autonomy, they walk away immediately, and the dialogue has been shutdown.

So, when we think then about reaching midwives and clients with these now awesome educational materials you all have, what are we going to do here? We're going to be creative in our approaches. So, many of you asked about myths and we'll return to that in a minute, but some of the examples of ways I would suggest being creative with this community is use things like a myth-busters approach. Don't make them sound stupid, instead just be like, so there's a myth. Everybody loves games, make it a game. Make it something interactive. Use numbers with narratives. Use testimonials from other home birthed clients and midwives, storytelling goes a long way. Meet people where they're at, not where we want them to be, not where we assume they will be, but meet them where they're at and then adapt our materials and approaches from there.

Some of you from different states, you have actually really good relationships with midwives, and you can start there, and you're just perfecting an already good system. Others of you are like, where are the midwives, why can't I even find them? So we have to start where we are at, not where we want to be. Where do parent go? If we want to literally meet them where they're at. Parents go to a lot of different places but the answer is if you give the materials to the hospital to then disseminate to the home birthed clients, that's probably not going to work, they are not going to the hospital. So think about organizations for parents, like citizens for midwifery. They're reaching consumers. Think about local places throughout your state that parents go. [inaudible 00:33:21] pairing groups, prenatal yoga. I'm totally serious about the prenatal yoga. WIC, right? Women infant and children. Other social services. The library. Reach the parents, and then also reach the midwives through those state professional associations, and using any local contacts you have. In your state, in your communities, in nationally. Something that you're doing here with me, as Yvonne introduced, right? If I'm well connected I have this opportunity to bring us all together. There's many people like that in our field, use them, take them out to lunch, they'll love you it'll be great.

And one of the things you want to recognize is, this is a reciprocal relationship when you able to hit both the parents and the midwives. Because the parents will start to hear you say newborn screenings are important, they're important, they're important, and then eventually they'll go to their midwife and say hey, I keep hearing about this newborn screening thing, but I'm not quite sure yet. Do you think it's important? And by that point you will have wanted to reach the midwife right? And be able to say, okay, we've reached the midwife, so now they have good educational material, that the midwife will ideally say, yeah I'm so glad you heard about that I was just getting ready to talk to you, and vise versa you go to midwives, you reach them, they're able to go to their parents and reinforce the information they're hearing. So try to reach both audiences, they work in reciprocity together.

So, I said one of the creative approaches was myth busters. Let's talk about myths because you all asked some questions about that. So you asked, what are some of the main myths that circulate why people would decline newborn screenings.one of the first myths is that parents and midwives alike may think that there are very high rates of false positives especially on the hearing test. So, it's not an accurate test anyway, and not worth my time. That's something we hear a lot, it's going to be a false positive anyway, like, I don't even want to deal with it you're interrupting my time with my baby. We gotta break down that myth. What's another one, especially with the hearing test? Myth two, the hearing test doesn't matter for young babies. My baby can obviously hear, I dropped all the pots and pans in the kitchen and she totally tried to turn her head. Not what we're talking about completely. We're talking about something different with the hearing test, something more nuanced than that. Often times parents don't understand that. In a third myth I pulled out here with specifics to the heel prick in this case, and that is, my baby's DNA and my information won't be secure. These governmental agencies are notorious for being sloppy with data, and they may even be surveilling me.

This is a real myth that circulates, and we're going to call it a myth cause we understand there's protections in place like HIPPA and other things to protect people's data and DNA from being sold on the black market, we all get that. And yet, this is a real thing that circulates. We need to be ready to address that and break down that myth in a supportive way that doesn't sound condescending.

So, my tip four then, all of this lead to tip four which is, provide comprehensive, inclusive evidence informed supportive materials and be creative in how you disseminate them. And the questions that this particular and tip and what we just went over as a whole. You all had a lot of questions around educating parent and midwives, which is great, cause it's exactly where we want to be.

Now the next thing we want to address is, how do we help midwives integrate newborn screenings directly into their practice. So it doesn't feel like an add on, so it doesn't feel like this thing that they can never remember to do, but it's part and parcel with what they do. Day in and day out. Well, the first thing if we want to really get to that optimal integration piece. The first thing we have to do is acknowledge that structural constraints are very real, for parents and for midwives. These structural constraints include, how do I get these newborn screening done, without interruption to the baby

moon. So you know when people get married they go on a honeymoon? In our world, when people have a baby, they go on a baby moon. Where they just hang out with their baby and bond. So, what I just had this beautiful home birth and now you want me to drive somewhere to get my kid's hearing test done, and interrupt my baby moon? That's not going to fly. We have to find a way to overcome that structural constraint. Include ones like maternal rest, where midwives are saying, rest, rest, rest, don't leave the house for two weeks, and then the newborn screening program is like, go to this facility forty five minutes away and get a hearing screen.

How do we make it so that, different screenings, especially the heel prick, doesn't interrupt what they consider to be their bonding time together? Cost, I know this is one you all have talked about before. There's a real cost fear for both midwives and clients with the newborn screening, and we need to start to be creative on how we overcome that. There's concern over followup. So, especially for clients and midwives that live in more rural areas, where there's not a lot of services concentrated in a metropolitan place. What they are going to see is, well if something happens, I don't know how to get follow up, I don't know if I'll be able to afford followup care. So you know what, I'm not even going to bother, because no matter what the results say, I can't get my kid that early intervention for one reason or another. How do we help communicated to midwives and their clients, a full circle situation? How do we have the opportunity to show them what resources are available to them, if the screening comes back not perfect. We talked a little bit about legal status, we understand that to be a real structural constraint. Don't blame the midwife, blame the system.

And what about marginalization? Recognize their reality. Direct entry midwives are commonly marginalized because of the obstetric hierarchy, and we've documented that in some of our research and I've had other colleagues, and this is really important because midwives will be fearful oftentimes working with with any other professional that looks like they're part of the medical model. Looks like they're part of the state or the man, so to speak, and often that fear comes from a place of being constantly marginalized. They're professional self-question. Have a little compassion for that and recognition, and don't be that person, be someone that's actually and alley instead of an adversary.

And recognize that their reality is hard. And I wanted to give a little kind of lens into the reality of direct entry midwifery. So, midwives are on call from thirty seven weeks, through whenever you have your baby, which is usually by forty two weeks, or well induced, but you have that. You have the potential to be on call constantly for clients that are doubling or tripling up in a month. This is my AKA there aint no rest for the weary. They're always on call. They usually work in solo or small group practices. So they don't have an institution or hospital to be providing different services to them, and helping to support them. It's all them. Midwives face that marginalization and discrimination we were just talking about. They are constantly dealing with the assumptions from society that they are just witches with cauldrons, that bring hot packs to your home and magically woo a baby out. That's not what they are doing and yet that is a common misperception. And so midwives want to be seen as positive providers that are trained with positive outcomes. Midwives are a one stop shop, and this is particularity hard when it comes to newborn screenings.

Billings energy, you need a bill for something, it's the midwife! Ordering supplies, midwife, prenatal visit, midwife, birth, midwife. Newborn screening, midwife. There's no one to hand this off too. You are a one stop shop for almost everything with rare exception. That's a lot for one or two or three individuals in practice to handle, and so we have to find ways to make the newborn screening program accessible to them in a way that ads value to their practice and doesn't detract from what they are already doing. Midwives are also human, add to the fact that there's only twenty four hours in a day. And they have lives, in addition to everything they've already had to accomplish in the last few minutes of my screen, in my overview of them. They have families, they have continuing education requirements they need to do just like we have to do. And they have other things happening, so we have to find a way to make the newborn screening accessible, and available. And we need to remember that it costs money, both in terms that the actual screening can cost money, but also anytime they are spending on the newborn screening program is time away from something else, and time is money. So, again we have to find a way to really streamline them.

So, ultimately, we're going to work together, all of us To overcome these structural constraints, and this is truly the heart of interprofessional collaboration as we started with. So, what are some ideas? Some ideas we might be able to throw out there include, absorbing the cost as the newborn screening programs absorb the costs of the forms, of the lab work, because at the end of the day, we are not talking about a million births here. We're talking a small number of births happening in community birth settings, and yet every baby counts. Maybe, this was an idea Yvonne and I were batting around. Maybe create a special envelope that outlines the processes full circle. From the very beginning of why it's important to collect these specimens in a timely manner to the very end. Include the form in there and give it to them as a gift. What better way to establish a relationship than to say, I'm really hoping that you can do these newborn screenings, and in exchange, let me help you out. I'd like you to do the screening and I'm going to give you this lovely gift to help facilitate that.

Let's think about the ways that we can integrate this in a midwife's chart, that relies more on people like me not you, and it's something I will continue to do. I'm giving a charting presentation at our national conference two weeks from now. I'll talk about this exact thing to help them with timely reminders. Don't forget the lab forms or the samples in your car. How do we integrate this to make sure it's really robust in the competencies of direct entry midwives, and certified professional midwives. Again, that's more on our profession, but, and I happen to be leading a project on this, but working in relationship with all of you right?

And then of course you all have ideas too that , as we end the call here in just a few minutes, we can start sharing. As we exchange these ideas, as we implement them let's remember that this is intended to be a partnership between the different professionals, not a charity, and midwives don't want to feel like they're a charity work, they want to feel like a respected human, and we need to communicate everything we're doing.

So, my tip number five is acknowledge structural constraints and make concerted efforts to redress them in partnership not [inaudible 00:44:53]. And this helps to address several questions you all posed to us around how to help midwives collect satisfactory

specimens, how to get those specimens to a lab in a timely and proper fashion, and so on.

And finally as we end in the next minute or so, I wanted to really talk about this idea of tools we can have for communication, Interprofessional communication in this case, because arguably, newborn screening is crucial. It's crucial to the health, the optimal health, the neonate, and to childhood health, and so how do we make sure we have these difficult conversations? in the first thing we're going to recognize here is that most midwives and most parents are rational human beings that want what is best for their clients and children. When we see people repeatedly decline a given test or screening, we might start to question what's going on here, and we have a tendency to let our own biases creep in, and be like, I don't know, are we sure they're rational human beings? And the answer is they are, we just have to give them that benefit of the doubt and meet them where they are at. Because at the end of the day, they are rational human beings, but they are human, and they are subject to pitfalls. Including buying into fallacies, anecdotal false decision making, where they are like, oh hey you know what? My sisters kid, they declined the heel prick and their kid was fine so I don't need to do it.

We all do that, we compare ourselves. They might over trust physiology at times. So rather than finding this where we might dissolve our relationships because we're too judgmental, use it as a point of integration. Let's check our own biases when we approach these conversations. And of crouse that's not just for all of us on this call, but also for the midwives need to do this as well. And some resources I'm just going to leave you with, include critical conversations and outward mindsets, it's these two books here on your screen. Really, really great tools, and many midwives use these particular models of communication, so you'll quite literally be speaking their language.

So my finally tip here as we end is to acknowledge bias, treat them with compassion and embrace an outward mindset. So with that my closing words come from Carroll Ashenbrener, who once said "The healthcare we want to provide for the people we serve, safe, high quality, accessible, person-centered, must be a team effort. No single health profession can achieve this goal alone." So with that I'll say thank you we'll have about fifteen minutes or so for the rest of our call.

Yvonne: And Courtney you have like, three minutes?

Courtney: Oh I'm having my TA start my class so I can stay on till the last second. She'll get my classroom set up.

Yvonne: Okay, so if you guys want to unmute yourselves in the bottom left hand. You can unmute and ask questions if you have any, that would be great.

Courtney: And if you have questions, and also if you have any ideas for what's working in your state. Let's share them, right? For working with direct entry midwives.

Yvonne: Does anyone have any questions? We get a lot of questions, so I'm think you're having a hard time un-muting. Actually Sandy this is maybe where we will call on you as a

presenter, I know you've done a lot of work in Arizona, do you want to talk a little bit about that or do you have any questions? Given the work that you've been doing.

sandy: I'm unmuted now, right? Can you hear me? Okay, great, so thank you Courtney that was wonderful. I've probably spent five or six years working with licensed midwives, that's how we refer to them here, and I learned some things today so that you so much for that. Let's see, questions? Just the biggest hurdle that we are having right now with licensed midwives, not certified nurse midwives, not hospital based, are reimbursement insurance. They just keep running into these hurdles where they cannot jump through the hoops for the insurance, they are not reimbursable. We're asking them to absorb ninety five dollars for a blood spot screen, and then we have factions of agency that are saying well what's ninety five dollars, you're charging three thousand for a birth package certainly you can absorb ninety five dollars. And, so I'm working against that kind of us and them, but the biggest thing for me is, and I've talked to other states who have absorbed the cost I love that idea. I've been shopping that idea to anyone that'll hear me, and we've had great success. We offered grants for CTHD equipment, we now have like eighty percent of licensed midwives who have taken advantage of it and consequently we're getting timely CTHD screens.

So we know it works when you meet them in the place they are and try to offer support for them, but for us its that financial. Parents say they don't want to pay anything outside of the birth package, and the midwife says I'm just collecting the blood, it's the lab services I don't have anything to do with it. So I don't want to bail. So for us that's just a mountain of boulders that I cannot seem to move in Arizona.

Yvonne: So do other states have suggestions? I don't know if Linda is on the phone. She's not? In New Hampshire, the way they absorb the cost is they give them the filter paper for free and the hospitals pay. I don't know if anyone has a model like that. Does anyone have a model where they help offset the cost for midwives.

Speaker 4: Just to add to what new Hampshire does, they also bought the [inaudible 00:51:04]for all of the midwives [inaudible 00:51:09]

sandy: I stole the idea from some of the states for sure. But Courtney otherwise, if you can't help with the financial it's that license midwives working with insurance don't have that partnership model, they are not recognized as clinicians in the same way, and so from that aspect as a midwife, how do they continue to fight that battle to be recognized in every state as a licensed provider.

Courtney: Yeah, absolutely, and these things go hand in hand, right? Because when you have licenser integration and recognition, and can get reimbursed then this question about the cost kind of becomes a new point. So I think one thing we want to think about here for all of you, is a lot of that work has to be done within the midwifery profession, but one of the things that direct entry midwives across the United States face is a lack of allies outside of themselves, and when they go and they're trying to make a case for insurance reimbursement, or for legislation and legal recognition, it's so easy to shoot somebody down that's like well of course you think you should be recognized. It's your own profession. Whereas when other programs, some of the greatest success stories

we have around this have been when state agencies to other obstetricians, [inaudible 00:52:32] CNM's, everybody comes and testifies on behalf of the midwives, or goes to an insurance reimbursement meeting, gets all these different stake holders in the room, and lends that outward support, not only to the midwives in the model of care but basically. This is how is will help us.

Because even if the decision makers in the room don't care about midwives at the end of the day, they probably care about you, and they probably care about those newborn screening happening. So a lot of the times its easy to say well if they could do xyz that would actually really help us. It would really help neonatal and newborn health. That's an argument that many people are more receptive to, than a small group of midwives coming in and being like, reimburse us. That's a harder battle to be won. So I think supporting the efforts that are already happening in the state. Outwardly telling midwives will show up to those key stakeholder meetings and can really be a good way. They one thing I really want to say about reimbursement, cause that's a longer term goal. A long game, an endgame. It's interesting, parents don't want to pay the extra money, more than the "birth fee" midwives are like, why should I have to bill this. So either someone else needs to be billing, can we work out some kind of code or system for that? And or try to convince the midwives, and I've seen this work in some states, to just raise their birth package a hundred dollars.

If we're really talking about ninety five dollars. You know what? Thirty one hundred dollars, three thousand. The problem is when we try to add it on the back end, then it's like, one more expense, but if it's just part in parcel, and so in many midwifery practices they started doing exactly that. They just added it into their fee from the beginning. Thirty one hundred versus three thousand isn't probably isn't going to make or break something. Paying three thousand and then saying pay some more, sounds problematic.

Ivonne : Barb, from California says that they do direct billing to the parents. So it sounds like they are programed as a direct billing, which I don't know how that. I'm guessing Barb can't actually talk, which is why she sent the comment, but that's another model, and so I do like the idea of just raising the rate.

sandy: I think we're tried. Go ahead.

Yvonne: No. Go ahead, cause I'm going to take us in a different direction.

sandy: All I was going to say, and final on the billing is, we have been billing parents and they are not paying, and they are upset cause it's that back end like you said Courtney. If the education occurs in parallel to both the client and the midwives, and everyone understands it's an important and valuable screening preventative tool, then there are no surprises. Right now what we do is, a few months later everyone gets bills and nobody wants to pay.

Yvonne: So I'm going to move us a little away from the reimbursement, and just let you guys know, so we've got an ongoing partnership with Courtney, and one of the things we're

doing is, she and another midwife are actually looking at some of the materials, state materials, to talk to us about how it could be midwife friendly.

If you have something, that you want to actually be reviewed, you should let us know so that we include you in it. That would be really helpful, and it's just to help us get a sense of what that language would look like, or what those images are cause, as an outsider it can be hard to figure it out. I've also reached out to a few where Courtney is overseeing this group where they are doing the competencies, and so, we're going to be part of that, and so, newborn screenings. We'll have states that will help, and if you want to be part of that conversation. So she shared the competencies with us so we're going to try to meet a few times, and by the time we would be done around march, that would be when they would be looking at it anyway, and then they can take it back to the midwife community. So we can shape that roll, and we have three quality minutes. Does anyone have another question before I cut us off? Oh wait, Piper wrote in Iowa are sending a check from the parents with the newborn screening fee, with the blood spot collection form.

The other option is if you guys think this is interesting, but you would like to discuss in a smaller group like that [inaudible 00:56:59] that we had last week, let us know and we can set that up the next time we do those multiple topics. So if you just tell your coach or email or something. So anymore questions, comments? I know Iowa you guys are doing a ton of innovative stuff around this. Do you have anything you want to share? If you can talk.

Kim Piper: Hi, this is Kim Piper. Speaking for the rest of the crew, I'll be quick, one of the things that we're doing lately, we have only certified nurse midwives are recognized in Iowa, that's allowed to practice. So what we're having to do since there really isn't an organization that we can reach out to, for all the midwives in the state, we're going to them. So we're meeting one on one with them and trying to make whatever contacts we can. And one of the things that we're doing is, we're mailing or delivering a tote bag that we ordered, that has a newborn screening logo on the side of it. It's got a cooling compartment at the bottom, and then we filled it with tool kit for how to collect the specimen, how do you send it in, where can midwives submit the information. We put lancets and alcohol swabs in there and just anything that we can to help enable them to screen their babies. So, we're gotten many thank you notes from the midwives that have received those, and it's a good reason to reach out and have those conversations with them and they appreciate it.

Courtney: That's awesome, and you're hitting the nail on the head, right? That gift giving piece really does make a difference. You not only take away structural barriers around equipment and supplies but also it establishes a level of rapport, and trust. You want us and you think we're valuable enough to put this together for us. That's a big deal. Versus somebody who's like, we don't value you enough to help you but you have to do this. Those are two very different ways to come about the same issue. So that's really exciting in Iowa, and as you said if you don't have a professional association then it's reaching midwife by midwife and trying to ultimately to really have the opportunity to find a key contact that can help you find where there might be a conference coming up, or peer review coming up that we can get all the midwives in the room, cause getting

midwives in a room is also difficult, and so tacking on something that already exists is great and it sounds like you're doing a lot of that, very cool.

Kim Piper: Yeah, thank you.

Yvonne: Kim, just so you know, Iowa team, beth was asking if there's a way for you to share more information about those kits I know that. If you can maybe share something with us so we can put out to everyone that would be fantastic.

Kim Piper: Yeah, we'll just do an inventory, and then where we got our bags from and that kind of stuff, so.

Yvonne: That would be great. So we're right at the top of the hour. Thank you Courtney so much for taking time and really walking us through the model, it was really insightful. Thank you everyone for being a part of this call and we look forward to talking to you again.

Courtney: Thank you all. Bye.