Midwives Association of Washington State
Talking Points & Further Info

Priority #1: Maintain Existing Licensing Fee Cap (Budget Proviso)

Where the proviso stands:
Our licensing fee cap *budget proviso* has become part of the *maintenance budget*, or *4-year outlook* meaning that it would need to be cut for us not to get it. That cut can certainly still happen, but we are in a safer position because budget leaders consider it to be an ongoing item. It is in the current biennial budget and it was in Gov. Inslee's December budget proposal.

The ASK:
We are asking the legislature to continue our existing proviso at $150,000/year.

Some Background:

- Keeps our annual licensing fee capped at $550 rather than $3Kish.
- The total cost of the licensing fee cap is $300,000 for the biennium.
- A study commissioned by the legislature showed capping annual professional licensing fees for midwives more than pays for itself in avoided cesareans alone
- Since this cap was put in place (~2007?), the licensed midwife workforce has more than doubled, resulting in more families in Washington having access to high-quality, cost-effective care that in turn results in even greater savings to the state budget
- Current champions are Rep. Clyde Shavers and Sen. Manka Dhingra, plus many supporters!

Priority #2: Substantial Equivalency for Birth Center Inspections (HB 1824)

Where the bill stands:
This is HB 1824 and it is sponsored by Rep Barnard. There will be a hearing for it (Fri 2/14 @ 8am).

The ASK:
We request that the legislature allow birth centers accredited by the Commission for the Accreditation of Birth Centers (CABC), or any similar organization, to perform routine inspections on birth centers normally conducted by the DOH.

Important Notes:

- In case of imminent risk of harm to the public, DOH retains its right to oversight.
- Birth centers that are not accredited would continue to be inspected by DOH.

Some Background:

- CABC inspections **require** compliance with the state requirements. The inspectors obtain a copy of the state's statutes and rules to ensure that they are followed.
- CABC inspectors are experts in inspecting birth centers specifically; they are not generalists who inspect other types of facilities.
- It is expensive for DoH to conduct (duplicate) inspections that are already being done on a more regular basis by CABC than DOH can afford to perform.

Priority #3: Fair Reimbursement for Transfers from Community Birth Centers to the Hospital Setting (Budget Proviso)

Where the Budget Proviso Stands:

- To be submitted by Rep. Stephanie Barnard

The ASK:

- ☐ We need House members, Democrats especially, to contact budget leaders to tell them that they support Rep. Barnard's proviso request for birth center payment for transfers.
- ☐ We need a Senate Democrat to submit the same request on the Senate side.

Some Background:

- When there are transfers from the birth center, it is usually because a complication has arisen during labor, such that additional medical treatment is indicated. These labors typically require that the facility provide the same or more resources than for a normal labor that results in a birth center delivery. However, Medicaid only reimburses $366.68 for a transfer, which is not even enough to pay for the assistant. We are requesting $2500 for a transfer, or about half our costs for a normal delivery.
- Birth centers should be paid appropriately for labors that started in the community setting - even if they must transfer to a hospital for final delivery. This is the same as level 1 hospitals transferring a patient to a higher level hospital for a number of different medical reasons.
- Our estimate for the proviso is about $450,000/year.

Priority #4: Maintain funding for distressed birth centers and labor & delivery units

Where the funding stands:

- In the current budget

The ASK:

We know the budget challenges are significant, but we still feel we need to bring up these issues for the continuation of access to maternity care in our state (ie, we get it that the budget is horrible and yet, people are still having babies).

Important Notes:

- We want to be part of a successful system that includes access to L&D units when needed as the closures are also concerning to us and impact our practice limiting access to care in our communities for those who need it

Some Background:

- This would be a continuation of an existing program and the grants that were awarded so far have been critical to the survival of birth centers.

Birth Centers that have closed in the last 2 years:

- Cascade Birth Center - Everett, WA
- Greenbank Birth Center - Whidbey Island
- Empowered Pregnancy - Kirkland, WA
- Moonrise Birth Center - Mountlake Terrace, WA
- Eastside Birth Center - Bellevue, W

General Talking Points:

Describe the Midwifery Model of Care Secret Sauce

- Trust, intimacy, psychosocial focus, relationship building, continuity of care, uncomplicated & safe physiological birth
- Leads to fewer preterm births, less low birth weight babies, increased rates of exclusive human milk feeding
- Midwives offer high quality care and community birth is a legitimate cost saving policy that families want the option to choose
- Midwives take care of the whole person with attention not just to the physical, but also emotional and psychosocial.
- Intimately knowing the client and family and recalling what is going on for families in the present and in their history. Personalized and person-centered care including adapting care to what makes sense for the family while still being able to spend time having full conversations and shared decision-making; lengthy discussions about why something is recommended enabling them to make choices for themselves. Enabling new families to take an empowering role in their own family (as they are about to step into their new role as parents).
    - Intimacy: people rather than patients, not just numbers in a system. Clients want to be known by their care providers
    - Midwives help to birthing families not just babies
    - Midwives don't just measure things and note medical indicators, but we focus substantially on education addressing the whole person, not just their physical self
    - Midwives track medical care and needs but focus on social determinants of health when caring for the whole person, noting all factors that might be impacting their health physically and mentally
    - There is lots of talk right now in policy circles about how to help providers be better at addressing social determinants of health and it is already part of the midwifery model of care. Midwives are often taking on the roles described for a community health worker and a public health nurse.
    - Trust is built up over time because midwives answer phone calls, draw blood and more
    - With midwifery care, they aren't just getting ahold of customer service. Clients get personalized, patient-centered, person-centered care
    - Home visits are a routine part of care. Midwives are invited in because we are a trusted person in their lives during a very intimate time in the family's life
    - Also magic :)

Excerpts from MMR report:

“3. Expand equitable and high-quality health care by improving care integration, expanding telehealth services, and increasing reimbursement”

“Prioritize access to perinatal care in communities experiencing inequities, disparities, bias, or discrimination as apparent in maternal mortality data. Fund: o Culturally competent care, including community health workforce and value-based payment models that focus more on outcomes than on number of services delivered. o Increased access to out-of-hospital birthing care such as midwifery and doula services (e.g., funding for free-standing birth centers, rate increases for midwives, etc.). o Interpreter services, including services in a wider variety of languages.”

“Support legislation to increase access to doulas and midwives through one year postpartum across the state, prioritizing areas with limited access to these providers. o Support legislation and provide funding to establish a reimbursement rate for doulas, to be implemented by the Health Care Authority (HCA), once prior work to establish a credential for doulas is complete. 3.3 Increase funding for out-of-hospital birthing care, such as midwifery. Fund start-up costs for birthing centers in rural areas or areas that serve populations with disproportionate” see original for their emphasis