

Midwives Workgroup Meeting

September 20, 2012

Maryland Department of Transportation

Harry Hughes Suites 1 and 2

7201 Corporate Center Drive

Hanover, MD 21076

Meeting Minutes

Attending in person:

Bonnie Birkel, BSN, CRNP, MPH, Department of Health and Mental Hygiene (DHMH)

Ida Darragh, North American Registry of Midwives (NARM)

Susan Jean Dulkerian, MD, American Academy of Pediatrics, Maryland Chapter (AAP)

Karen Fennell, RN, MS, American Association of Birth Centers (AABC)

Jeremy Galvan, Maryland Families for Safe Birth (MFSB)

Delegate Ariana Kelly, Maryland House of Delegates

Janice Lazear, DNP, CRNP, CDE, University of Maryland School of Nursing (UMSON)

Joseph Morris, MD, Maryland Hospital Association (MHA)

Mairi Breen Rothman, CNM, American College of Nurse Midwives (ACNM)

Melissa Yates, MD, American College of Obstetricians, Maryland Section (ACOG)

Mary Lou Watson, MS, RB, Maryland Board of Nursing (BON)

Attending via telephone:

Jenifer O. Fahey, MPH, CNM, Expert in Midwifery Care

Elaine Flanagan, representative for Senator Karen Montgomery, Maryland Senate

Not in Attendance:

Joan Tilghman, PhD, WHNP-BC, CNE, Expert in Health Disparities

Staff: Maura Dwyer, DrPH, MPH

Other: Approximately 50 members of the general public also attended the meeting.

Follow-Up from Meeting #2 on August 23, 2012

- The Open Meetings Act entitles members of the public to observe open sessions of public bodies but does not afford the public any right to participate in the discussion. However, the Act does not prevent the establishment of a policy that does grant members of the public the opportunity to be heard at a meeting. At the discretion of the Midwives Workgroup Chair, a fifteen minute period for oral public input prior to the conclusion of the meeting has been made available at this and prior meetings. Guidance for public input has been posted on the workgroup's website. As noted in the guidance, public comments should focus items on the meeting agenda and/or discussion points between members during the meeting. Written materials for consideration by the workgroup may be submitted electronically to Dr. Maura Dwyer at maura.dwyer@maryland.gov for distribution to workgroup members or can be distributed at the end of the meeting.

The Open Meetings Act allows audio/video recording of meetings but restrictions can be imposed if such recording is disruptive.

- Copies of the AABC letters to Maryland Medicaid were shared with workgroup members as requested by Karen Fennell. The Medicaid program has responded that Medicaid pays the facility fee for deliveries at birth centers. The facility fee is the same as facility service fee, the fee that is paid in a hospital. Currently, four Managed Care Organizations have contracts with birth centers. Amerigroup and Priority Partners contract with both Bay Area and Special Beginnings; UnitedHealthCare contracts with Bay Area; and Diamond/Coventry contracts with Special Beginnings. Medicaid will be making regulation changes related to delivery at birth centers. The changes will be available for public comment

before they go into effect.

- We have reserved meeting space at DHMH for November 15th for an additional workgroup meeting if necessary. A workgroup member has requested that a different date in November be selected if the workgroup consensus is that an additional meeting is necessary. If there is a fifth and final meeting, it will be open to the public for observation, but there will not be time on the agenda for oral public input. As already noted, public input can be submitted electronically to Dr. Maura Dwyer for distribution to workgroup members.

Data Presentation by Maura Dwyer, DHMH

We had a request for “conditions” in states that are more “friendly” to midwifery practice. Presented here are data reported by the Kaiser Family Foundation, which provides recent data on key birth outcomes, by racial and ethnic group, for all 50 states:

- Infant Mortality Rate (deaths per 1,000 live births) by Race/Ethnicity, Linked Files, 2005-2007: low infant mortality rates among Hispanics drive low infant mortality rates in states with large Hispanic populations.
- Births of Low Birthweight as a Percent of All Births by Race/Ethnicity, 2009: high rates of low birthweight births among African Americans drive high rates in states with large African American populations.
- Percent of Live Births by Cesarean Delivery by Race/Ethnicity, 2009: “midwife-friendly” states such as California, Texas, Florida and Virginia have higher C-Section rates but interpretation is limited without obstetric provider data.
- Percentage of Mothers Beginning Prenatal Care in the First Trimester by Race/Ethnicity, 2006: “midwife-friendly” states such as Texas, New Mexico and Florida have low rates of early prenatal care but interpretation is limited without indicators of access to care.

We have requested Maryland Vital Statistics data regarding birth outcomes in Maryland (such as rates of infant mortality, low birthweight, very low birthweight, fetal death, neonatal death, labor and delivery complications), controlling for potentially confounding factors such as maternal age, race/ethnicity, maternal conditions, Medicaid coverage, maternal education, and first trimester prenatal care, where possible. We will provide these data to Workgroup members prior to the October meeting.

Discussion Points Related to Data Presentation

- Comparisons between hospital and home births will be limited as it is not possible to determine through the data which home births were planned home births. Further, comparisons by provider type will be limited by misclassification between ‘CNM’ and ‘Other Midwife’ and under-reporting by midwives not licensed to practice in Maryland.

Key Points from Presentation by Susan J Dulkerian, MD, American Academy of Pediatrics, Maryland Chapter

See PowerPoint slides.

Key Points from Presentation by Melissa Yates, MD, The Maryland Chapter of the American Congress of Obstetrics and Gynecology

See PowerPoint slides, and additional comments provided by Dr. Yates during her presentation (but not included in the slides):

- Included in your handouts is the Washington State “Smooth Transitions: Enhancing the Safety of Planned Out-of-Hospital Birth Transports” Report, which provides a US example of how to work together. There are a number of stipulations though, see examples of the criteria for transport in the report.
- A New Mexico hospital is made aware of all home births by placing home births on “The Board” of all deliveries in their area. This is a great tool for integrating home births.
- BMI > 40 and small for gestational age were added recently to high risk criteria.

Key Points from Presentation by Joseph Morris, MD, Maryland Hospital Association

- Dr. Morris worked 15 years in private practice and 5 years as a hospitalist in collaborative practice with CNMs. Dr. Morris understands why women want a midwife, they have a certain touch physicians do not have. There are barriers to midwifery practice in Maryland and physicians are aware of them. Anne Arundel Medical Center and Bay Area Midwifery Center’s model represents a viable example for Maryland. The CNM-staffed birthing center is located right next to the hospital. Very few women need to be transferred out of the CNM group. Can be transferred to the hospital in five minutes because the facility is so near but sometimes 5 minutes is too long.
- Hospitalists see the high risk patients; the physicians and CNMs work hand in hand

and have mutual respect for one another. For example, if the hospitalist is called to do assisted vaginal delivery, the physician may do the delivery but then CNM resumes care because it is their patient, they deliver the placenta, etc. If there is a C-section the CNM is first assist and participates in the delivery so there is no break in care.

- When Dr. Morris was Chief Resident at the University of Maryland a patient came in with a failed home birth, hostile towards physicians and hospitals. Dr. Morris tried for two hours to convince the patient to have a C-section but the patient refused. Dr. Morris did a forceps delivery and the baby died one day later. He was served papers one year later for not doing a C-section. The insurance company went belly-up and the law suit went away but was still incredibly wearing.
- As a hospitalist, a patient came in with a failed home birth and obstructed labor. She pushed for 9 hours and the baby hadn't passed mid-pelvis which indicated a C-section. The parents said do what you need to do. CNM became upset in front of the family stating the family should be offered a forceps delivery. Dr. Morris asked the CNM to leave because the family was happy with the care.
- Obstetric care is highly unpredictable. Dr. Morris has five children of his own and when his wife was in labor with his oldest child, everything was fine and she was in the late stages of delivery and everything suddenly went down hill. The cord was wrapped around his daughter's neck three times and she was limp upon delivery. If didn't have some intervention, don't know what would have happened.
- Liability issues are paramount – five physicians Dr. Morris used to cross-practice with are no longer practicing because of malpractice. It affects CNMs and OBs. One strike and you're out because suit amounts are so large (\$10 million). Dr. Morris's brother was told by his insurance company to settle (he was Physician of the Year in Anne Arundel County) in a case where he was not at fault and he can no longer practice because the malpractice premiums are so costly.
- The Hopkins case caused Hopkins to question if they should continue practicing OB. They said no but they're Hopkins, they have no choice. Dr. Morris's father, who was an OB, fought these same issues in 1967 and little has changed.
- There will be no physicians to collaborate with CNMs if this does not change. Dr. Morris is tired of working so long for change with so little success in the Maryland legislature. One lawmaker runs a law firm that sues physicians and CNMs.
- The malpractice issues would affect CPMs just like CNMs and OBs. If want more midwifery care, need to address malpractice.

Discussion Points Related to Presentations

Neonatal Care

- Congenital Cyanotic Heart Disease Screening method is pulse oximetry.
- Everything in Dr. Dulkerian's presentation regarding neonatal care is within the scope of a CPM. Congenital screening is not because it is new but it could be. That's what state regulations are for.
- CPM's ability to give Vitamin K shots is dependent upon the state. Ida Darragh's state only allows them to administer it orally but the program is 30 years old. Resuscitation varies by state too. Virginia doesn't allow CPMs to administer oxygen. The CPMs have the training to administer oxygen but are limited by their state's scope of practice. This could be done in Maryland within the guidelines received by AAP.
- Majority of families are very concerned with the safety of their child and will bring their infant to pediatrician within 24-48 hours for all the checks and screenings. Some families won't comply but that is the case with all care. Patient autonomy is part of any care. Can cover in informed consent so families are aware and make informed decisions.

Liability

- Only one state with CPMs requires that they have liability insurance (Florida). In Washington it's only required if the CPM accepts Medicaid. It's not required or deemed necessary in the 24 other States.
- If we mandate that collaborating physicians have liability insurance then they won't sign on.
- There is a purpose to insurance, as a consumer protection. Not having liability insurance puts the family at some risk.
- How malpractice functions in the real world, however, is to give insurance companies control over medical practice, not just to provide families some protection.
- Physicians don't want collaborative agreements because they are then responsible.
- Physicians don't want responsibility for something that happens when they're not there.
- Wyoming has a non-vicarious liability clause. If a physician is called for consult they can't be held liable for talking with the midwife. Could possibly get this into Maryland's legislation.

- In Maryland, just looking for who has a big insurance policy (and thus, deep pockets); don't need bad outcome and practice to initiate a lawsuit.
- Do hospitals really want to be aware of home births (like New Mexico hospital, where home births are put on "The Board"), but then what is their liability? Lawyers say no. And clients might want a different hospital, distance might be a factor, etc.
- We cannot wait for tort reform, need to address the CPM-related issues now. It is safer to address now and to regulate them.
- Addressing malpractice is not a charge of this work group. It will be noted as a barrier to all obstetric providers but it is not a reason to prohibit licensing of CPMs. Re-establishing a malpractice work group may be a recommendation we make.
- The malpractice issue will be a continuous barrier to creating a true system of safe transfers of care (as well as a threat to the quality of maternity care in the state).

Transport

- ACOG's recommendations are fantastic. Wish they were actually followed. Midwives don't feel safe to follow though. Integrated care is a two-way street. Need protocols for receiving providers and hospitals. Have been told by a physician that she (a CNM) was disruptive to their practice environment and that she needed someone to work with but physician declined to be that physician that she could work with. Need respect for patient and midwife as equal partners.
- Communication between family, midwife and physician is key. Families are reacting to history. Anecdotes are important because of what they say regarding relationships and communication, especially when problems arise. Hospitals can be very negative when there is a problem. Don't want decisions to transfer colored by a midwife's fear of the implications for her license.
- There is a quality improvement interview questionnaire regarding planned out of hospital birth transport at the back of the Washington "Smooth Transitions" report that is a useful tool.
- Would love for CPMs to be able to go with transported patients because of their knowledge of the patient's history and ability to provide support and to advocate with the physicians. Because so few providers know how CPMs work it is difficult for them to know all that CPMs can do.

Collaborative Agreement

- Collaborative agreement needs to be defined so that is not just essentially a permission slip. There needs to be a team approach. Not sure how to legislate this though. It is very difficult to get OBs to respond to requests to develop collaborative agreements so how do you get OBs and CPMs on the same page?
- In Maryland it's no longer a "collaborative agreement," it's a midwife's plan. A physician's name can be listed on the plan but depending where the patient lives and the physician practices, the physician may not see the patient. No signature by the physician is required.
- ACNM did research looking at outcome data in four states with collaborative agreements and five states without and the outcomes (low birthweight, infant mortality, early prenatal care) were better in states without the requirement for a collaborative agreement.
- ACNM does not support any written plan. An oral surgeon does not require a dentist to make an agreement in order to refer to them; a surgeon would like to have records but they can practice without a written document of any kind.
- What works is a plan between the midwife and her client. They put a plan in writing but not with any physicians.
- Can share the plan for an emergency with physicians just so that the transition, if necessary, is seamless, but not to gain the physician's permission.
- Transfer agreements in other states depend on who the under-writer is. All charts to with the patient. Collaboration has meant agreement in the courts.
- Most states just require enough information for the midwife and client and they make the decisions and plan.
- Why is a collaborative agreement with an individual instead of with a hospital?
- Recent Institute of Medicine report (which will be forwarded to Work Group members) cites a lot of evidence that advance practice nurses do not need collaborative agreements.

CPMs

- Selecting low risk candidates is a factor in the positive outcomes for home births, which include CPM births, so CPMs are apparently selecting low risk candidates.
- Would like to hear more about the oversight of CPMs. What happens after licensure? What is the quality and peer review piece? Actually, more information on the oversight of physicians without admitting privileges, CNMs, CPNs, etc. would be

useful but CPMs are new so want more information on them in particular.

- Also would like more information on the educational requirements of CPMs and their scope of practice.

VBAC

- Only four of 26 states prevent VBACs at home and the outcomes have been ok.
- The issue of availability and support of VBAC (true availability and support) in hospitals will need to be addressed if VBAC is going to be a factor that makes women risk-out of home birth.

Birthing Centers

- The physicians' presentations were very much in line with the birthing centers although birthing centers were against VBAC until they collected more data.
- There is nothing at birthing centers that a CNM wouldn't have at a home birth.
- ACOG and Dr. Morris do not recommend a VBAC delivery at a birthing center. They recommend a setting where an emergency C-section could be done.

Evidence

- There are three classifications for strength of the evidence supporting ACOG's recommendations: A) strong; B) inconsistent/poor; and C) expert opinion. ACOG recommendations use 1/3rd class A evidence overall; 5% class A for mode of delivery; and use Class B most often, which is disconcerting.

Public Comment

- VBAC issue is a big concern. Never would have been able to have VBAC in a hospital with a 12 hour stall and tub labor, would have been given a C-section. Not all hospitals prohibit VBACs though.
- Concerned that CPMs won't be able to choose which patients they will take on as hospitals dictate those decisions.

- Home birth mothers are very concerned about safety and are informed consumers. They believe home is the safest option for children. They deserve a qualified provider and if they can't find one, they will be driven underground. They deserve to make this choice. There will be outliers of course but information about risks can be handled in informed consent.
- Informed consent is more accurately represented as shared decision-making.
- Distance between physician providers and patients could mean that CNMs need collaborating physicians in every hospital which is not realistic and thus a limitation of requiring collaborative agreements.
- Midwives have good outcomes because they spend significant time building relationship with patients (through “well pregnancy counseling”) and are not as constrained as physicians.
- It is the mother's choice to labor as she wants. Mothers are often willing to sign to acknowledge whatever risks may be present and what the provider will and will not do in order to protect that choice.
- If parents had some birth insurance they could purchase to balance out the risks, may be a way to share responsibility in a real, live way given the current situation of the physicians' significant liability. The family would take out the insurance, not the provider.
- CPMs welcome continuing education from the state to ensure all tests are done (such as the new congenital heart disease screening). Regulation can ensure deliveries are safe.
- Many women choose home births because they get more time with the midwife and education. The collaboration is what they're looking for. It is the responsibility of the hospital and OBs to receive a transferred patient if necessary.
- It is for the mother, together with her practitioner, to make determinations and choices regarding delivery. They should discuss and assess the risks each is willing to accept and care providers work within their scope of practice. If women are given the information, the real numbers and facts, the true circumstances, they will make the best decisions for themselves. Instead, women are often pressured with fear and not trusted to make these decisions. Informed consent, contracts and releases are some tools that can be used to limit liability for practitioners.

Items for Follow-Up

- Institute of Medicine report

- Oversight of CPMs, scope of practice and educational requirements.
- Maryland data

The meeting concluded at 4:15 PM

Next Meeting:

Thursday, October 25, 2012, 2-4:00 PM

Maryland Department of Health and Mental Hygiene

Room L-1

201 W. Preston Street

Baltimore, MD 21201