Midwives Workgroup Meeting
October 25, 2012

Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Room L-1
Baltimore, MD 21201

Meeting Minutes

Attending in person:
Bonnie Birkel, BSN, CRNP, MPH, Department of Health and Mental Hygiene (DHMH)
Jenifer O. Fahey, MPH, CNM, Expert in Midwifery Care
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)
Brynne Potter, representative for Ida Darragh, North American Registry of Midwives (NARM)
Mairi Breen Rothman, CNM, American College of Nurse Midwives (ACNM)
Mary Lou Watson, MS, RB, Maryland Board of Nursing (BON)

Attending via telephone:
Senator Karen Montgomery, Maryland Senate

Not in Attendance:
Susan Jean Dulkerian, MD, American Academy of Pediatrics, Maryland Chapter (AAP)
Melissa Yates, MD, American College of Obstetricians, Maryland Section (ACOG)

Staff: Maura Dwyer, DrPH, MPH

Other: Approximately 40 members of the general public also attended the meeting.

Follow-Up from Meeting #3 on September 20, 2012

- Reviewed handouts: materials inside the folder are from today's speakers, materials outside the folders are handouts from Workgroup members. Updates were provided by NARM for the "State Case Studies of Non-nurse Midwives" that was emailed to the Workgroup on Monday; please use the version dated October 25, 2012 as it is the most up-to-date. A map of the number of OBs and CNMs providing obstetric care in Maryland as of March 2012 is included. These counts are collected through quarterly surveys of Local Health Department staff by DHMH's Maternal and Child Health Bureau.

- Please submit expense reports for reimbursement of mileage and parking costs to Maura Dwyer.

- Based on feedback from the Workgroup members, a 5th meeting is not warranted but we will be hosting a conference call on Wednesday, November 14, from 3-5pm.

- We are asking each Workgroup member to provide options for each of the four charges to the Workgroup on behalf of the organization s/he is representing for inclusion in the final report. These options shall be submitted to Maura Dwyer by close of business on Friday, November 2nd. You may propose as many options as you see indicated; they do not need to be mutually exclusive. Please be succinct and do not use numbering, bold, underling, italics or all caps or insert any tables, charts, pictures or other graphics.

- We will use our conference call on November 14th (3-5pm) to review the options proposed from each of you, and prepare a final draft report for your review on November 16th. The deadline for comments on the draft will be Tuesday, November 27th. The final draft will be submitted to the Deputy Secretary of Health on December 1st. The final report to the General Assembly will be submitted on January 1st.

Key Points from Presentation by Jenifer O. Fahey, MPH, CNM, Expert in Midwifery Care: "Midwifery in Maryland, a Hospital-based CNM's Perspective"

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

- Ms. Fahey has been a CNM for 12 years; she is one of 7 CNMs on faculty with the UMD School of Medicine. She believes in the midwifery model as the standard for maternity care. She also knows that some women require the care of physicians capable of providing services (including emergent cesarean section) that midwives to do not provide. She therefore believes in collaborative practice and is fortunate to work in a setting where she has such a practice and is supported by her OB and MFM colleagues. Ms. Fahey had one of her babies in a birth center and one in the hospital with her CNM and OB colleagues.
- Want women to make informed choices, not choices based in fear. She does not want women to flee hospitals based on fear.
- Hospital-based CNMs can be called by physicians to work with a woman to change positions during labor instead of receiving an epidural, for example, but CNMs can only do that if they're there, at the hospital.
- Many of the well-performed studies on home births occur in systems with integrated care.
- Ms. Fahey had a bad experience with a woman who was en route to her planned, hospital birth and simply did not make it. Ms. Fahey caught up to her on the highway and attended the birth in the ambulance that picked her up on the highway and took them to the nearest hospital. It was there that she experienced what she has heard many women and midwives who wind up needing a transport experience, which was a cold reception and a scolding upon arriving on Labor and Delivery, including the statement, "What the hell happened here and why is there a midwife," before even checking the patient.
- Ms. Fahey underscored that many women choose home birth because VBAC is not an available option in many Maryland hospitals or with many providers. Ms. Fahey's practice, which does provide VBACs, has received as transfers of care a number of women late in pregnancy who originally were told by their providers that they could have a VBAC, but were then near term and told they had to have a scheduled C-section.

Key Points from Presentation by Mairi Breen Rothman, CNM, American College of Nurse Midwives: "Home Birth and the Public Health Response: Promoting Informed Choices and Healthy Outcomes"

See PowerPoint slides, and additional comments provided by Mairi Breen Rothman during her presentation (but not included in the slides):

- Ms. Breen Rothman wants it on record that she is very disappointed that two of the physicians are not here today to hear the presentations on midwifery practice. She thanks Dr. Morris for his attendance and will offer to do the presentation personally for the two other physicians.
- Her presentation is in the context of planned home births that have an attendant, including birth center births. Birth center births are just like having a home birth at someone else's house. They are a fantastic option. A home birth has all the equipment and supplies you would have at a birth center.
- Regarding the research on home births: the study by Johnson and Daviss included deliveries by unlicensed midwives and the outcomes were still good. The Wax Study has been refuted by several authors, including authors of the studies which were included in Wax's meta-analysis.
- Mairi's two-CNM practice does about 75 deliveries per year. They turn several mothers away each month because they are at capacity. They waited approximately five years to be licensed in Maryland, which was in stark contrast to Washington, DC where they just had to show they graduated from an accredited program, were certified, and completed continuing education. Staying licensed is difficult in Maryland, too, where investigations by the Board of Nursing can take 2-3 years; the CNM's license may be suspended in the meantime.
- Many insurance companies don't cover home births or consider pregnancy to be a pre-existing condition, which is illegal in Maryland, and there is no recourse because most of the companies are based out of state.
- A lot of unattended home births are CPMs; the family goes to LHD and physician signs off there. Data shows 25% of home births are attended by physicians; those are likely CPM-attended.
- Prenatal care provided by a CNM is on the same schedule as an OB provider, with the same labs and sonograms. Most visits are done in the home but also through group appointments with other women at the same point in their pregnancy. Two CNMs attend every birth because there are two patients.
- At the home birth: IV set-up, oxygen, Pitocin and other medications, resuscitation equipment, sutures, syringes. CNMs monitor vital signs, contraction patterns, nutrition, energy and monitor the baby according to ACOG Guidelines for Intermittent Auscultation or more frequently. Baby is left on the mother for 1-2 hours following delivery, cut the cord when the mother goes to the bathroom, put baby skin to skin on dad. CNMs leave only when mother can eat, drink, nurse, and shower unassisted, and baby has been thoroughly examined and has nursed.
- Baby is seen by CNM the next day, goes to the pediatrician the day after delivery or pediatrician comes to home, and CNM sees baby the third day. Mother is seen on postpartum days 1 and 3, and again at 2 weeks and 6 weeks postpartum by CNM.
- Transfers are rare and are largely due to failure to progress among first time mothers. The CNM calls area hospitals to see who is on where; transfer to CNM if possible.

- Emergencies: call 911; IV line in; get mother stable; call Labor and Delivery and give full report; go straight to Labor and Delivery.

Key Points from Presentation by Brynne Potter, CPM, North American Registry of Midwives (NARM).

Ms. Potter presented information regarding CPM practice on behalf NARM (at the request of Ida Darragh):

- Ms. Potter is a CPM, licensed in Virginia; had a home birth practice but is currently not practicing. She sits on the NARM Board of Directors. She has co-authored two papers, including the Policy Brief (*CPM: Recognizing a Valued Maternity Care Provider)* handed out today, and has another paper on the way.
- The policy recommendations in the executive summary of the Policy Brief (*CPM: Recognizing a Valued Maternity Care Provider)* are the focus of her presentation.
- NARM recommends establishing licensure based on the CPM credential, with oversight provided by some board of midwifery that includes CPMs. NARM also mandates data collection for CPMs because they are a hidden population caring for a hidden population.
- States with regulatory guidelines that pre-date the NARM CPM certification are not the models to consider for Maryland.
- NARM's position regarding practice is in agreement with ACNM, which is that CPM practice should look like CNM practice. The dividing issue is educational requirements. The CNM degree requires completion of an academic, masters' level, nurse-midwifery education program whereas the CPM requires a high school diploma and completion of an apprenticeship education program. The apprenticeship fieldwork training must span at least 2 years and include a certain number of clinical hours. Most CPMs, however, do attend some sort of formal education via community colleges, un-accredited midwifery programs, etc.
- Disparate licensing requirements between states represent a barrier to safety and accountability. It requires that nationally certified midwives practice within a varied scope of practice and level of integration within regional health settings. Setting a common licensure would increase consumer awareness of midwives and their scope of practice. The first step to bringing coherence to practice is licensure. The CPM should be the criteria for licensure.
- Maryland is at a crossroads with health care reform and a workforce shortage. The innovative educational framework for CPM education that is based on competencies with more fieldwork than academic training would serve Maryland.

Discussion Points Related to Presentations

Board of Nursing (BON)

- When a charge is made against a CNM (or any nurse), a determination is made regarding the health of the public. If it is determined that there is a safety risk, which occurs in a small number of cases, the license is suspended. There is an investigation, which includes interviews with everyone involved, which can take some time. The first option a nurse is presented with is a pre-settlement conference, where the nurse can explain what happened and ask for leniency. There usually is a settlement made at that point. If the nurse doesn't agree or the settlement conference can't come to agreement, the BON makes a decision regarding whether there is merit to the case or whether it should be ended. If the decision is to continue the case, there is a hearing with the accused nurse. The process doesn't have to

take 2 years; 2 years would be the longest the entire process would take given the many steps involved.

- There was a backlog of investigations but the BON has caught up under new leadership.
- One of the four CNMs reported to be performing home births in Maryland currently is suspended and awaiting clearance from the BON. She was serving southern Maryland. There was another CNM suspended who served the eastern shore and some of southern Maryland. Currently only Prince George's, Anne Arundel, Howard and some of Baltimore and Montgomery counties are able to access CNMs to attend home births (not including out of state CNMs). See map, "Homebirth Midwife and Birth Center Availability in Maryland," provided by Jeremy Galvan from Maryland Families for Safe Birth.
- A small percentage of nurses actually get suspended but out of the four CNMs with complaints in the last two years, three have had temporary suspensions, and their cases were not reviewed by their peers. The BON deals with a large volume of cases, a tiny fraction are CNMs. The BON does not have a CNM representative. There is not a representative for every specialty because there are over 60 specialties in nursing. They do have a representative for Advance Practice Nurses, which includes CNMs.

<u>Liability</u>

- Several years ago malpractice was so out of control, nurses couldn't afford malpractice insurance, OBs couldn't afford for their CNMs to have it, CNMs lost places to do their practicums and had to stop practicing.
- Physicians and CNMs don't want to be responsible for what the other does. The medical legal issues are central to this. It presents an impasse. It's not that physicians don't appreciate midwives but they don't agree with everything they do.
- If midwives are treated like the independent, licensed providers then there is no need for a practitioner to take responsibility for another's actions. This would eliminate barriers to collaboration and the medical malpractice issues.

<u>Collaborative Agreement</u>

- A collaborative plan and an attestation are not the same. A collaborative plan requires only that a physician is willing to put his/her name on the plan. No signature is required but it may serve to protect midwives as physicians sometimes deny they agreed to collaborate.
- Maryland Families for Safe Birth is not opposed to an environment where all providers are working together; the current environment is what they are opposed to.

<u>CPMs</u>

- There are three national credentials for midwifery: CNM, CPM and the CM (Certified Midwife). The CM is part of the ACNM model and is recognized in New York, New Jersey and Rhode Island. It is a non-nurse midwifery program. The educational requirements are different than the CPM. It requires 18 months of midwifery education in an ACNM-accredited school of midwifery in addition to a Bachelor's degree in any subject with completion of specific science courses. The challenge is the need for a board to oversee the CMs. It would not be appropriate for CNMs to oversee non-nurse professionals (same challenge that exists for CPMs). There are approximately 70 CMs in the country. Nursing schools are not opposed to CMs, it is the licensing that is the challenge.

- The core competencies of midwifery are different than nursing. There is no nurse-midwifery program, there are nursing programs and there are midwifery programs.
- National certification for CPMs is consistent with EMTs (Emergency Medical Technicians); they don't follow state-specific regulations, just national.
- Families will continue to use CPMs if they have to. The safest thing to do is license them, get education and training opportunities in the state for CPMs, and make Maryland a model.

VBAC
- Fear of C-section is something that the policy side can help address and where there is the responsibility to facilitate choices.

Evidence
- Prenatal Care registry data will be published in January. CPMs are included in that data and their outcomes look just as good as CNMs.
- Maryland Families for Safe Birth noted the Wax study was flawed but even they reported no increase in perinatal death rates among home births.

Medicaid
- Medicaid covers CNM professional fees in all settings.

Training
- Maybe it would be possible for the State to subsidize out-of-state midwifery education programs, such as the Frontier Nursing University's CNM program, so that Maryland students get in-state tuition. However, there is still the challenge of not having enough preceptor sites for clinical training for CNM students.

Public Comment
- It is unclear how the physicians on the Workgroup who missed today's presentations will be able to offer recommendations.
- CPMs are needed to provide mothers with options. Mothers are interested in midwives, not a CNM vs. CPM vs. CM. She was forced to choose a CPM for VBAC experience and a CNM for proximity to her home.
- Physicians often don't like the choices mothers make, like declining bloodwork.
- The public's health is served by having the provider a mother chooses. Need more providers to facilitate this choice and more oversight.
- Physicians, not nurses or CNMs, speak negatively of other midwives. Need to educate medical and nursing students about midwifery, but medical students in particular.
- Almost every Maryland CPM has been at every Workgroup meeting. CPMs practice at great personal risk to provide home births for women in Maryland. Need to consider who's at the table, making decisions. Hope CPMs can safely sit at the table and take part in the conversation.
- When emergencies do occur, need to go to a hospital where midwives will be respected. Opted to go to a Virginia hospital because the midwife wouldn't have been respected in Maryland.

- Practiced in OB unit of a hospital as a nurse and saw home births with CNMs and CPMs, believe CPM is a wonderful option.

Items for Follow-Up

- Provide options for the final report to Maura Dwyer by COB on Friday, November 2, 2012.

The meeting concluded at 4:15 PM

Next Meeting:

Phone conference on Wednesday, November 14, 2012
3-5pm
Workgroup Members only