

**Midwives Workgroup Meeting**  
August 23, 2012

Department of Health and Mental Hygiene  
201 West Preston Street, L-1  
Baltimore, MD 21201

**Meeting Minutes**

**Attending in person:**

Bonnie Birkel, BSN, CRNP, MPH, Department of Health and Mental Hygiene (DHMH)  
Susan Jean Dulkerian, MD, American Academy of Pediatrics, Maryland Chapter (AAP)  
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)  
Senator Karen Montgomery, Maryland Senate  
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:**

Ida Darragh, North American Registry of Midwives (NARM)  
Joan Tilghman, PhD, WHNP-BC, CNE, Expert in Health Disparities

**Staff:** Maura Dwyer, DrPH, MPH

**Other:** Approximately 25 members of the general public also attended the meeting.

**Follow-Up from Meeting #1 on July 12, 2012**

- Maura Dwyer will provide staff support to the Workgroup in place of Anna Robert, MSN, DrPH, who moved to San Francisco. Maura has a Doctorate of Public Health from Johns Hopkins School of Public Health and a Master of Public Health from George Washington University. Maura's contact info: [maura.dwyer@maryland.gov](mailto:maura.dwyer@maryland.gov) and 410-767-3702.
- Midwives Workgroup web site is available:  
<http://dhmh.maryland.gov/midwives/SitePages/Home.aspx>. All meeting materials, minutes and agendas will be posted at this site.

**Key Points from Presentation by Karen Fennell, RN, MS, American Association of Birth Centers (AABC)**

**Background on Birth Centers**

- AABC Standards for Birth Centers are being updated with major revisions anticipated. Copies of current standards are available for Workgroup members only.

- Birth Centers are accredited by the Commission for the Accreditation of Birth Centers, the only accrediting body devoted only to birth centers.
- First Birth Center opened in New York City in 1975; today 82% of States have regulations for licensing Birth Centers.
- 30% increase nationally in birth centers in the past 5 years, although no increase in Maryland, where 5 Birth Centers have closed since 1998: Greenbelt in 1998; Frederick in 1998; Baltimore City in 2004; Bethesda in 2007; and Huntington in 2008. Two Birth Centers remain in Maryland; both are located in Annapolis.
- The Birth Centers in Maryland closed because a majority of OB/Gyns refuse to collaborate with CNMs as they do not get paid to collaborate. There is only payment if there is a formal referral. Further, Midwives get patients from all over Maryland. Even when there is a collaborating physician, distance can prohibit them from actually seeing the patient.

#### Barriers to Practice: Liability

- Myth of Vicarious Liability - goes back to the early 1980s when an insurance liability crisis led to major reform at the Federal level. Most CNMs and many OB/Gyns lost malpractice insurance. One underwriter continued to provide liability coverage to birth centers but moved out of malpractice insurance in 1990.
- Maryland currently ranks in the top 5 most expensive States for malpractice insurance with a premium averaging \$34,000 per year. The first premium drop in Maryland (of about \$2,000 per CNM) occurred last year.
- Malpractice suits very common in obstetrics. The most common suits are for neurological problems. Very few are due to negligence but the families have nowhere to go to get the money to support a disabled child for life and so sue the OB providers as well as birth facilities. Thus, OBs and CNMs must purchase insurance coverage up to the age of majority of the last child they delivered, “the tail.” This has driven providers out of the field.
- An ACOG survey of 10,000 OB/Gyns (out of 35,000 asked to participate) on malpractice found that 77% had experienced at least one liability event in their career; 42% of the claims started in residency training.
- Without Tort Reform it will be difficult to make any significant progress in MD. The Harkin Amendment in the Affordable Care Act (ACA) requires MCOs (all except Federal plans) to include non-physician providers as of 2014. Will be looking to the State Insurance Commissioner to see if they will enforce this in Maryland.
- The Family Health & Birth Center of Washington, DC (the only free-standing birth center in DC) paid \$250,000 per year in malpractice insurance. They became a Federally Qualified Health Center (FQHC) and now are protected under the Federal Tort Claims Act. However, the real cost savings are in the positive birth outcomes.

#### Barriers to Practice: Admitting Privileges

- Hospitals refuse to grant admitting privileges to CNMs, saying there is no need. AABC believes this contributes to transport safety issues, consumers who feel degraded, and disruption in continuity of care. The transport rate for birth centers is low (5-10%) and has not changed in 30 years. Primary reason for transport is failure to progress. Should consider the Admitting Privileges legislation in Washington, D.C as a model for Maryland.

### Barriers to Practice: Certificate of Need Denials

- Need legislation that distinguishes birth centers from hospitals, thus allowing birth centers to be located and operated near a hospital without requiring a certificate of need as if they were competing with the hospital.

### Barriers to Practice: Board of Nursing (BON)

- BON has not given CNMs or Certified Nurse Practitioners (CNPs) support for operating their own businesses and does not support the licensing of Certified Professional Midwives (CPMs).
- CNMs are regulated by a body (the BON) that does not include a CNM.
- Lack of Due Process - when the BON receives a complaint, they are quick to suspend a CNM's license. In contrast, the Medical Board takes the position that a physician is innocent until proven guilty.
- Trends in Texas, California and Florida show CPMs and CNMs opening Birth Centers together.
- AABC recommends creating a new Board for CNMs and CPMs.

### Barriers to Practice: Collaboration Requirements

- The proposed Maryland legislation would have removed requirements for collaboration between CPMs and OB/Gyns. Many States don't have such requirements and it works well.

### Barriers to Practice: Data

- The true shortage of OB providers in Maryland is hard to define. When the State conducts its official shortage estimates it does not capture OB shortages, only Primary Care. In Charles County, for example, only one OB practice accepts Medicaid patients. The state should do a special study of OB shortage areas.

## **Discussion Points Related to AABC Presentation**

### Liability

- Cost of liability insurance in a practice for a CNM isn't low enough to make up for the lower revenue a CNM can bring in (due to more limited scope of practice than an OB/Gyn).
- The average OB/Gyn is sued 2.5 times in their career. Whether or not physician is found to be at fault, their insurance premium will increase sharply, often forcing the provider to stop delivering. Physicians must also report any actions in which they are involved, even if they are not found to be at fault. This has forced many of the OB/Gyns who collaborated with CNMs to stop practicing. The average age OB/Gyns in the U.S. stop practicing is age 43, after having practice for only about 13 years.

### Reimbursement

- Maryland is in violation of the federal law that requires payment of a birth center facility/facility services fee. A mandate was issued on July 1, 2010 that requires reimbursement for birth center facility fees but many MCOs refuse to pay. Maryland birth centers no longer take Medicaid patients for this reason. AABC has sent numerous letters to Medicaid without response. AABC is working with the Women's Law Group to get Medicaid to respond.

- The Family Health and Birth Center in Washington DC Birth serves mostly Medicaid patients and has cut infant mortality rates in half.
- In 2010, Maryland General Hospital's percentage of births attended by CNMs was 67.0%, and they were #2 in the state for the lowest C-section rate among hospitals.
- CPMs in particular address the challenges related to cost because their practice and training costs are less, they have their own licensing body, and their outcomes are very good.

#### Board of Nursing

- The BON's primary focus and first responsibility is always the protection of the public. When there is a complaint or accusation, in order to protect the public, the BON will suspend the license of the CNM while the issue is under review.
- It appears that CNMs are treated differentially in that a complaint against any other type of nurse would not result in suspension.
- There are 214 CNMs licensed to practice in MD; fewer than half are actually practicing Midwifery. There are only 2-3 practices in Maryland that are run and owned by CNMs. CNMs feel too vulnerable to practice in Maryland.
- BON will be presenting at the next meeting.

#### Collaboration Requirements

- Other practitioners do not have the collaboration requirements of a CNM. For example, no agreement is required between a physician and a surgeon if the surgeon needs to be called. Further, there are no clinical practice guidelines for receiving transferred patients. Maryland needs a standard transfer form and procedures to facilitate seamless transfer between midwives and physicians. This contributes to physicians' unwillingness to accept patients as they don't know where the patients are coming from. This issue will be examined at the next workgroup meeting.

#### Data

- Many OBs are involved in research but are not practicing; don't have data regarding the decrease in OBs practicing OB care.
- We need to access the federal resources to address shortage areas but do not have the data to demonstrate where there are obstetric provider shortages.

#### Closure of Maryland CNM Training Programs

- The University of Maryland's CNM program started in the early 2000s with a grant to support the significant costs of CNM training. The grant ended and the program closed in 2009. Contributing factors included the significant costs of malpractice insurance, declining enrollment, and difficulty in finding preceptor sites for student training.
- The Johns Hopkins University School of Nursing's (JHUSON) CNM program was started in 2008 by Dr. Betty Jordan and has graduated 20 CNMs to date. JHUSON was approached by Shenandoah University, which had a HRSA (Health Resources Services Administration) grant to increase providers in rural counties. JHUSON students earn a Master of Science in Nursing from Hopkins and a Certificate in Midwifery from Shenandoah. Enrollment is increasing with 10-12 graduates expected in 2013, and 20 expected in 2014. Program capacity is approximately 30 students.

- Finding preceptor sites for students is also a challenge for JHUSON. Howard County General Hospital has approximately 800 CNM-attended deliveries per year but they serve as Georgetown's preceptor site. JHUSON cannot use Howard as a preceptor site even though it's in the Johns Hopkins Medicine system. Johns Hopkins Hospital (JHH) is not a clinical site for CNMs. The CNMs at JHH decline to precept because of the impacts on their productivity. Medical student preceptors receive payment but CNMs do not. HRSA grant dollars are important for addressing this barrier.
- Local Health Departments (LHDs) used to offer clinical experience for CNMs. Prince George's Health Department, for example, was a clinical site for Georgetown CNM students. Most LHDs discontinued prenatal care clinics when Medicaid established MCOs. MCOs do not contract with LHDs, and only one Maryland LHD provides prenatal care, focused almost exclusively on uninsured immigrant women.
- Graduates from UMSON's CNM program also had difficulty finding jobs in Maryland upon graduation. 97% of CNMs work in hospital settings. Other options for CNMs include outpatient Gyn, LHD family planning clinics, teaching, or serving as "physician extenders" rather than as CNMs. Many CNMs want to practice true midwifery after the significant investment in their training; however, many who do practice report having to serve too many patients to be able to practice the true midwifery model.
- University of Maryland's CNM practice (with 8 CNMs) is based at the School of Medicine.
- California, Texas, Florida and New Mexico are more hospitable to Midwifery practice (in terms of their training, regulations, laws, etc.) and thus employ more Midwives.
- Those in Maryland who are interested in Midwifery training access distance learning programs such as Frontier Nursing Service, the University of Cincinnati, and Philadelphia University. Students in these programs are typically able to complete their coursework on-line and/or on-site at the University and train where they live.

### **Data Presentation by Maura Dwyer, DHMH**

#### **CNM and Midwife attended births as a percent of births, Maryland, 1998 and 2010**

- CNM-attended births decreased 17% between '98 and '10; Midwife-attended births increased by 86%. Only Baltimore County and Baltimore City experienced statistically significant increases in CNM-attended births. Baltimore County, Montgomery County and Prince George's County experienced statistically significant increases in Midwife-attended births.
- Data sources: Maryland Vital Statistics, 1998 and 2010 Maryland birth certificates.
- Data Limitations: On the 1998 birth certificate, Birth Attendant's name and title were entered by hospital staff as text and were then coded as MD, DO, CNM, Midwife or Other. On the 2010 birth certificate, the Birth Attendant's title was collected from hospital staff through checkbox option: MD, DO, CNM/CM, Other Midwife, Other (Specify). Greater than 90% of 'Other Midwife' attended births occurred in hospitals, suggesting CNMs may be misclassified as 'Other Midwife.'

#### **Percentage of Births to Women Receiving Prenatal Care in the First Trimester by Race/Ethnicity and Jurisdiction, Maryland, 2010**

- Prince George's County, Washington County and Baltimore City had the lowest rates of first trimester prenatal care in 2010. Rates in Maryland are lowest among Hispanics and African Americans, with 50.1% and 59.8%, respectively, receiving first trimester prenatal care.

- Data source: Maryland Vital Statistics, captured through the birth certificate, using obstetric estimate of gestational age.
- Data Limitations: a change in data collection methodology in 2010 (using obstetrical estimate versus mother’s last menstrual period to estimate gestational age) resulted in a decrease in the percentage of births to women receiving prenatal care in the first trimester.

### **Discussion Points Related to Data Presentation**

- Non-licensed Midwives are not willing to be listed as Birth Attendant in Maryland because they are not recognized and licensed by the State. Thus, the “Other Midwife” data likely represent a significant undercount of other Midwives as well as misclassified CNMs.
- The statistically significant decrease in CNM-attended births in Frederick County reflects the closing of the Frederick Birth Center and the CNM Service at Frederick Memorial Hospital.
- The new estimates of women receiving prenatal care in the first trimester may not be fully accurate but are of significant concern to DHMH. DHMH is implementing several strategies to improve access to first trimester prenatal care.

### **Public Comment**

- There is a serious shortage of home birth Midwives. Only three practice in Maryland currently. Many Maryland women are interested in having a home birth but cannot find a Midwife and are “forced underground” to deliver at home, unattended, without prenatal or postpartum care. Many of these women have had previous poor birth outcomes and lack private insurance to pay for the delivery.
- Many women choose to deliver with a CPM because they cannot find a CNM to attend their home birth and have been very happy with the quality of care they received from the CPMs.
- Many women feel home births are safer for mom and baby, particularly in relation to VBAC delivery. Many worry they cannot get a VBAC delivery in a hospital, and want to avoid a first Caesarean Section.
- Many of the barriers facing Midwives are similar to those facing physicians (malpractice insurance, low reimbursement, insurers who don’t provide coverage, etc.). Recommendations that follow from the Workgroup should address other provider barriers as well. Strategies will fail if they fail in the “physician world” too.

### **Items for Follow-Up**

- Issues regarding Medicaid reimbursement for birth center facility fees: AABC’s attempts to contact Medicaid (without response) will be forwarded to the Medicaid program for comment; AABC will share the letters to Medicaid with the Workgroup.
- The feasibility of a study regarding obstetric provider shortage will be explored.
- Public comment request: Information regarding conditions in states that are doing a good job with CPMs and Birth Centers.

The meeting concluded at 4:00 PM

### **Next Meeting:**

Thursday, September 20, 2012, 2-4:00 PM  
 Maryland Department of Transportation, Harry Hughes Suite  
 7201 Corporate Center Dr, Hanover, MD 21076