

Midwives Workgroup Meeting

July 12, 2012

Department of Health and Mental Hygiene
201 West Preston Street, L-3
Baltimore, MD 21201

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)

Jenifer 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)

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

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

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

Attending via telephone:

Delegate Ariana Kelly, Maryland House of Delegates

Senator Karen Montgomery, Maryland Senate

Mary Lou Watson, MS, RB, Maryland Board of Nursing

Unable to attend:

Joseph Morris, MD, Maryland Hospital Association (MHA)

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

Staff: Anna Roberts, MSN, DrPH

Other: Approximately 20 members of the general public also attended the meeting.

Introductions

- Bonnie Birkel, Chair of the Midwives Workgroup, called the meeting to order. Workgroup members introduced themselves and stated the name of the organization they represented.
- Fran Phillips, RN, MHA, DHMH, Deputy Secretary for Public Health Services welcomed workgroup members and thanked them for their commitment and participation. She stated that DHMH is very committed to supporting the workgroup and noted that the workgroup's

purpose and goals aligned with those of the federal Centers for Medicare and Medicaid (CMS): 1) improve the health of communities; 2) improve the consumer experience; and 3) drive down the cost of healthcare or improve efficiency. The Deputy Secretary Phillips also briefly reviewed the charges to the workgroup:

1. Analyze the shortage of certified nurse midwives in Maryland, including barriers in training nurse midwives and barriers in nurse midwifery practice in hospitals and in non-hospital settings;
2. Evaluate consumer concerns and motivations surrounding the birthing process, including the choice to pursue a home birth and concerns related to hospital births;
3. Conduct a review of current legislation and regulations in other states concerning the licensing, educational requirements, and scope of practice of certified professional midwives; and
4. Review available evidence regarding the safety and outcomes of births attended by certified professional midwives (CPMs), certified nurse midwives (CNMs), and obstetricians, as well as the safety of home births compared to hospital births.

American Association of Birth Centers (AABC) representative, Karen Fennell, and others noted that birth centers were not mentioned in charge #2 and #4, and there was consensus that birth centers should be added to charges #2 and #4.

Ground Rules

Bonnie Birkel reviewed “ground rules” expectations regarding member participation, and anticipated meeting formats:

1. This is the first of four scheduled meetings; additional meetings may be scheduled if indicated. Future meetings have been scheduled and were announced to members via e-mail from Anna Robert. Date, times, and place will be posted on the DHMH web site.
2. Conference line will be available for group members for all meetings.
3. Members may not send alternates to represent them. If members cannot attend a meeting(s) but have something they would like to have shared at the meeting, they should contact workgroup staff or Bonnie Birkel.
4. The meetings are open to the public and public comments will be solicited at the end of the 2nd, 3rd and 4th meeting.
5. The general format for future meetings will be a total of 45 minutes for presentations, 60 minutes for questions and discussion, and 15 minutes for public comment.
6. All proceedings of the group will be put on the DHMH website. This will include meeting minutes, presentations, and handouts, unless specified by workgroup members that

information shared not be made available to the public. For instance, the Standards for Birth Centers that were included in the current meeting packet are only for workgroup members.

7. A workgroup report will be developed and reviewed by workgroup members prior to being submitted to the Maryland General Assembly by January 1, 2013.

Clarification/Discussion for Each Charge to the Workgroup

#1 -- Analyze the shortage of certified nurse midwives in Maryland, including barriers in training nurse midwives and barriers in nurse midwifery practice in hospitals and in non-hospital settings.

There was a general consensus that more data is needed, and specifically more data is needed on the shortage of certified nurse midwives (CNMs). Members shared the following observations/issues:

- HRSA only provides workforce shortage data for primary care providers, not OB/GYNs or CNMs
- Maternity care was not studied in the Governor's Workforce Investment Board Report.
- Of the approximately 200 CNMs licensed in the state, only 3 to 4 CNMs are performing home births in Maryland.
- From the home birth consumer perspective, there is a shortage of CNMs who are performing home births, so from the consumer perspective, it may not be a shortage of CNMs, but a shortage of CNMs who engage in home births.
- CNM-attended births declined dramatically approximately ten years ago after the closure of several birth centers. Ms. Rothman noted her own practice has no openings for new clients until February 2013.
- Data on Maryland births occurring at birth centers in Washington, DC and Northern Virginia are full of Maryland families.
- DHMH collects some data on home births from birth certificates, there are data limitations, i.e. home births may be reported as attended by a physician because the birth certificate gets signed off by a physician at an ER or the health officer at a local health department.

#2 – Evaluate consumer concerns and motivations surrounding the birthing process, including the choice to pursue a home birth and concerns related to hospital births.

Bonnie Birkel asked workgroup members to consider ways in which consumers concerns could be best addressed but noted that consumer issues have strong representation on the workgroup from MFSB which is providing information on consumer issues at this meeting.

#3 -- Conduct a review of current legislation and regulations in other states concerning the licensing, educational requirements, and scope of practice of certified professional midwives (CPMs).

Bonnie Birkel noted that DHMH can provide workgroup members with a state-by-state review that was conducted earlier this year, and asked workgroup members to recommend any specific states to follow up with after hearing the short presentation from the North American Registry of Midwives (NARM) on today's agenda. It was noted that other states may have licensed CPMs some time ago in political environments that are much different today. In some states, the availability of CPM accreditation came after laws and regulations were already in place, and thus they would not serve as good examples. It was suggested that each of the workgroup members could present which state(s) they think would serve as a model that could work in Maryland.

Ms. Rothman (of ACNM), provided the following general definitions of Certified Nurse-Midwife (CNM), Certified Professional Midwife (CPM), Certified Midwife and Lay Midwife:

- CNM – a practitioner with a degree in nursing and who then gets accredited through the Accreditation Council on Midwifery Education (master's degree).
- CPMs – national credential, non-nurses, scope of practice limited to the childbearing year and out of hospital births.
- CM – non-nurse midwives with training from the Accreditation Council on Midwifery Education.
- Lay midwife – anyone who is catching babies without certification or formal training.

#4 – Review available evidence regarding the safety and outcome of births attended by certified professional midwives, certified nurse midwives, and obstetricians, as well as the safety of home births compared to hospital births (and birth centers).

The Maryland Families for Safe Birth (MFSB) representative, Jeremy Galvan, noted that MFSB has accumulated all of the literature and offered to share with workgroup members. It was suggested that the workgroup focus on peer-reviewed publications when evaluating scientific evidence. Another suggestion was that DHMH conduct a new search to be sure the workgroup has the most recent data/literature from non-biased sources. It was noted that the American College of Nurse-Midwives (ACNM) has an annotated bibliography that is continuously updated on a daily basis and there is no need for DHMH to do a special search. One suggestion was that each workgroup member share or present the literature they view as the most rigorous in terms of scientific evidence.

Concern was raised that the scientific literature may not report outcomes and safety from the individual's experience. In addition, the workgroup should not focus just on immediate outcomes, but also important to consider other things that can be measured (c-section rates, repeat c-section rates, increase in maternal morbidity a result of interventions with the first pregnancy and birth, and subsequent secondary outcomes). It was further noted that it is

important to consider the need for care and follow-up of the newborn, particularly with regard to required newborn screening, as additional outcomes of interest.

North American Registry of Midwives Presentation -- Certified Professional Midwives (CPM) Licensure – Ida Darragh

Bonnie Birkel noted that the North American Registry of Midwives (NARM), was provided time on the agenda for this meeting because representative Ida Derragh was uncertain if she would be able to travel from Arkansas to attend future meetings in-person. Ms. Darragh made the following key points:

- CPMs are often called “direct-entry” midwives and are not generally nurses.
- CPM is a national credential but each state sets the licensure requirements for CPMs; 26 states currently license CPMs
- NARM is not an educational institution, it is a certifying agency, and is the only certifying agency that requires out-of-hospital birth training
- NARM’s position statement on licensure of CPMs was reviewed (handout)
- An overview of states that license CPMs was provided (handout); some states require CPM credential for licensure, some do not.
- A news article was reviewed (handout) from local newspaper in Washington State that summarized a Washington study concerning CPMs. Bonnie Birkel noted that the full report from the study would be provided to the workgroup.
- As Director of Testing for NARM, Ms. Darragh works with each state that licenses CPMs, verifying the certification status of CPMs to states.
- It is difficult to find outcome data for CPM births. There is no national database of outcomes like infant mortality rates for CPMs. Most states do not collect the information and states that do collect data aren’t consistent in the variables that they collect...
- No state that has a licensure program has ever shut down a CPM practice as a result of poor outcomes or problems. Every state that licenses CPMs has given NARM positive feedback.

Questions & Answers

Can a nurse become a CPM? Yes. Can someone already trained/certified as a Women’s Health Nurse Practitioner be certified as a CPM? Yes, but a nurse cannot work under both scopes of practice at the same time.

Is there a minimal educational requirement for CPM?

High school education is the minimum requirement; there is no requirement for college education. Competencies are verified in clinical settings, not in educational settings. Ms. Darragh stated that level of education is not relevant to training and competencies for a CPM.

How has NARM dealt with malpractice issues?

NARM does not deal with it. Florida is the only state that requires malpractice insurance. No other states do.

How have CPMs dealt with liability issues?

NARM does not believe malpractice is an issue because people do not file suits against CPMs. Parents have taken an active role and made an active decision to have their birth with a CPM. NARM requires that all CPMs provide informed consent. Ms. Fennell (AABC) noted that there are insurance carriers who will provide liability coverage for CPMs and if they were licensed in Maryland, they would be able to obtain liability insurance. Ms. Rothman (ACNM) noted that client autonomy and choice of a home birth are the key reasons that midwives don't get sued. Home birth midwives are not required to have liability insurance. Of the CNMs who do home births, some do and some don't carry liability insurance.

A broader discussion of home birth began following this presentation and will continue at future meetings. Members requested a copy of the Consensus Statement from Home Birth Summit that was held in October 2011, and any other such official statements from national organizations, prior to the next meeting.

Maryland Families for Safe Birth Presentation – Consumer Issues – Jeremy Galvan

Jeremy Galvan read prepared statement (provided after the meeting -- attached). Maryland Families for Safe Birth (MFSB) started as a Facebook page. There are currently 300 active volunteers who are drawn from very diverse backgrounds. Key points:

- MFSB's "non-negotiable truths:"
 - Women are at all times autonomous
 - Women, either alone or with their partner, choose the place of birth, their attendants and the care they receive
 - All women in maternity care settings should receive respectful, woman-centered care.
 - All women and families planning a home or birth center birth have a right to respectful, safe and seamless consultation, referral, transport, and transfer to the nearest appropriate care facility, if necessary.
 - They ask DHMH to license and uphold care standards of CPMs so that citizens can have legal access to both CNMs and CPMs to serve their home birth and birth center needs within a system of cooperation and integration throughout the maternity care system.
- Primary consumer concerns
 - Limited access to legal home birth midwives (of 200+ CNMs licensed in the state, only 4 CNMs in the state do home births – consistent with national CNM trends why if liability insurance is not an issue??)

- Lack of due process for CNMs who have had a complaint lodged against them with the Board of Nursing
- Lack of VBAC (vaginal birth after Caesarean) availability in Maryland hospitals despite ACOG's statement that women should be offered the option of a VBAC (cited this as one of the main reasons women choose a home birth is that they want a VBAC).
- Hospitals' inflexibility regarding evidence-based practices, such as delayed cord clamping, skin-to-skin contact immediately after birth, competent breast feeding support, allowing baby to lay on mom's chest in bed, physiologic delivery positions, declining routine IVs, intermittent auscultation of fetal heart tones, light nutrition and hydration, infrequent vaginal exams, declining pharmaceutical pain management,
- Hospital atmosphere of constant questioning about the family's refusal of intervention and culture of not supporting the woman's effort.
- A medical system in which OBs feel pressured to practice defensive medicine and resultant problems with home birth transfers. The OBs in Maryland should be the experts on high-risk birth and emergencies. When a woman is transferred from home to hospital, she should be received with compassion and respect. The midwife (CPM or CNM) should be able to hand over records and give report, so that care is seamlessly transferred to another provider while the midwife is permitted/encouraged to maintain her supportive relationship. There should be a standardized transfer form, much like paramedics provide to hospitals.

In conclusion Mr. Galvan commented that licensing CPMs would be a small step in the right direction for improving birth outcomes in Maryland. MFSB believe CPMs should be under the board of midwifery, which should include nurse midwives who are doing home births. MFSB is open to how CPMs are licensed in the state – just want safe care.

General Discussion – Key Issues

Vaginal birth after a cesarean: The Maryland Section of American College of Obstetricians and Gynecologists (ACOG) representative, Dr. Melissa Yates, noted that VBAC policies vary greatly from hospital to hospital and are largely related to policies of medical malpractice insurers. Mr. Galvan noted that a situation in which a women demanded VBAC/refused a c-section, child services were called. Dr. Lazear noted that nursing students at University of Maryland do not receive training in hospitals that do not support VBAC, but also noted her concern that VBAC at home is much higher risk. The workgroup should consider who is a good candidate for a home birth, including for VBAC or breech births, to ensure that those who are attending home births are seeing appropriate candidates. Jen Fahey commented that ACOG and ACNM are working together now in a way that they haven't in the past. Her CNM hospital-based practice has been able to offer women VBACs. Bonnie Birkel noted that there are no data available presently to support that VBAC is a primary reason women are seeking home births.

Home birth: Ms. Rothman noted that in her experience, more women are seeking home birth because they don't want the risk of a FIRST c-section. Few look at the morbidity that can occur with the first c-section when reviewing the outcomes in the literature. In her practice, women tell her they are choosing a home birth because that is the safest place for themselves and babies. She noted that her practice serves many healthcare providers (nurses, pediatricians, neuroscientists) who are choosing a home birth. Mr. Galvan noted that his wife chose home birth, because she wanted a natural birth with minimal intervention, which is very hard to facilitate in a hospital -- it is possible to have "good births" in the hospital, but it is very hard to do. Mr. Galvan agreed that who is a good candidate for a home birth is important, but MFSB believe any woman should be able to give birth wherever she wants, and likewise, a midwife should not be forced to deliver someone that she does not want to deliver if she doesn't agree that the woman is a good candidate. Risk assessment and decision making are already integral to CPM training and CPM practice should not be legislated. However, AABC countered that there is no standard definition of low-risk. This is a decision that a medical professional must address. Need to consider co-management. Birth centers do a lot of co-management with physicians for high-risk women.

Integration of care: Delegate Ariana Kelly noted that the main consumer issue that came up during the hearing focused on the integration of care, transfers, and professional communication. She personally chose a home birth because she could not risk a c-section (and the longer recovery time as she needed to get back to work), and asked Mr. Galvan to address any difficulties in the transfers that he has heard about. Mr. Galvan noted the primary issues in transfers are for emergencies, not as a result of the care provided by the CPM or CNM. Ms. Rothman added that while most homebirth attendants (including CNMs in Maryland) must have a plan for a transfer of care, there is no requirement for procedures or plans on the receiving end (the hospital). Ms. Darragh noted that all CPMs are required to have to have a written back-up plan for mom and baby, but there is no requirement that a physician agrees to it. As far as transfer of care, the best way to ensure safe transfer is to be a legal provider. The Maryland Chapter of the American Academy of Pediatrics Maryland Chapter (AAP), Dr. Sue Dulkerian noted that we must specifically address the safety of the newborn with regard to mandated newborn screening tests, and plans for immediate evaluation and resuscitation if necessary before transfer can be arranged. It would be important to assure CPMs are trained to assure transfer of care to primary care providers. There was consensus to have this issue placed on the agenda of a future meeting and for DHMH to look for "best practices" in other states.

The meeting concluded at 2:15 PM

Next meeting: Thursday, August 23rd, 2-4PM, Room L-3 at DHMH.