President’s Letter

Although daunting challenges and barriers remain for creating unfettered access to CPM care for childbearing women, the profession is gaining significant momentum, both in the States and on the Federal level. In many instances, CPMs are no longer “knocking on the door”; instead doors are opening and CPMs are being invited in. While it remains essential for CPMs to continue to address our many challenges, it is also important to stop for a moment to notice where the doors are opening and the opportunities emerging for CPMs to fully step into their role as primary maternity care providers in our country.

Already in 2011, legislation securing the position of licensed midwifery and increasing access to CPM services has passed in Idaho, Vermont, Colorado and Oregon and a new CPM-owned birth center has opened in Washington. Take a look at “CPMs in the News” to read more.

The organizations and agencies that support the CPM continue to grow in capacity: more schools are seeking MEAC accreditation; the Association of Midwifery Educators (AME) is in its fifth year of supporting educators and students; NARM has undertaken a review of the general education eligibility requirements for CPM certification while the number of CPMs builds steadily every year; and MANA’s Division of Research Statistics Project continues its growth as one of the world’s largest, prospective databases on midwife-attended birth, out-of-hospital birth, and normal birth practices. Read these exciting reports for ways that you can participate.

NACPM increases its capacity to effect change in the maternity care system with every coalition it joins. Explore the MAMA Campaign’s exciting new bill, H.R. 1054, introduced in the House of Representatives in March, as well as recent unique opportunities to align our work with the vision of the Center for Medicare and Medicaid Services (CMS) for improving perinatal
outcomes in the U.S. Read about NACPM’s participation with ACNM and MANA to influence policy and research with the first-ever U.S. consensus statement on normal birth; about an exciting consensus summit in October in Washington, DC to better support and care for women choosing home birth; and a unique national coalition to promote improved maternity care on the Federal level.

And last, but by no means least, learn about the inclusion of CPMs in Congressional maternity care reform legislation; the natural role of CPMs in an important policy trend in maternity care - Health Information Technology - in Brynne Potter’s article, Patient Centered Health Records are the Pathway to a Healthy Maternity System, and about CPMs and the mainstream in Ellie Daniel’s piece on Why Accreditation Matters.

We hope you enjoy this exciting journey through the first half of 2011 for CPMs. Please write to us at info@nacpm.org and watch your email in-box for new ways coming soon for participation in your national professional association for CPMs in the second half of 2011 and beyond.

With very best wishes for a wonderful summer,

Mary Lawlor, CPM
President, NACPM

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NACPM and the Coalition for Quality Maternity Care

In April, 2011, nine national professional, consumer, and human rights organizations formally launched the Coalition for Quality Maternal Care (CQMC) to champion the urgent need for national strategies to improve the quality and value of maternal and newborn health care in America.

The founding member organizations of the CQMC include: the American Association of Birth Centers; American College of Nurse-Midwives; Amnesty International USA; Association of Women’s Health, Obstetric and Neonatal Nurses; Black Women’s Health Imperative; Childbirth Connection; International Center for Traditional Childbearing; Midwives Alliance of North America; and, the National Association of Certified Professional Midwives.

The launch of the CQMC comes on the heels of the release of “Women in America: Indicators of Social and Economic Well-Being,” an inter-agency federal report of how women are faring in the United States today and how these trends have changed over time. Prepared by the Department of Commerce and the Office of Management and Budget in support of the White House Council on Women and Girls, the publication specifically highlights current challenges in maternal health, including the highest US cesarean birth rate on record at 32 percent of all births in 2008, (most recently 32.9%) the resulting increase in complications for women and their newborns, and higher costs. The report also notes that the US maternal mortality rate, which was declining until the mid-1980s, is now significantly higher than for many European countries.

The CQMC is working to establish national strategies to ensure access to affordable, high quality maternity care for all women and infants. It seeks to achieve this goal by removing barriers to optimal maternal health practice, promoting models of care that are evidence-based, improving maternity care choices for women, and reducing disparities in maternal and newborn health outcomes. CQMC meets monthly, and pays particular attention to Congressional legislation designed to improve the quality of maternity care in the U.S.
Colorado Passes Sunset Review

On May 11, just hours before the end of the 2011 session, the Colorado State legislature adopted Senate Bill 88, renewing the regulation of direct-entry midwives until the next sunset review in 5 years. SB 88 provides, for the first time, the ability of Colorado midwives to obtain and administer Vitamin K, Rhogam and anti-hemorrhagics, the administration of IV fluids, and the repeal of the prohibition against registered nurses simultaneously being licensed as midwives in the state. Suturing was removed from the bill by the House sponsor when it became clear the bill would not pass with it included; however the statute does require the various stakeholders to meet and discuss authorization to perform suturing of perineal tears later this year.

The steady progress of this bill through the legislature is testimony to the respect that the midwives have gained in the state since the last sunset review ten years ago. It seems that home birth midwifery is an idea whose time has come in Colorado. The Colorado Midwives Association sincerely appreciates the efforts of the many, many families and midwives from across the state who wrote letters and made calls, securing this victory for home birth families – compelling testimony to the power of grassroots activism!

Karen Robinson, CPM, RM
President, Colorado Midwives Association

Insurance Must Pay For Home Birth In Vermont

On May 18, surrounded by a happy group of mothers, children, midwives and public health advocates, Gov. Peter Shumlin signed S.15 into law, requiring insurance companies to reimburse midwifery care by CPMs and CNMs, including home births.

Previously, CPM and CNM services were reimbursed by the Vermont State Medicaid program, while private insurance companies refused to pay for these services, forcing women to pay out-of-pocket even while paying insurance premiums on policies that included comprehensive maternity coverage. S.15 ends this discrimination, and Vermont joins neighboring New Hampshire, as well as Washington State and a few other states that make it possible for healthy women with low-risk pregnancies to be able to rely on insurance if they choose the option of a home birth with a CPM or a CNM.

In addition, S. 15 establishes a multidisciplinary maternal mortality review panel in Vermont to review maternal deaths, identify factors associated with those deaths and to make recommendations for system changes to improve health care services for women in the state. The bill requires that the Commissioner of Health include a licensed CPM on the panel.

Passionate advocacy by midwives, mothers, Vermont Public Interest Research Group (VPIRG) and a wide array of supporters from across the state, helped save this bill from attack by the health insurance industry and ensured its passage in the last week of the legislative session. We are pleased to share this important hopeful news with midwives, mothers and advocates around the country.

Cassandra Gekas
VPIRG Health Care Advocate

Cont. on pg 6
NACPM and the Normal Birth Task Force

In June of 2010, ACNM issued an invitation to NACPM and MANA to participate in the development of a U.S. consensus statement on normal birth. Mary Lawlor and Suzy Myers represent NACPM in this unique collaboration with ACNM. As we all are painfully aware, normal physiologic birth is under ever-increasing siege in the United States. CPMs, as primary maternity care providers whose training and model of care intrinsically promote normal physiological birth, have decades of experience in providing un-interfered-with birth, in the only settings (home and birth centers) where women today can be guaranteed the option of normal birth. As providers committed to normal physiological birth, CPMs have a compelling interest in positively impacting the maternity care system as a whole. A U.S. consensus statement on normal birth could guide future birth policy and research, and make a contribution to the world-wide effort to protect and preserve normal birth.

The collaboration is using the Delphi method, a structured communication technique that relies on a panel of experts who answer questionnaires in a series of rounds in order to produce a statement. Two rounds have been completed, and additional input is currently being collected. Presentations of the work to-date took place at the ACNM Annual Meeting (May 2011), the International Normal Birth Research conference in Europe (June 2011) and the ICM Conference in South Africa (June 2011). Mary Lawlor participated in the ACNM presentation, and Suzy Myers presented for NACPM at the ICM Conference. We will keep you updated on the progress of this collaboration.

News From MEAC

Two schools have been re-accredited by the Midwifery Education Accreditation Council in recent months. Birthwise Midwifery School, located in Bridgton, Maine, was re-accredited for the period June 21, 2011 to June 20, 2016. Their grant of accreditation includes a campus-based program and a community-based program.

The Department of Midwifery at Bastyr University, located in Kenmore, Washington, was re-accredited for the period April 28, 2011 to April 27, 2015. The Department of Midwifery started their re-accreditation review process as the Seattle Midwifery School, but during the course of their review, merged with Bastyr University, re-located to the Bastyr campus, and launched a Master’s Degree in Midwifery program.

The MEAC Board of Directors also approved an application from Maternidad la Luz to include a two-year (six quarter) program in their grant of accreditation. For more information about these and all of the schools accredited by MEAC, visit our website at www.meacschools.org.

In other action, the MEAC Board of Directors has decided to make it mandatory that all schools applying for accreditation complete an orientation workshop provided by MEAC. The workshop includes an explanation of the standards for accreditation, the application process and fees as well as instructions for the preparation of the comprehensive Self-Evaluation Report that must be submitted by all schools. The decision to require the workshop follows an evaluation of applications received in recent years that were not successful. Schools may participate in one of the scheduled workshops or make individual arrangements for training by contacting MEAC at info@meacschools.org.

Are you someone who maintains an active practice and stays abreast of current best practices? Are you interested in the quality of midwifery education? MEAC is seeking to expand the team of volunteers who review continuing education applications. The applications come in electronic format and follow very specific guidelines. MEAC CEU reviewers receive an electronic copy (email attachment or thumb drive or CD) of the application and a review form to complete; evaluation results are to be sent back to MEAC within 30 days. CEU Reviewers are asked to access approximately 2-3 applications per month. Some of the applications can be evaluated in an hour, while a large conference could take 5 or more hours. Please contact MEAC via email, ceu@meacschools.org, if you are attracted to becoming a MEAC CEU reviewer or have questions.
One of the primary jobs of the Midwives Alliance Division of Research is to maintain the MANA Statistics Project. MANA Stats is one of the world’s largest, prospective databases on midwife-attended birth, out-of-hospital birth, and normal birth practices. We have been collecting data on planned, midwife-attended births since 1993, and in 2004, we launched our 2.0 data collection instrument online. On May 5, 2009 (International Midwives Day), we debuted the new and improved 3.0 data form, facilitating data collection on over 300 variables relating to the Midwives Model of Care™. The MANA Stats project currently has over 600 active contributors, including CPMs, CNMs, CMs, traditional midwives, and students/apprentices, and our database contains over 27,000 records and counting. We are also pleased to announce that the 2004-2007 dataset (collected on the 2.0 form) is now available for researcher access. Many contributors have told us that data is power, and we certainly agree! In a political and cultural climate where both threats and opportunities for health reform exist, we see the MANA Stats project at the forefront of providing the robust, comprehensive data needed to advance the midwifery profession, decrease health disparities, and improve maternal-child health for all families. As one contributor proudly said: “By contributing to MANA Stats, I know I am helping to change the face of normal birth both here and abroad. I am proud to be a MANA Stats Contributor!”

The 2004-2007 dataset is a voluntary sample of primarily out-of-hospital births (OOH) that are heavily weighted towards CPM-attended deliveries. Preliminary statistics emerging from the 2004-2007 dataset demonstrate the importance of a midwifery-dominated maternity system and are comparable to other published studies on homebirth outcomes. For example, the rate of low five-minute Apgar scores for all intended homebirths, regardless of actual place of delivery, is 1.37% (118/8611), and the rate of labor occurring before 37 weeks is 1.4% (123/8,758). The spontaneous vaginal vertex birth rate (all births where the mother went into labor intending to deliver at home minus all non-vertex presentations, cesarean sections, forceps and vacuum extraction) is 91.6% (n=8961), the forceps rate is 0.2% (18/8,863), and the vacuum extraction rate is 1.1% (98/8,863). The cesarean section rate for all women who went into labor intending to birth at home is 5.03% (442/8,788), and the rate of low birth weight infants (<2500 grams) is 0.93% (81/8743). In addition, we have also calculated three types of transport rates: intrapartum transports (IP), neonatal transports (NEO), and postpartum transports (PP). Intrapartum transports occur when a mother is transferred to the hospital in labor prior to delivery. Neonatal transports occur when the infant is successfully delivered at home, but is then transferred to the hospital for complications in the immediate postpartum period. Postpartum transports occur when the birth is completed at home, but the mother is then taken to the hospital for complications. The IP rate is 10.6% (933/8,807), the NEO rate is 0.8% (69/8807), and the PP rate is 1.76% (155/8,807). The above values are all similar to those reported in the CPM 2000 study.

The MANA Stats project remains a voluntary sample of midwife-attended births, and while our statistics are strong, we cannot claim full representativeness for the midwifery profession. The voluntary nature of the dataset remains a weakness, but you can help! Please consider becoming a contributor to MANA Stats and help us to increase access to high-quality midwifery care through research and data collection. To enroll, visit us at www.manastats.org or email us at support@manastats.org. All midwives are welcome to enroll. If you would like to learn more about the dataset, or to apply for researcher access to the 2004–2007 dataset, please visit us at www.mana.org/statiform or email us at research@mana.org.

We express our sincerest gratitude to all our current contributors for your endless dedication to the MANA Stats Project. Your data contributions are invaluable! We look forward to welcoming new and returning contributors, and through research, uniting all midwives in our common commitment to healthy mothers and babies.

With appreciation and many blessings.

Missy Cheyney, PhD, CPM, LDM
Chair of the MANA Division of Research, Corvallis, OR
Maternity Care Reform Bills Introduced in House of Representatives

Rep. Conyers Introduces Maternal Health Accountability Act, H.R. 894

H.R. 894, the Maternal Health Accountability Act of 2011, introduced by Rep. Conyers (D-MI-14th) and Rep. DeGette (D-CO-1st) in the U.S. House of Representatives, would provide grants to states to establish state maternal mortality review committees to examine pregnancy-related deaths and to identify ways to reduce maternal mortality rates. Amnesty International’s Deadly Delivery: The Maternal Health Care Crisis in the U.S., One Year Update, reports that the U.S. has fallen from 41st to 50th in world ranking in maternal mortality, and that states reporting higher than average cesarean rates (over 33% of births) have a 21% higher risk of maternal mortality than states with cesarean rates less than 33%. In addition, women living in low-income areas across the U.S. were twice as likely to suffer a maternal death as women in high income areas, and African American women have a maternal mortality ratio 8 times higher than the Healthy People 2010 target goal.

H.R. 894 calls for the establishment of multi-disciplinary review committees, including obstetricians, midwives, nurses, consumers and others, to recommend prevention strategies. Because of the tremendous importance of this bill for childbearing women in our country, NACPM has endorsed H.R. 894, in spite of the elimination of CPMs from this stakeholder list in the bill at the insistence of ACOG. NACPM and the MAMA Campaign have reached out to Rep. Conyer’s office to discuss the importance of including CPMs in these review committees, and were well received. NACPM and MAMA are being vigilant for any opportunity to include CPMs in these review committees in the future.

To be noted, as reported elsewhere in this newsletter, the recently-passed S.15 in Vermont, specifies that a CPM be appointed to the Vermont maternal mortality review board.

Rep. Roybal-Allard Introduces the MOMS for the 21st Century Act

The Maximizing Optimal Maternity Services for the 21st Century Act was reintroduced by Congresswoman Roybal-Allard in the 112th Congressional Session in June 2011. This bill will improve maternal health outcomes in the United States by harnessing the best evidence in maternity care delivery, expanding federal research on best maternity care practices, developing a comprehensive on-line database for consumers and health care providers of up-to-date reviews of maternal care practices, authorizing a national consumer education campaign to inform women about evidence-based maternity care practices, and supporting a more diverse maternity care workforce through federal grants and education loan repayment programs.

Home birth, birth centers and Certified Professional Midwives are referenced throughout the bill in sections on data collection and reporting, providing information for consumers, the designation of maternity care health professional shortage areas, inclusion in Centers for Excellence on Optimal Maternity Outcomes, participation in the development of a shared core maternity care curriculum, and federal loan repayment programs. NACPM is grateful to Rep. Roybal-Allard for her leadership on this important piece of legislation, and for including CPMs in these initiatives to improve care for women and infants.

“H.R. 894 calls for the establishment of multi-disciplinary review committees ... to recommend prevention strategies.”
Idaho Approves LMs as Medicaid Providers

With licensing for CPMs in Idaho just two years old, thirty-five CPMs are now licensed midwives in the state, with an increase of several more expected in the fall of this year. Now women served by these CPMs will have access to Medicaid reimbursement, thanks to a successful legislative effort this year, spearheaded by Michelle Bartlett, CPM, LM of Idaho Falls and our wonderful lobbyists. This legislation allowing pregnant women on Medicaid the option of using a Licensed Midwife sailed through in just one session with hardly any opposition. The vote in both the House and Senate Health and Welfare Committees was unanimous with only one “no” vote on the Senate floor! The rules process will take place over the summer, with hope for implementation of the reimbursement in the fall of this year.

In addition to increasing women’s access to Licensed Midwife services, this legislation is expected to produce significant savings for the Idaho Medicaid program, which pays for over 40% of births each year in the state. We are proud to take such a significant step forward for the state, for the women and families we serve and for the effort to protect and grow our profession in Idaho.

Barbara Rawlings, LM, CPM
Outgoing President, Idaho Midwifery Council

Washington State Welcomes New CPM Birth Center

In March 2011, Seattle welcomed Center for Birth, a new multi-suite birth center in the heart of the city, with a gala party that included Ina May Gaskin. The birth center was established by Tina Tsiakalis, CPM, who completed her studies at the Seattle Midwifery School in 2009.

Since 2007, when the Community Birth & Family Center closed for a tear-down-and-rebuild that never came to fruition, the city of Seattle has been without a “main” birth center. Tina was encouraged by members of the Seattle birth community to step up and fill this very important void in families’ birth choices. Center for Birth occupies a 5000 sq. foot building overlooking Lake Union and the Space Needle, a Seattle landmark. The birth center consists of three spacious and light-filled birth suites designed to promote serenity with their soothing colors and clean decor. Extra-deep tubs were specially chosen to provide the most comfortable experience possible for laboring women, and there is a separate private shower room. A welcoming family room provides space for guests, and storage and amenities specifically for the birth attendants (a midwife sleeping room!) abound.

“Labor stairs” connect the birth center to the first floor of the building, where there are five offices occupied by complementary practitioners including midwives, a lactation consultant, an acupuncturist, and a massage therapist. An extra large “waiting room” doubles as event space.

Founder and director Tina Tsiakalis is delighted the doors of Center for Birth have been opened to the wonderful community of midwives and their clients in the greater Seattle area. Tina is a CPM, a licensed midwife, and a member of the group practice Seattle Home Maternity Service, founded by Marge Mansfield and NACPM board member, Suzy Myers.

One of the Birth Center’s three spacious and light-filled birth suites
The MAMA Campaign celebrated its second birthday in April 2011 with the introduction of HR 1054, the “Access to Certified Professional Midwives Act of 2011” by Congresswoman Chellie Pingree (D-ME-1st) in the U.S. House of Representatives. MAMA is deeply appreciative to Congresswoman Pingree for her leadership in this important milestone for direct-entry midwifery in the U.S. We are grateful as well to Representatives Gwen Moore (D-WI-4th), Jim McDermott (D-WA-7th), Peter Welch (D_VT_At-Large), Jay Inslee (D-WA-1st), Kathy Castor (D-FL-11th), and Michael Michaud (D-ME-2nd) for their cosponsorship of the bill.

The MAMA Coalition is more committed than ever to increasing women’s access to CPM services. The Campaign is taking a steady office-by-office approach to building Congressional support for HR 1054, including focused outreach to Republican offices. MAMA is investing significant resources to increase the capacity of the Campaign, including an upgraded administrative system, a new data base platform, and hiring administrative and technology staff. Visit us at www.mamacampaign.org.

Additionally, MAMA has built strong relationships with the staff at the Centers for Medicare and Medicaid Services (CMS) to support implementation of the birth center provisions in the Affordable Care Act (ACA) passed last year as they apply to CPMs. MAMA is pleased that the recently released CMS State Plan Amendment template, containing implementation guidance to state Medicaid offices, specifies that Medicaid reimbursement of birth center provider fees applies to CPMs.

In June, MAMA had two unique high-level opportunities to provide recommendations to the top Medicaid officer, Dr. Donald Berwick, Administrator of CMS and visionary national health care leader.

- Mary Lawlor was invited by Dr. Berwick to represent the MAMA Coalition on June 2nd at a symposium for 40 national health care leaders. Dr. Berwick spoke to participants of the significant resources that the U.S. spends on perinatal care while our outcomes worsen every year. Under his leadership, CMS is seeking advice on how to improve perinatal outcomes, and CPMs were invited to the discussion.
- On June 8th, Mary Lawlor and Ellie Daniels from MAMA, along with Billy Wynne and Katie Pahner from Health Policy Source and Dr. Jeff Thompson, Chief Medical Officer of Washington State, were privileged to have a personal meeting with Dr. Berwick and four members of his staff. MAMA had the opportunity to recommended that CMS focus on the needs of the majority of childbearing women and infants who are low-risk; increase access to CPMs and birth centers to assure appropriate care for this population that too often suffers the consequences of inappropriate interventions; and include CPMs and birth centers in performance measurement, reporting and payment reform initiatives.

“The MAMA Coalition is more committed than ever to increasing women’s access to CPM services.”
Coordination between care providers is recognized as an important component of high quality maternity care. However, most maternity care providers in the US work in a climate that does not support genuine and effective communication. Providers face multiple obstacles to collaboration, from concerns about liability to cultural influences. Despite the convergence of mandates for change led by government initiatives and private projects, the key to actually realizing the vision of a continuous health care system for maternity care lies in patients’ changing perceptions regarding choices.

**Federal Mandates: Increase Tech for Patients & Providers**

Changes that stem from the 2001 Institute of Medicine (IOM) report, Crossing the Quality Chasm: A New Health System for the Twenty-first Century, are now articulated in the recently issued, Electronic Health Record Incentive Program; Final Rule by the Department of Health and Human Services. They include increasing access to technology for both providers and patients. These technology mandates are already changing how providers understand and utilize medical records, and their impact on patients will likely be very noticeable among childbearing women whose relative youth and comfort with tech tools make them highly competent self-advocates for health care.

**Norms for Natural Birth on the Internet**

Mothering communities on social networks, forums, and email are already fueling a trend towards pregnant women meeting their own healthcare needs outside of the model of the standard medical home. In my practice, women often comment that they chose me based on recommendations from online forums, essentially making fundamental life decisions based on online customer reviews. Through online and social settings, women who are seeking “natural childbirth” have come to expect that they will be hiring more than one provider to support their goals for childbirth. Often this patient derived “team” includes an obstetrician and doula, but can grow to include counselors, lactation consultants, massage therapists and yoga instructors.

Currently, few of these specialty and sub-specialty providers have a framework for communication with the primary provider (obstetrician or midwife) and the primary provider may not even be aware that the patient is seeking or receiving this supplemental care.

**Shifting to a Patient Centered Approach means new challenges for Providers**

As technology removes education and communication barriers, increased consumer interest in a broad array of birthing options often lead to multiple points of care for the same condition. Health care directed by patients instead of providers is a model that reflects a system similar to developed countries, but can also create communication obstacles between providers related to privacy, ethics, and opposing methods to achieve common goals for health outcomes.

Although providers may show understandable wariness over this shift, research indicates that a change to patient-centeredness can benefit the patient-provider relationship. As information shifts from provider to joint control it serves to enhance patient perception of health care responsibility. New collaboration tools are being encouraged on both the federal and community level, seeking to remove obstacles in the quest for optimal outcomes… something everyone can agree on!

**Patient Portals and Open Notes**

There is little doubt that maternity providers are embracing technology opportunities for record keeping. Grant incentives from the federal government as well as increasing frustration with complicated systems have generated a surge in EMR development. Every provider wants an iPhone app for their practice, but are they ready to share their notes with their patients?
Members of AME, a not-for-profit corporation, are schools, educators and administrators with the common goal of building a robust network of support and resources for direct-entry midwifery education. AME provides solutions to educators, support for developing midwifery curriculum and enhancing administrative best practices, and access to collaborations and connections needed to succeed in teaching, nurturing and mentoring the midwives of the future. AME helps to create networks to support school administrators, and strives to be a resource for all midwifery educators and preceptors, whether within large institutions, in small independent schools or in the midwife-student apprenticeship dyad.

AME membership gives midwifery educators access to information on developing quality midwifery education programs, a forum to discuss current issues in midwifery education with colleagues, and the e-newsletter “Giving Birth to Midwives.” The AME website provides information about midwifery education and practice for aspiring midwifery students, support in finding midwifery schools and answers to many of their questions. Soon the AME website will host student research as we move toward our goal of an on-line, peer-reviewed midwifery research journal.

For three years in a row, AME has presented sessions for educators at the MANA conference, including, in 2010, “Mentoring Student Midwives” by Suzy Myers, MPH, LM, CPM, and “Teaching Cultural Competency to Midwifery Students” by Justine Clegg, MS, LM, CPM and Jennie Joseph, LM, CPM. AME has submitted six proposals for educator sessions for the 2011 CAM/MANA Midwifery Conference in Niagara Falls. (Look for us in the conference brochure and at www.associationofmidwiferyeducators.org!)

Six years ago, MEAC formed the Outreach to Educators Project (OTEP), with a $30,000 grant from the Daniels Foundation, to meet the needs of existing and aspiring midwifery programs, strengthen direct-entry midwifery schools, encourage accreditation, and advance direct-entry midwifery education. Heidi Fillmore-Patrick, CPM, OTEP’s coordinator, performed a needs assessment after contacting all the U.S midwifery schools, and developed a webpage and a newsletter, “Giving Birth to Midwives,” written by and for midwifery educators and published three times a year. (Copies of the original newsletters can be found in the resources section of the AME website.)

OTEP had its first meeting at MANA 2005 in Boulder, Colorado, and in 2006 at MANA 2006 in Baltimore, Maryland, AME was birthed to carry on the work of OTEP.

AME brings midwifery educators of all kinds together to improve midwifery education. New and developing schools can benefit from mentoring, and established schools can share solutions to the challenges presented by the ongoing changes in student populations and the U.S. health care system.

Supported by its membership, AME’s benefits include a website listing for members, voting at the annual meeting, and participation in the educator’s discussion group. Plans for the future include continuing education and professional development for members.

Midwifery Educators: Join AME and play a role in our development and growth! Visit us at www.associationofmidwiferyeducators.org; write to us at myglesia@bastyr.edu; call us at 207-647-5968.

With best wishes from the AME Board:
Mary Yglesia (Bastyr University, WA), President
Marla Hicks (Nizhoni Institute of Midwifery, CA), Vice President
Susi Delaney (Birthwise Midwifery School, ME), Treasurer
Justine Clegg (Commonsense Childbirth School of Midwifery, FL), Secretary
April Kline (Midwife’s College of Utah, UT)
Breyette Lornitz (University of Virginia, VA)
Stephanie Salfholm (Bastyr University, WA)
I live and practice midwifery in a small town of about 8000 people. Our town is home to a Bank of America call center, which employs about 4,000 people from all around the county. Several years ago, our practice hosted a showing at the local movie theater of “The Business of Being Born”. Following that event, we signed on a client who worked for Bank of America. She thought, if Rickie Lake could do it, so could she! Following her successful and ecstatic home birth, she confessed to us, “I never imagined I would choose to give birth at home. It just seemed so weird, so counter-culture, not for me. I thought midwives were a bunch of hippies, and babies were lucky to make it at home!” She shared her positive experience with many co-workers, and two by two, they started to come into our practice. We got savvy about insurance billing. We polished up our documents and presentation. Two years after the movie showing, we had our busiest year ever, and the trend has continued. Our practice had hit the mainstream.

Why am I telling you this story, and what does it have to do with accreditation? I am an apprentice trained midwife, right out of the 70s. I had my first baby unattended at home in 1978, and went on to have two more with a midwife. My family grew up with the midwifery movement, and I became a CPM in 1997. I became a CPM in order to serve more women, and because I believe the credential represents a standard of care and a level of proficiency of which I’m very proud.

In 1991, a group of educators began meeting to explore ways in which to bring peer support, consistency, and excellence to midwifery education. Ten years later, those entrepreneurial visionaries successfully achieved federal recognition from the US Education Department, opening the door for scores of midwifery students across the country to have access to Federal Financial Aid. In 2010, the Midwifery Education Accreditation Council successfully gained re-recognition from the USED, defending itself against several challenges to its innovative and modest but solid foundation. Midwifery education, and its accrediting agency, MEAC, had hit the mainstream!

I will forever support multiple routes of entry into the profession of midwifery. As an apprentice-trained midwife, I understand first hand the reasons why some women need and want more traditional, community-based learning experiences. As a faculty member at an accredited midwifery school, I have also witnessed the tremendous shift in the characteristics of women coming into our program. The majority of my students today are young, childless, and come to midwifery school with a college degree. They use financial aid for their midwifery education, and expect to graduate with a professional credential that will allow them to start practicing and earning money as midwives. They aspire to fulfill many and diverse dreams: to open birth centers and community-based home birth practices, to become part of the Canadian maternity system, to travel to underserved populations, to become active in state and federal politics, to improve the national maternity system, and to make the art and science of midwifery a central part of their life. They are midwifery pioneers in the mainstream!

The professional midwifery movement has a crown jewel that is begging to get dusted off and properly displayed, and that is accreditation! As we navigate the choppy waters of professional licensure and federal recognition, we find the apprenticeship route of entry increasingly called into question. In our fervent defense of apprenticeship, have we lost sight of the whole vision our professional roots dreamed of? We had the vision that gave birth to our movement, that organized around a federal credential, that created a credentialing process that honored multiple ways to be trained, that brainstormed what we needed to do to become educational accreditors for our diverse schools, and that has led to more than 1700 credentialed autonomous midwives in less than 15 years. Some of those midwives came through apprenticeships, some through schools. We created a profession that offers optimal access to women with diverse learning styles, family and economic limitations, and geographic realities. There is no one way that is better than another; it all leads to a common denominator, which is the CPM.

Why does accreditation matter? It remains the first accomplishment in the midwifery movement where we have fully achieved federal recognition. It is that part of the movement that dips its feet into the mainstream waters. It is the portion of our educational fabric that is easily understood by the mainstream,
On Wednesday, October 13th 2010, NARM held a Focus Group as Phase One of a four step process to review General Education Eligibility Requirements for certification as a CPM. The following is a summary report of the findings of the Focus Group. The report includes a rationale for the review process, an overview of the 4 steps in the process, and summaries of feedback on proposals presented by the NARM Board.

Rationale for Eligibility Review

The primary mission of the North American Registry of Midwives is to develop, administer and evaluate a certification process through a standardized system for those engaged in midwifery practice. This process results in the credential, Certified Professional Midwife (CPM), which is accredited by the National Commission on Certifying Agencies (NCCA). NCCA sets standards for the evaluation of criteria for certification that NARM follows in the development and ongoing administration and evaluation of educational content utilized in the validation of skills and knowledge required for certification.

Certified Professional Midwives have the potential to play a critical role in the development of systems of maternity care that incorporate the principals of the Midwives Model of Care. The CPM is a rapidly growing profession, with 150 new CPMs certified in 2009 and a steady increase in new applicants every year. There are currently 26 states that utilize the CPM or components of the CPM certification process for licensure and there are at least 10 states with legislative efforts underway to achieve recognition of the CPM. In 2009, an unprecedented campaign was undertaken to achieve the goal of federal recognition of the CPM credential through inclusion in the Health Care Reform legislation. The MAMA Campaign was incredibly successful in drawing together advocates and organizations dedicated to integrating the CPM into the maternal child health care system.

This heightened attention on the CPM credential has led to increased scrutiny of all components and standards for certification. Advocates for CPMs have had to face public denigration of the quality of education and training required for certification. Despite the fact that there is significant evidence to show that CPMs are adequately trained to provide safe and effective maternity care, NARM is being asked again and again to raise standards in order to answer concerns among the greater maternity care community about the quality of care that CPMs provide.

The developers of the CPM credential originally determined general education requirements outside of specific skills and knowledge content areas defined in the job analysis. These include experience requirements (such as a minimum numbers of births attended prior to submission of application for testing), prerequisite education documentation (such as CPR, high school education), and requirements for documents related to professionalism (such as practice guidelines and informed consent documents). For a more detailed history on the creation of the CPM credential and NARM standards for evaluation, please visit our website.

The NARM Board determined that ongoing evaluation of general education requirements for all applicants should be conducted in a format that is in keeping with NCCA standards. The board developed a process that includes all of the steps involved in setting criteria for skills and knowledge.

NARM recognizes that any changes to requirements will have an impact on the number and quality of applicants for certification.
Two years ago, the Homebirth Section of the American College of Nurse Midwives (ACNM) invited a work team to convene a multi-disciplinary, multi-stakeholder summit to have a frank and productive conversation about how to best support and care for women who choose homebirth. Mary Lawlor and Suzy Myers from NACPM were invited to participate on a summit steering committee that includes consumer advocates, CNMs, CPMs, obstetricians and pediatricians.

Future Search, a non-profit organization that provides uniquely innovative and effective planning services around the world, will facilitate the summit, scheduled for October 2011 outside of Washington, D.C. The Future Search structure is a two and one-half day meeting based on a set of principles that tap into the capacity of people to engage in cooperative action for the common good. The Future Search design will bring together seventy-two delegates across nine stakeholder groups, participants who have “authority, information, expertise, need and resources”, to engage in open-minded dialogue, bringing the “whole system” to the table.

The goal of the summit is to establish what the whole system can do to support those who choose homebirth, and envision the care, safety net, consultation, collaboration and referral processes necessary to make homebirth the safest and most positive experience for all involved. A careful consensus process of the steering committee has identified individuals (a challenging task with so many worthy potential invitees in each category) to be invited from the stakeholder groups (consumers, consumer advocates, home birth midwives, obstetricians and OB family practice physicians, collaborating providers such as nurses and pediatricians, health insurers, health policy, research and education, and health systems) in order to ensure that the whole system is at the table.

The NACPM Standards of Practice state: **NACPM members recognize that optimal care of women and babies during pregnancy and birth takes place within a network of relationships with other care providers who can provide service outside the scope of midwifery practice when needed.** NACPM is pleased to engage in this important conversation with other stakeholders.

**Cont. from pg 8**

**Patient Centered Health Records**

Once patients have direct access to the chart, they can go on to share it with family members and even other providers, essentially creating their own collaborative relationships to develop holistic care. Convincing providers to shift from thinking of their notes as a support for a billing code and towards a collaborative narrative of the progress of the patient's health is the goal of an ongoing study called “Open Notes”. In line with the Health and Human Resources’ Meaningful Use Criteria target of giving patients access to a visit summary within three days of their visit, this study involves giving direct access to the progress notes to the patient via a secure web portal.

Other studies indicate benefits such as fewer provider mistakes in history taking, empowerment and education of patients, and improvements in patient-provider communication are great, while the concerns of confusing patients and complicating patient-provider communication are slight. Private Practice, web based practice management software for midwives is launching this January with a secure patient portal that allows midwives to give their clients access to progress notes, lab and ultrasound reports, and a secure messaging system that can integrate communication into the medical record. Because most midwives already use a practice model that enhances patient empowerment through shared decision making, an open and transparent charting system is anticipated to be easier for midwives to adopt. As the Institute of Medicine urged society to view the note not as an artifact, but as a living, interactive document shared between patients and providers, midwives view their patient relationship in a personal context where a shared chart will be supportive rather than conflicting with basic principles.
NARM Eligibility Review

The goal is to minimize as many unforeseen consequences of any changes as possible and to ensure that all changes are made with the intention of maintaining the high level of competency that the credential ensures to the public and to our profession.

Four Phases of Review:

The first step in the process is an initial focus group of stakeholders to provide a platform for review and discussion of proposals developed by the NARM Board for possible changes to current General Education requirements. This process was completed with a Summary Report to the Board this April.

The second step in the process is now underway and involves a survey developed by the NARM Board that carries forward the response to the proposals from the Focus Group. This survey will include revisions to the proposals based on the report from the Focus Group and will be designed to seek further input from CPMs on the potential impact on any proposed changes.

The third step in the process involves evaluation of all feedback and final determination by the NARM Board of changes to requirements.

The fourth and final step in the process involves determination of implementation steps for any changes. The Board recognizes that some changes will require careful implementation as we consider applicants who are midway through their education process and the impact on schools and programs that will need time to integrate any new requirements into their curriculums.

Why Accreditation Matters

and easily accessed by students who are looking for an educational experience that they can finance in the mainstream and defend in the mainstream. It is a portal where the radical can slip into the mainstream and stir up a change!

But what does accreditation require, and how can we support it? Midwifery education accreditation is a framework for self-evaluation that allows diverse educational programs to be academically and financially successful in the context of the mainstream. The work of a professional accrediting agency is detailed, exhaustive, and answers to many federal requirements for accountability and consistency. As such, it requires specialized expertise, dedication, political savvy, and money. Accreditation is supported by the fees of the participating schools, and can be burdensome. The only way to lighten the load is to increase the numbers of accredited schools. Just as the increased numbers of CPMs has resulted in multiple state licenses, a federal campaign for recognition, and contributed to a 20% increase in the number of home births in the past seven years, so could an increase in the number of accredited schools result in a lighter financial load to each school and a greater mainstream acceptance of CPMs! Accreditation enhances the credential, because it can be understood in the mainstream. Accreditation takes nothing away from other routes of entry, because it will always remain just one of many ways to gain midwifery education, and will be chosen by just some. Accreditation needs our support!

I don’t watch TV, so when I first heard of Ricky Lake, I had to ask, “Is that a man or a woman?” Now I know. Ricky Lake is a woman who had the key to unlock the mainstream door in my birth community! If I had avoided tapping into that possibility, because I don’t watch TV talk shows, or never heard of Ricky Lake, I might not have met the mainstream part of my community that is now a part of the local homebirth community. It would have been a loss, for them and for me.

If we don’t learn how to highlight the achievement of midwifery education accreditation, and celebrate how valuable it is to our movement, it will be our loss. If we don’t continue to support it and aspire to achieve it, we will lose it in our community. If we become afraid of losing apprenticeship and resort to stepping on each other to hold it up higher, we will all suffer. If we don’t learn to speak the mainstream language, we will never find ourselves in circles of mainstream conversation where we can build a compelling argument for the excellence of our profession. If we create midwifery education programs but don’t take advantage of the support and validation that our own accreditation agency, MEAC, provides by participating in the accreditation review process, we are undermining the strength of our profession. Accreditation matters!

Please consider learning more: www.meacschools.org
HB 2380: Victory for Midwives and Families in Oregon

We are pleased to report the unanimous passage of HB 2380 that improves the Oregon midwifery statute, while preserving voluntary licensure. In Oregon, licensure is achieved by passing the NARM examination and additional, state-mandated training and examinations. With few exceptions, licensed midwives in Oregon are also CPMs, as are many of the women who choose to forgo state licensure, and practice as “traditional midwives” (as Oregon law and administrative rules refers to them).

As a result of HB 2380:

Licensed Direct-Entry Midwives (LDMs) now have legally protected peer review. Formerly, we were the only class of care providers who did not have an open and protected forum to learn from the peer review process without fear of subpoena by trial lawyers.

An LDM majority was restored to the Board of Direct-Entry Midwifery. Prior to this legislation, we were the only professional board without a majority of its own practitioners serving.

The Oregon birth certificate and fetal death certificate will also be changed to accurately capture planned and unplanned out-of-hospital births and transports. In addition, it will differentiate between provider types, including licensed and traditional midwives. The Center for Health Statistics will create an annual report on birth outcomes for all provider types in Oregon.

Receiving physicians will be exempt from liability for injuries “caused by a transporting midwife.” They will not be exempt from liability in cases where they have contributed to the injury or from liability incurred through their own care.

We are cautiously optimistic that the physician liability provision will improve relationships and communication during transports, and pleased with our stronger relationships with Oregon legislators. HB 2380 is an enormous victory for midwives and families in Oregon.

Silke Akerson, CPM, LDM, President of the Oregon Midwifery Council, Missy Cheyney, PhD, CPM, LDM Chair of the Oregon Board of Direct Entry Midwifery
NACPM’s New E-News!
We hope you enjoy NACPM’s bimonthly E-Newsletters. Watch for additional occasional special E-News issues and updates. The next hard-copy NACPM News will be mailed out in December, 2011, and the 2011 NACPM Annual Report will be mailed to each member in February 2012.

Please send comments and suggestions for the NACPM E-News to president@nacpm.org. Thank you!

NACPM Chapters Pilot Project
Would CPMs in your state like more direct support from NACPM? Would the CPMs in your state like more of a voice in the development of NACPM? NACPM recently announced the “birth” of a three-year pilot project to develop an NACPM state chapter system. Read about NACPM Chapters on our website at www.nacpm.org/nacpm-chapters.html

Welcome to the first NACPM Chapters: Maine, Wisconsin and Oklahoma!
For more information, contact Gretchen Spicer from the NACPM Board at gspicer@mhtc.net. Gretchen can answer your questions and help your state chapter get up and running.

Coming Your Way in the Spring of 2012!
NACPM and the Association of Midwifery Educators (AME) will co-host a special symposium for CPMs, educators and CPM allies in Washington DC in the Spring of 2012. Watch for an announcement and information very soon!