Certified Professional Midwives

Caring for Mothers and Babies in Virginia

Commonwealth
Midwives Alliance

Certified Professional Midwives in VA

- Licensed by the BOM since January 2006
- 5 member Midwifery Advisory Board under the BOM (Obstetrician, 3 CPMs, Citizen member)
  - **Board Members**

  http://www.dhp.state.va.us/medicine/advisory/mw/Default.asp
  - **Regulations**

  http://www.townhall.virginia.gov/chapter/ViewChapter.cfm?Vac=127&Chapter=130
- Currently 30 licensed midwives located around the state

CPM Scope of Practice

CPMs in VA are licensed to:

- *provide primary maternity care to women and their newborns throughout the childbearing cycle.*
- *identify and refer women or their newborns who require medical care to an appropriate practitioner.*

http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2957.7

Midwives Model of Care

- The **Midwives Model of Care** is based on the fact that pregnancy and birth are normal life processes.

  The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention
- The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Midwives Model of Care

- “Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle”
  - Standard lab tests
  - Involve mother in self-care
  - Continuity of care
  - 30-60 minute average prenatal visit
  - Balance evidenced-based care with traditional practices. (herbs, homeopathy, yoga)

Midwives Model of Care

- “Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support”
  - Start to finish labor support
  - Informed choice includes both the risks and benefits of accepting or avoiding a test, procedure, or drug
  - Respect for mother’s culture and preferences
  - Effective breastfeeding support


CZC

Midwives Model of Care

- “Minimizing technological interventions”

"... giving birth at home bears similar risks of intrapartum and neonatal mortality as low-risk birth in hospital, but planned home births are associated with lower rates of medical interventions.”

“... The study participants experienced substantially lower rates of epidurals, episiotomies, forceps deliveries, vacuum extractions, and cesarean sections than women with low risk pregnancies who gave birth in hospital."

Johnsson and Daviss, **Outcomes of planned home births with certified professional midwives: large prospective study in North America**
http://www.bmj.com/cgi/content/full/330/7505/1416

Midwives Model of Care

- “Identifying and referring women who require obstetrical attention”
  - Midwives are trained to recognize signs of complications before they become emergencies.
  - Optimal outcomes for mothers and babies are achieved when there is trust and respect among providers
  - Autonomous practice removes liability based obstacles to midwife-physician relationships

Statutory Immunity

§ 54.1-2957.12. Immunity.

No person other than the licensed midwife who provided care to the patient shall be liable for the midwife's negligent, grossly negligent or willful and wanton acts or omissions.

Except as otherwise provided by law, no other licensed midwife, doctor of medicine or osteopathy, nurse, prehospital emergency medical personnel, or hospital as defined in § 32.1-123, or agents thereof, shall be exempt from liability (i) for their own subsequent and independent negligent, grossly negligent or willful and wanton acts or omissions or (ii) if such person has a business relationship with the licensed midwife who provided care to the patient.

A doctor of medicine or osteopathy, nurse, prehospital emergency medical person, or hospital as defined in § 32.1-123, or agents thereof, shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation to or accepting referral from the midwife.

(2005, cc. 719, 917.)

Systematic Review of Recent Out-of-Hospital Birth Studies

Included Studies

- Northern Region Perinatal Mortality Survey
- National Birthday Trust Study
- Ackerman-Liebrich et al.,1996
- Wiegers, Keirse, et al., 1996
- Meta-analyses, Olsen, 1997, 2000
- Johnsson and Daviss, 2005
- Murphy and Fullerton, 1998
- Janssen, 2002, 2003

Excerpted from a presentation given at the American Public Health Association Conference Boston, MA November 2006 by Saraswathi Vedam, CNM & Deren Bader, CPM, DrPH

Systematic Review of Out of Hospital Birth Studies; Summary

- Perinatal mortality
  - comparable home birth populations - 0.6-2.5/1000
  - U.S. Birth Centers - 1.3/1000
  - Uncomplicated hospital births - 1-2.9/1000
- Maternal and fetal outcomes
  - fewer medical interventions (induction,augmentation, episiotomy, operative vaginal birth, and cesarean)
  - better Apgar scores, less severe lacerations
  - findings supported by clinical trials of elements of care

Systematic Review of Out-of-Hospital Birth Summary: Referrals from home to hospital

- 7-18% antepartum referrals for obstetric reasons (IUGR, previa, PIH, preterm)
- 8-12% intrapartum (IP) referrals
- 1-2% postpartum maternal referrals
- 1-2% neonatal referrals
- urgent transfer 1/1000

Reasons for Intrapartum Transfer to Hospital Facility

- 5-15% of all planned home births
- failure to progress (65-75%)
- prolonged rupture of membranes
- meconium staining
- nonvertex presentation
- fetal distress
- desire for pharmaceutical pain relief
- bleeding
- hypertension

Reasons for Postpartum Transfer

- Maternal
  - Retained placenta
  - postpartum hemorrhage
  - laceration repair
- Neonatal
  - inability to establish normal respiration
  - congenital anomaly
  - low birth weight
  - low Apgar
  - birth trauma
  - sepsis

Intrapartum Transfer of Care Plan

- Upon initiation of care, the midwife develops an individualized Intrapartum Transfer of Care plan with each client.
  - Includes nearest hospital with maternity services, distance from hospital, EMS estimated response time (rarely used)
  - This is in accordance with the Virginia State Law for Licensed Midwives. *§ 54.1-2957.7 through § 54.1-2957.13*

Components of a Transport Protocol

- Identify the need for transfer of care.
- Midwife will call the nearest tertiary care center with maternity services (per the client's transport plan).
- The midwife will speak with the attending physician, reporting on all relevant details and confirming the plan for transport.
- The midwife will provide access to all client records to the receiving physician.
- As per Virginia state law, the midwife will accompany the client to the hospital, providing care until transfer of care has been made to the attending physician.

CPM-EMS Call Report

1 home birth transport out of every 1000 will involve EMS

When the midwife makes the call, she provides the following information:

- **maternal/infant condition**
- **what actions have been taken by the midwife to assess and stabilize the patient/s**
- **what emergency equipment the midwife has and does not have at her disposal in the home**
- **how the midwife would like to collaborate with EMS providers during the transport**

CPM-EMS Collaborative Care

Upon arrival at patient's home, EMS will receive report from the midwife including:

- Vital signs
- Brief description of reason for call
- Brief description of current patient condition
- Brief description of all actions taken to stabilize patient

CPM Skills- Newborn Resuscitation

- Adult and Infant CPR certification (required)
- Most CPMs are advanced NRP providers

  Includes-

  - Overview and Principles of Resuscitation
  - Initial Steps in Resuscitation
  - Use of Resuscitation Bag and Mask
  - Chest Compressions

CPM Skills- 3rd Stage Management

- Assessment of hypovolemia/shock
- Manual removal of placenta
- Bi-manual compression/uterine massage
- Administration of oxygen and anti-hemorrhagic medications*

*currently restricted by VA Statute

CPM- Emergency Medications

- All CPMs are trained and certified to deliver emergency anti-hemorrhagic medications such as IM pitocin, IM methergine, and PO methergine.
- Currently, VA law does not allow for the carrying or administering of any controlled substance by CPMs

CPMs: Our potential in Virginia

- Integration of Licensed Midwives into existing healthcare systems
- Coordination of efforts to support compliance with state health programs for women and infants
- Identifying and removing obstacles to optimal care for women and babies birthing out of hospital in Virginia

Additional Information

CPM Professional Certification:

Commonwealth Midwives Alliance (CMA) www.commonwealthmidwives.org

- State professional organization

North American Registry of Midwives (NARM) www.narm.org

- Job Analysis
- Test Specifications
- Credentialing Process
- Continuing Education/Recertification

National Association of Certified Professional Midwives (NACPM)
www.nacpm.net

- CPM Guidance Documents- Practice Guidelines referenced in VA statute

Additional Resources

- EMS/Homebirth Resource Packet- available at Symposium or contact info@commonwealthmidwives.org

  Contains:

  - Directory of licensed CPMs in each EMS Region
  - Sample transport guidelines- Washington state
    - http://www.washingtonmidwives.org/assets/MAWS_PLANNED_OOH_BIRTH_TRANSPORT_GUIDELINE.4.24.pdf
  - Sample planned homebirth transport forms- Washington state.
    - Maternal: http://washingtonmidwives.org/assets/matern_transpt_form.pdf
    - Newborn: http://washingtonmidwives.org/assets/newbn_transpt_form.pdf
  - Overview of CPM emergency training
  - Overview of conditions likely to initiate a call to EMS