Committee of Health Coverage, Insurance and Financial Services
LD1205 *An Act to Amend the Data Collection and Reporting Requirements for a Licensed Midwife*

Maine Association of Certified Professional Midwives: **IN OPPOSITION**

Senator Bailey, Representative Perry, Distinguished Members of the HCIFS Committee,

The Maine Association of Certified Professional Midwives respectfully asks the committee to consider voting LD1205 OUGHT NOT PASS.

Midwives are huge proponents of data reporting and collection. Midwives have been participating in nationwide data collection *long* before licensure. With licensure, midwives voluntarily *continue* to file these statistics, along with happily providing annual reports to the overseeing Board of Complementary Health Care Providers, *and* diligently filing vital statistics data through the Department of Health and Human Services.

Amended LD1205 proposes eliminating data collection from the board. It proposes the DHHS instead hold the information previously housed.

While the required significant program changes to the DHHS's system *would* be cumbersome and carry a fiscal burden, MACPM instead opposes amended LD1205 as an inefficient, inappropriate and irresponsible avenue for data collection refinement that would result in inequitable data collection methodology.

Consolidating the data points currently collected into the DHHS will require their program have a system for licensed midwives to report when a transfer care occurs prenatally, in labor, or postpartum to another care provider. This aggregated data *is* valuable, but cannot be isolated to licensed midwives.

Maine is in a maternal health state of crisis, with continued hospital labor and delivery closures, maternity care deserts, and a provider shortage. This aggregated data needs to be collected by *all* birth providers in the state. This includes obstetricians, certified nurse midwives, family practice doctors, etc. Licensed midwives are *not* the only out-of-hospital perinatal birth providers. It is also imperative that we include facility to facility transfers, as we analyze how to best support rural Maine with continued facility closures.

We cannot thoughtfully analyze data that has not been *comprehensively* collected.

As you can see below, MACPM works collaboratively with a multitude of state organizations and initiatives dedicated to perinatal quality improvement. That work is based on quality research of quality and equitable data collection.

- Perinatal Quality Collaborative of Maine
- Perinatal Transitions Collaborative
- Perinatal Leadership Coalition of Maine
- Perinatal and Neonatal Level of Care Guidelines
- Plan of Safe Care
- Maternal, Fetal, Infant, Mortality Review Pane
- Maine State Breastfeeding Coalition
- Maternal Health Task Force
- Perinatal Systems of Care
- Alliance for Innovation on Maternal Health
- Permanent Commission on Racial, Indigenous, and Maine Tribal Populations's Report on Racial Disparities in Prenatal Access

MACPM supports continued refinement of DHHS and the DAVEs methodology. Broad change requires broad input from the perinatal health community and it would be inappropriate, inefficient, and inequitable for this process to occur through this statute.

We can agree on the importance and value of comprehensive data collection, reporting, and analysis.

We respectfully recommend this process move through rulemaking directly with the DHHS and the broader perinatal community.

MACPM urges the committee to vote LD1205 OUGHT NOT PASS and respectfully offer counsel to the committee for inquiries on the status of community perinatal healthcare, collaboration, and commitments to excellent data collection and reporting in Maine.

Sincerely,

Morgan Miller
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Licensed Midwife Data Points
referenced in amended LD1205
and the location of collection within
The Department of Health and Human Services
and
The Board of Complementary Health Care Providers

DHHS licensed midwife data points CURRENTLY **collected:**	**BCHCP licensed midwife data points** CURRENTLY **collected:**
National provider index number[1]	License number[5]
Name of midwife	Name of midwife
Births that occurred outside of a hospital	Births that occurred outside of a hospital
Fetal demise, infant death, maternal death[2]	Fetal demise, infant death, maternal death
Prenatal transfer of care[3]	Prenatal transfers of care
In labor transfers of care*[4]	In labor transfers of care
Immediate postpartum transfers of care	Immediate postpartum transfers of care
Complications resulting in morbidity or mortality	Complications resulting in morbidity or mortality

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OUT-OF-HOSPITAL BIRTH HISTORY

Historically — Indigenous midwives

1970s — Renewed interest in homebirth

1992 — NARM, credentialing organization, is formed

2008 — Bill to allow CPMs to "acquire and administer" 5 medications is signed

2020 — CPMs required to be licensed. State began issuing licenses in December 2019

Colonization — European trained midwives and eventual shift to hospital birth by 1950-60

1991 — First CPM exams given in US, including Maine midwives

2006 — Southern Maine Midwives' Collective is formed and later that year becomes MACPM

2016 — Bill requiring licensure for CPMs is signed

Mar. 2021 — Rules adopted to govern the practice of CPMs

CERTIFIED PROFESSIONAL MIDWIVES

TRAINING & LICENSURE

TRAINING

- 3-5 year MEAC Institution Training
- Clinical Residency
- NARM Exam
- Cultural Competency
- 3 Year Recertification
- Continued Education Hours
- Peer Review Hours
- BLS Certified
- NRP Certified

OVERSIGHT

- Board of Complementary Health Care Providers
- North American Registry of Midwives

FORMULARY

Acyclovir, APNO, Antibiotics, B6 Injectable, Epinephrine, Erythromycin, IV Fluids, IUDs, Lidocaine, Methergine, Misoprostol, Naloxone, Nifedipine, Nitrous Oxide, Ondansetron, Oxygen, Oxytocin, Procasll, Rh Immune Globulin, Sterile Water Injectible, Suture Material, Tranexamic Acid, Vaccines, Vitamin K, and more

SCREENINGS

Bloodwork, Cultures, CCHD, Hearing Screen, Newborn Metabolic Screen, NSTs, and more

EQUIPMENT

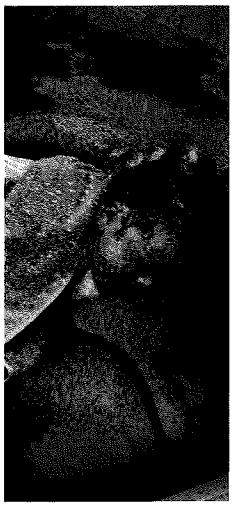
EFM, Doppler, LMAs, Ultrasound, Adult/Neonate Pulse Oximeter, Venipuncture, and more

EMERGENCY SKILLS

Breech Presentation, Essential NRP, PPH, Shoulder Dystocia, and more

LOW-RISK PERINATAL CARE

Maine CPM absolute transfer of care regulations.



Reasons for Antepartum Transfers of Care
Uncontrolled GDM, Hypertensive Disorders, Placenta Previa, Breech Presentation, Abnormal Lab Findings, Abnormal Ultrasound Findings, Significant Anemia

Reasons for Intrapartum Transfers of Care
Breech Presentation, Genital herpetic lesions, Sx of Preeclampsia, Dehydration, Acidosis, Clinical Exhaustion, Pain Relief Excessive Bleeding, PTL, Sx Uterine Rupture, Prolapsed Cord, Clinically Significant Abdominal Pain, Seizures, Suspected Chorioamnionitis, Fetal Intolerance of Labor, Lack of Descent after 3h of Effective Pushing, Shock, Retained Placenta

Reasons for Postpartum Transfers of Care
Post PPH Support, 3rd/4th Degree Perineal Laceration, Uterine Prolapse, Shock, Sx of Uterine Infection, Sx of Retained Placental Fragments

Reasons for Newborn Transfers of Care
Congenital anomaly requiring timely care, Persistent abnormal vital signs, Upper airway obstruction, Persistent respiratory distress, Persistent pallor or central cyanosis, 10min APGAR below 7, Post-resuscitative care after chest compressions, Sx newborn hemorrhage, Seizures, Hypertonia or tremors