Dear Committee Members,

My name is Kathryn Dewar and I am a licensed, certified professional midwife (CPM) in Maine since July 2022, practicing in the Western Mountains of Maine. I am also a newly elected Co-Chair of MACPM, a registered Democrat, and use she/her pronouns.

I am in opposition to LD1205 as it is currently written. I am in support of robust data collection among all providers attending births in the state of Maine. CPMs report data through the filing of live birth certificates using the Database Application for Vital Events (DAVE) and annually to the Board of Complementary Health Care Providers, all of which is publicly available. I have attached our current data reporting to this document and highlighted the line items that correspond to LD1205. Note that anything on the Live Birth Certificate would be an item reported via case by case; also in the event of a transfer from a planned home birth to hospital, the facility is responsible for submitting the Birth Certificate and the midwife transferring loses agency.

It would be more appropriate for changes to data collection with the Database Application for Vital Events to go through DHHS/CDC, such as the recent change with reporting on Substance Use, and not through CPM statutes.

Thank you for your consideration and your service to our beautiful state of Maine.

Sincerely,
Kathryn Dewar CPM, LM, IBCLC

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
BOARD OF COMPLEMENTARY HEALTH CARE PROVIDERS
35 STATE HOUSE STATION
AUGUSTA, MAINE

04333-0035

Janet T. Mills
Governor

Anne L. Head, Esq.
Commissioner

Geraldine L. Betts
Administrator

DATA COLLECTION

Reference: 32 MRS §12539 Data Collection and Reporting for a Licensed Midwife
Report. Each year by February 1st, a midwife licensed by the board shall report to the board, the following information regarding cases in which the midwife assisted during the previous calendar year when the intended place of birth at the onset of care was an out-of-hospital setting.

Electronic Submission of this report – By filing this report you are hereby certifying that the information provided is true and accurate.

Date of This Report:	
Licensee Name: A	
License Number:	Expiration Date:
Email Address:	

In the white space below the question, please fill in your response to each question. If you have nothing to report, please list N/A or "nothing to report." Please **type** all information – handwritten report will not be accepted.

A. The total number of clients served as primary maternity caregiver at the onset of care.

Licensing (207)624-8620
Hearing Impaired/TTY MAINE RELAY 711

www.maine.gov/professionallicensing
Fax: (207)624-8666
OFFICE LOCATION: GARDINER ANNEX
76 NORTHERN AVENUE, GARDINER, MAINE

B. The number, by county, of live births attended as primary maternity caregiver.

B, Line 10 on Birth Certificate

C. The number, by county, of cases of fetal demise, infant deaths and maternal deaths attended as primary **maternity caregiver at the discovery of the demise or death.**

B, C, Line 11 on Birth Certificate

D. The number of women whose primary maternity care was transferred to another health care practitioner during the antepartum period and the reason for transfer.

D, Line 33 on Birth Certificate

E. The number, reason for and outcome of each nonemergency transfer during the intrapartum or postpartum period.

E, Line 27-31 contain several instances in which care would have been transferred on Birth Certificate

F. The number, reason for and outcome of each urgent or emergency transport of an expectant mother in the antepartum period.

F, Line 33 on Birth Certificate

G. The number, reason for and outcome of each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

G, Line 34 on Birth Certificate

H. The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.

H, Line 10 on Birth Certificate

I. A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate.

Lines 32, 43, and 44 on Birth Certificate

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
220 Capitol Street
Augusta, Maine 04333-0011
Tel; (207) 287-5500; Toll Free: (888) 664-9491
TTY: Dial 711 (Maine Relay); Fax (207) 287-1093

State of Maine
Medical Worksheet for Birth Certificate

Mother's Medical Record Number_____ Case Number_____

Child

1. Child's Name (First, middle, last, suffix)

2. Date of Birth	3. Time of Birth _____ □AM □ PM □Military □Unknown	4. Sex □ Male □ Female □ Unknown

Mother/Parent

5. Mother/Parent Current Legal Name (First, middle, last, suffix)

6. Mother/Parent Height (Feet, inches)	7. Mother/Parent Pre-Pregnancy Weight (Pounds)	8. Mother/Parent Weight at Delivery (Pounds)

Mother/Parent Health

9. Cigarette Smoking per day before and/or during Pregnancy *(For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked, if none, enter "0".)*

Average number of cigarettes or packs of cigarettes smoked per day: _____

	No. of Cigarettes (Per Day)		No. of Packs (Per Day)
First Three Months of Pregnancy	_____	or	_____
Second Three Months of Pregnancy	_____	or	_____
Three Months before Pregnancy	_____	or	_____
Last Trimester of Pregnancy	_____	or	_____

Place of Birth

10. Type of Place of Birth
H
□ Hospital □ Home Birth Unplanned □ Hospital Unknown if Planned Home Birth
□ Freestanding Birthing Center □ Home Birth Unknown if Planned □ Other
□ Home Birth Planned □ Clinic/Doctor's Office □ Unknown

11. Facility Name (If not an institution, provide street number, street name, city, town, and zip code)
B

12. Facility NPI Number

13. Facility Address

Prenatal

14. Date of Last Menses *(mm/dd/yyyy)*	15. No Prenatal Care □	16. Date of First Prenatal Care Visit *(mm/dd/yyyy)*	17. Date of Last Prenatal Care Visit *(mm/dd/yyyy)*	18. Total Number of Prenatal Care Visits

19. Total Number of Previous Live Births *(Do not include this child)*
Now Living _____
Now Dead _____
Date of Last Live Birth _____ *(mm/yyyy)*

20. Number of Other Pregnancy Outcomes *(Spontaneous or induced losses or ectopic pregnancies)*
Other Outcomes (Number) _____
Date of Last Other Pregnancy Outcome _____ *(mm/yyyy)*

Substance

21. Prenatal Substance Exposure
Was the infant exposed to substances during the pregnancy? □ Yes □ No
If Yes, please indicate the type of substance. *(Check all the apply)*

□ Methadone	□ Stimulants (amphetamines, methamphetamine, other)	□ Alcohol
□ Buprenorphine (Suboxone/Subutex)	□ Cocaine	□ Nicotine
□ Vivitrol	□ Cannabis/Marijuana/THC	□ Mitragynine
□ Heroin	□ Benzodiazepines	□ Other (Specify)
□ Other Opioids	□ Barbiturates	_____

22. Was mother enrolled in Medication Assisted Treatment (MAT)?
□ Yes □ No □ Unknown

Substance *(contd.)*

23. Was the infant identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or having Fetal Alcohol Spectrum Disorder (FASD)?
☐ Yes ☐ No

24. Plan of Safe Care and Referrals
Was a Plan of Safe Care (POSC) documented prior to hospital discharge?
☐ Yes ☐ No ☐ Caregiver Declined

25. Was a referral(s) made for the infant/family/resource family? ☐ Yes ☐ No
If Yes, please select the type(s) of referral *(Check all that apply)*
☐ CradleME (General Referral) ☐ Women, Infants, and Children Nutrition (WIC)
☐ MaineCare ☐ Public Health Nursing (PHN)
☐ Lactation Consultant ☐ Child Developmental Services (CDS)
☐ Maine Families Home Visiting (MFHV) ☐ Cribs for Kids (Crib Given) ☐ Other (Specify) _____

Pregnancy Factors

26. Pregnancy Factors / Risk Factors for This Pregnancy *(Check all that apply)*
☐ Pre-Pregnancy Diabetes ☐ Previous Preterm Birth
☐ Gestational Diabetes ☐ Other Previous Poor Pregnancy Outcomes
☐ Alcohol Use Disorder ☐ Mother Had a Previous Cesarean Delivery *(If yes, specify how many)* _____
☐ Drug Use Disorder ☐ Multifetal Gestation
☐ Group B Strep ☐ Pregnancy Resulted from Infertility Treatment *(If yes, check all that apply:)*
Hypertension: ☐ Fertility-enhancing drugs, artificial insemination, or intrauterine insemination
☐ Pre-Pregnancy (Chronic) ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete
☐ Gestational (PIH, Preeclampsia) intrafallopian transfer (GIFT)
☐ Eclampsia
☐ None of the Above

27. Infections Present and/or Treated during This Pregnancy *(Check all that apply)*

☐ Gonorrhea	☐ Chlamydia	☐ Measles	☐ Varicella
☐ Group B Strep	☐ Hepatitis B	☐ Rubella	☐ COVID-19
☐ Syphilis	☐ Hepatitis C	☐ Toxoplasmosis	_____Confirmed
☐ Herpes Simplex Virus (HSV)	☐ HIV/AIDS	☐ Tuberculosis	_____Suspected
☐ None of the Above	☐ Unknown		

28. Obstetric Procedures *(Check all that apply)*

☐ Cervical Cerclage	☐ External Cephalic (Version-Successful)	☐ Unknown
☐ Tocolysis	☐ External Cephalic (Version-Failed)	☐ None of the Above

Labor

29. Onset of Labor *(Check all that apply)*
☐ Artificial Rupture of Membranes ☐ Prolonged Labor (≥ 20 hours) ☐ Spontaneous Labor
☐ Premature Rupture of the Membranes ☐ Precipitous Labor (< 3 hours) ☐ Unknown ☐ None of the Above

30. Characteristics of Labor and Delivery *(Check all that apply)*

☐ Induction of Labor	☐ Antibiotics	☐ Anesthesia during Labor
☐ Augmentation of Labor	☐ Clinical Chorioamnionitis	☐ Non-Vertex Presentation
☐ Moderate/Heavy Meconium Staining	☐ Steroids (Glucosteroids)	☐ Fetal Intolerance of Labor
☐ Unknown	☐ None of the Above	

Delivery

31. Method of Delivery
Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No ☐ Unknown
Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No ☐ Unknown
Fetal presentation at birth ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown
Final route and method of delivery *(Check one)*
☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown
E. If cesarean, was a trial of labor attempted? ☐ Yes ☐ No

32. Maternal Morbidity *(Check all that apply)*

☐ Maternal Transfusion	☐ Ruptured Uterus	☐ Unknown at This Time
☐ Midline Episiotomy	☐ Unplanned Hysterectomy	☐ None of the Above
☐ Perineal Laceration, 3rd Degree	☐ Admission to Intensive Care	
☐ Perineal Laceration, 4th Degree	☐ Unplanned Operation (Specify) _____	

33. Mother/Parent Transferred for Maternal Medical or Fetal Indication Prior to Delivery
☐ Yes ☐ No ☐ Unknown
If Yes, name of facility mother transferred from: D,E

34. Infant Transferred within 24 Hours of Delivery
☐ Yes ☐ No ☐ Unknown
If Yes, name of facility infant transferred to: G

Newborn

35. Newborn Medical Record Number

36. Infant Birth Weight *(Grams preferred, specify unit)*
_____Pounds/Ounces
_____Grams

37. APGAR Score *(Score at 5 minutes)*
If 5-minute score is less than 6,
(Score at 10 minutes) _____

38. Obstetric Estimate of Gestation *(Completed weeks)*
_____

39. Plurality *(Single, Twin, Triplet, etc.) (Specify)*
Birth Order _____

40. If Not Single Birth
(Number of infants in this delivery born alive) _____

41. Is Infant Living at Time of Report C
☐ Yes ☐ No ☐ Unknown
☐ Infant Transferred Status Unknown

42. Is the Infant Being Breastfed at Discharge
☐ Yes ☐ No ☐ Unknown

Newborn Factors

43. Abnormal Conditions of Newborn *(Check all that apply)*

- ☐ Assisted Ventilation Required Immediately Following Delivery
- ☐ Assisted Ventilation Required for More Than 6 Hours
- ☐ NICU Admission
- ☐ Newborn Given Surfactant Replacement Therapy
- ☐ Antibiotics Received by the Newborn for Suspected Neonatal Sepsis
- ☐ Seizure or Serious Neurologic Dysfunction
- ☐ Significant Birth Injury (Specify)
- ☐ Unknown
- ☐ None of the Above

44. Congenital Anomalies of Newborn *(Check all that apply)*

- ☐ Anencephaly
- ☐ Meningomyelocele (Spina Bifida) Confirmed
- ☐ Cyanotic Congenital Heart Disease
- ☐ Congenital Diaphragmatic Hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb Reduction Defect
- ☐ Cleft Lip with or without Cleft Palate
- ☐ Cleft Palate Alone
- ☐ Down Syndrome Karyotype Confirmed
- ☐ Down Syndrome Karyotype Pending
- ☐ Suspected Chromosomal Disorder Karyotype Confirmed
- ☐ Suspected Chromosomal Disorder Karyotype Pending
- ☐ Hypospadias
- ☐ Unknown
- ☐ None of the Above

Attendant/Certifier

45. Attendant's Name *(Please print name)* A

Attendant's Name *(Signature please)*

Title ☐ MD ☐ DO ☐ Certified Nurse Midwife (CNM) ☐ Certified Professional Midwife (CPM)
☐ Certified Midwife (CM) ☐ Other Midwife ☐ Unknown ☐ Other (Specify)_____

46. Certifier's Name *(Please print name)*

Title ☐ MD ☐ DO ☐ Certified Nurse Midwife (CNM) ☐ Certified Professional Midwife (CPM)
☐ Certified Midwife (CM) ☐ Other Midwife ☐ Unknown ☐ Other (Specify)_____

47. I certify that this child was born alive at the place and time and on the date stated.
Signature B

48. Date Certified