An urgent notice to all NARM preceptors or preceptors: It’s time to review

Did you know that charts are legal documentation of the care of a client? Did you know that the CPM application is a legal document validating a student’s education? In both cases accuracy is of primary importance. Legal documentation is a layer of protection, and in a court of law if it is not written down, it did not happen. Without the accuracy, honesty, and integrity of preceptors and students, the NARM application process can not work. In order to uphold the quality and reputation of the credential for all CPMs, failure to meet these basic tenets must result in removal of preceptor privileges for CPMs and suspension of applications for students.

The NARM application process was developed and is maintained by NARM in order to uphold the vital essence of midwifery education: mentoring relationships between midwives and students. The core components of the NARM application are the validation of experience and competency of entry level midwives by experienced midwives who take responsibility for ensuring the capability of the next generation of midwives. Competency in midwifery includes more than just clinical skills. The CPM also needs to be able to sufficiently document the care that she provides as well as the care she teaches others to provide. The NARM application is part of that documentation.

The NARM applications department has been seeing an increase in the number of poorly documented applications. Many of these mistakes or inadequacies could be avoided if preceptors had a better understanding of their responsibilities when reviewing and signing students’ applications. NARM has put together a few suggestions for preceptors that will hopefully clarify the process and make sure that the student has reflected your participation accurately. Please see page 7 for the NARM Suggestions for Documentation of Clinical Experience.
**Letters to the Editor**

**Dear CPM News,**

Thanks for your great newsletter! I’m writing to you hoping to get in touch with other midwives who know Pat Connor. Pat is an incredible midwife and midwifery educator in El Paso, Texas, and some of her former students are organizing a fund and a scrapbook to honor her and acknowledge how many lives she’s touched over her career. We have a website, www.welovepat.org, and we’re hoping that readers who know Pat will visit the site, or email Rinn or Nechama at rinnmandeville@yahoo.com or firebirch@yahoo.com. Networking is our biggest challenge, and we would love help in getting the word out. Pat doesn’t know about this, but we hope that we can get in touch with as many of her friends and former students as possible. Thank you for your help.

Nechama Wildanah, CPM

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**The following letter is in response to an interview with Ruth Cobb in the Spring CPMNews:**

I am a "new" midwife in Austin Texas and have had my own practice for the last two years. I trained with a midwife who knows that it takes at least 50-75 (with at least 20 as primary) births, if not more, before the aspiring midwife can really call herself one. She also always looks deeper than just the numbers and taught me much about the power of intuition regarding the mothers and their babies. I feel so grateful to have been trained in a way that honors all aspects of becoming and being a midwife.

I have now assisted over 40 families as primary midwife and I really can connect to what Ruth is saying about her energy being so drawn to the families that want this experience of homebirth. It is sacred, spiritual and powerful. Some births I am more needed than others.

Some women have all the right circumstances in alignment for a birth that is so flawlessly easy that I wonder whether I could have taught the dad the handle it himself!! Then there are the ones that every bit of my training, common sense, stamina and memory are called into play. I also keep Anne Frye's latest book in my kit so that if it's really late and I'm really stumped I have the wisdom of many midwives in my back pocket!

In my community I believe that midwives do seem to tolerate each other's differences. We must be different from each other in order to effectively serve the population of home birthing families. Without diversity, we fail the community because as each midwife's approach is different, each woman's needs are different. Some women prefer a more hands-on, quasi-medical approach to pregnancy and birth. There are midwives here able to provide that service. Other women prefer a more laid-back hands-off approach. I know there are midwives who can provide that energy as well. Usually, what I see is that each woman seems to choose the right midwife for her for the care she needs.

It is even more important now than ever to provide a wide spectrum of midwifery options in our community as the CNM's were removed from the local hospital several years ago. I believe that this act has put more pressure on the birth centers of our community as well as do home birthing mothers. I am hoping that one of the hospitals in our community will eventually invite the midwives back in.

I do not believe that a midwife's innate sense of "knowing" has gone by
the wayside. I check into my own intuition before and during every birth. Sometimes my intuition just slams me in a dream or during my yoga practice. I'll just get a "hit" about one of my clients. I am usually right and never disappointed about following these hunches. Many of my colleagues employ their intuition as well, so I would like to reassure you, Ruth, that this long-honored skill is not being thrust aside in favor of numbers.

I know I am not an "old" midwife, but I resonated with many of Ruth's comments and felt instantly compelled to respond.

Good luck on your journey through the change, of becoming a wise crone midwife. We young ones need you and your wisdom.

Blessings,
Vicki Meinhardt, LM, CPM
Wholistic Birthways
www.wholisticbirthways.net

Midwives in Crisis Settings

Circle of Health International (COHI) is a US-based NGO working with midwives in crisis settings. COHI has worked in post-tsunami Sri Lanka, post-hurricane Louisiana, Tibet, Tanzania, Israel, Palestine, and hopes to expand to South Sudan in 2008. COHI's membership is midwives, nurses, OB/GYNs, public health professionals, researchers, and activists. COHI is always looking for Board members and field volunteers. Please visit www.cohintl.org if you'd like to learn more about our work, or send an email to info@cohintl.org.

Upcoming Conferences

Following are conferences that NARM Board members will be attending:

Midwifery Conferences:

Midwives Alliance of North America (MANA)
Traverse City, MI
October 16-19, 2008

NARM also attends:

Council on Licensure, Enforcement and Regulation (CLEAR)
Charleston, NC
January 10-12, 2008

Coalition for Improving Maternity Services (CIMS)
Kissimmee, FL
March 6-8, 2008

• National Conference of State Legislatures (NCSL)
  New Orleans, LA
  July 22-26, 2008

• Council on Licensure, Enforcement and Regulation (CLEAR)
  Anchorage, AK
  September 24-27, 2008

• American Public Health Association (APHA)
  San Diego, CA
  October 25-29, 2008

• National Organization for Competency Assurance (NOCA)
  San Francisco, CA
  November 19-22, 2008
Greetings from the NARM Applications Department. We hope you are all having a wonderful new year. We continue to get busier every month.

As of December 1, 2007 the NARM Applications Department has received a total of 89 applications for 2007. We have total of 106 applicants currently in CPM process.

- 35 PEP Entry Level applicants
- 10 PEP Special Circumstances applicants
- 59 MEAC applicants
- 1 Registered Midwife from the United Kingdom applicant
- 1 Certified Nurse Midwife applicant

There were 89 applications sent out to people requesting application packets.

- 100 New CPM certificates were issued so far in 2007.
- 31 PEP Entry Level
- 5 PEP Special Circumstances
- 50 MEAC
- 11 State Licensed
- 3 Certified Nurse Midwives

The total number of CPM Certificates issued as of December 1, 2007 is 1341!

### Table of Comparison

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### Recertification

The policy for recertifying is that every CPM is required to send in CEU verifications with their Recertification Application.

### Inactive Status

We have had 15 people take advantage of the inactive status last year, making a total of 65. Inactive CPMs will continue to receive the CPM News and may recertify within a six year period. Inactive status must be established within 90 days of the CPM expiration, and is maintained annually for up to six years. Inactive status is renewed each year by filing an intent to be inactive and a fee of $35.00. During this period, inactive CPMs will receive all NARM mailings, but may not use the CPM designation or refer to themselves publicly as a CPM, or as certified by NARM. During the six year period, an inactive midwife may renew the certification by submitting the recertification form and fees ($150.00, 25 continuing education hours, five hours of peer review, plus the recertification form documentation).

### Expired CPMs

CPMs whose certification has been expired for more than 90 days, or who have not declared inactive status, will be given expired status and will be required to follow the new policy on reactivation to be recertified.

All of NARM’s policies regarding recertification, certification status, or reactivation are available on the web at www.narm.org.

### Audits

The Applications Department generates random audits from all applicants and CPM’s recertifying. One (1) out of every five (5) applicants will be audited. Items requested for audit are Practice Guidelines, Informed Consent document, forms and handouts relating to midwifery practice, Emergency Care Plan, and Peer Review verification.

### Delinquent Applications

If, at the end of one year the application is either incomplete or an examination is not scheduled, a letter will be sent to the applicant giving notice of expiration of the extension. An applicant may request an additional six month extension on the application process by submitting the following:

- A letter of request with an explanation of the need for an additional time.
- Resubmit two copies of a current driver’s license.
- Resubmit two copies of a current CPR card.
- Resubmit two copies of current photos.
- Submit additional fee (money order or Cashier’s check) in the amount of $200.00

Failure to respond or submit additional requirements will result in the applicants file being closed and the application being archived. The applicant will have to resubmit a new application with appropriate fees.

All of NARM’s policies are available on the web at www.narm.org.

The Applications Department is here to help you with any questions.

NARM Applications
P.O. Box 420
Summertown, TN 38483
applications@narm.org

Please include your CPM number in any correspondence.
National Provider Identifier (NPI) Midwife Categories Redefined!

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

There has been some confusion in the past about which category to register under. The good news is CPMs will no longer have to decide between "Certified Midwife" and "Lay Midwife" when applying for a National Provider Number (NPI). The previous "Midwife, Certified" classification has changed to "Midwife" and has a new definition. If you previously registered as "Lay Midwife" you may go in and edit your classification to "Midwife." The address to register is: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Under the Other Service Providers Type the definition and the title for the Midwife, Certified Classification was changed to:

- **Midwife**

  A Midwife is a trained professional with special expertise in supporting women to maintain a healthy pregnancy birth, offering expert individualized care, education, counseling, and support to a woman and her newborn throughout the childbearing cycle. A Midwife is a skilled and independent practitioner who has undergone formalized training. Midwives are not required to be nurses and may be trained via multiple routes of education (apprenticeship, workshop, formal classes, or programs, etc., usually a combination). The educational background requirements and licensing requirements vary by state. The Midwife may or may not be certified by a state or national organization.

  Source: The National Uniform Claim Committee

2008 California Association of Midwives Conference

"Circle of Life, Center of Light"

Come join us May 16-18 in Occidental, California for an inspiring weekend filled with fun and education. This conference is open to anyone interested in birth work including, professionals, students and doulas. Speakers this year include Pam England ( Birthing From Within), Robbie Davis-Floyd (medical anthropologist specializing in reproduction), Mary Jackson with Ray Castellino (Womb Surround process work), Gail Hart and many others. CEUs are available to LMs, CPMs and RNs.

We also offer enticing vendors, stimulating entertainment, great midnight stories, and the latest about California midwifery politics. This will be one of the best and affordable conferences this year. Your fee includes lodging, food and entertainment for the entire weekend!

Volunteers and seniors will receive discounts. For more information contact Fawn Gilbride at (707) 251-8747 or homebirthmidwife@sbcglobal.net
Practice Guidelines

Certified Professional Midwives utilize documentation throughout their practice. They document skills and knowledge in order to attain their credential, and they continue to use documentation in their practice. Documentation helps them inform their clients of who they are and how they practice, and it is used to verify clinical assessments and care plans throughout the pregnancy and birth process. While individualized practice is a hallmark of the midwives model of care, standardization of document language can help midwives to clearly and legally communicate with clients and peers. In order to support CPMs and CPM candidates, NARM will be publishing articles in the CPM News that will hopefully clarify standards for documentation.

Examples of Practice Guidelines can be found at www.narm.org/practiceguidelines.htm.

We don’t actually have any examples there yet, just the description of what practice guidelines are from the CIB which is reprinted below in the newsletter.

Midwives need to understand the terms standards, clinical guidelines and protocols so they can use them in the same way that others in the medical and legal fields do. This is a mechanism by which to protect the midwife, her practice and the midwifery profession.

The term protocol is confusing sometimes because it is used differently from location to location, state to state. In general, protocols need to be carefully written, or midwives can damage themselves legally. The midwife should be certain that the way she practices and interacts with clients fits within her protocols. For example, a protocol in Florida between a CNM and a physician serves as a contract to limit the midwife's practice. Should she deviate from working within the protocol (in this case as determined by the agreement she has with the physician), she may be liable for damages in a malpractice claim and may be unable to get insurance coverage for her defense. The same is true for a midwife whose practice uses written protocols. Most of the time protocols are decided by a group of practitioners and serve to insulate the group from legal action should one of the members deviate from them.

The terms Guidelines and Standards should NOT be interchanged. Standards provide the midwife with process. Clinical guidelines provide research-based information. Standards are rigid. Clinical guidelines may be flexible to meet client needs and the particular circumstances. Clinical guidelines do not take the place of standards, but rather provide research-based options for decisions.

Clinical Guidelines are:

- Operational tools to assist in clinical decision-making
- Detailed and client-focused
- Based on procedures or clinical conditions
- Recommended courses of action and/or practices for meeting standards of care
- Sources of continuity, quality of care and a range of acceptable practices and options that can be adapted to specific needs

— Suzanne Hope Suarez, excerpted from "Protocols vs. Guidelines," Midwifery Today Issue 73

From the NARM Candidate Information Bulletin:

All Certified Professional Midwives are required to have a written Practice Guidelines document. Practice Guidelines are specific descriptions of protocols that reflect all of the care given by a midwife from the initial visit throughout pregnancy, birth, postpartum and newborn care. A Practice Guidelines document is different from a midwife’s Informed Consent document or client handouts. Practice Guidelines vary in length depending on the amount of detail regarding the scope of a particular midwifery practice.

Practice Guidelines are based upon the standards, values and ethics held by the midwife and inform the actions taken by the midwife in specific situations. They should reflect the Midwives Model of Care. Standards, values, and ethics are more general than Practice Guidelines, as they reflect the philosophy of the midwife. NARM recognizes that each midwife has specific practice protocols that reflect her own style and philosophy, level of experience, and legal status Practice Guidelines may vary with each midwife.

NARM does not set guidelines for all CPMs to follow, but requires that they develop their own written Practice Guidelines document.

Practice Guidelines contain specific details about the way a midwife conducts her practice, under both normal and abnormal conditions, and may contain absolutes such as, “I will not accept as a client a mother who does not agree to give up smoking,” or may outline conditions under which a midwife will make decisions, such as: “I will accept a client who smokes only if she agrees to cut down on smoking, maintains an otherwise exceptional
diet, and reads the literature on smoking that I will provide for her.” (These are given only as examples and are not meant to convey that smoking must be covered in a midwife’s practice protocols.) Another example of a protocol could reflect action taken when a client is postdates. The guideline could state that at 42 weeks, the client will be referred to a back-up physician for further care. Or the guideline could read that at 42 weeks the client will be given information on the risks and benefits of continuing to wait for labor, or options such as home induction or referral to a physician.

State law or rules and regulations can be used as the basis for Practice Guidelines, understanding that a law defines the scope of practice and that Practice Guidelines are the specifics of how a midwifery practices within the law.

NARM recommends that the midwife base practice documents on the following resources:

- The NARM Written Test Specifications in the Candidate Information Bulletin
- The Midwives Model of Care
- The MANA Core Competencies
- The MANA Standards and Qualifications for the Art and Practice of Midwifery
- The MANA Statement of Values and Ethics
- Core Competencies for Basic Midwifery Practice
- Standards for the Practice of Nurse-Midwifery
- Code of Ethics for Certified-Nurse Midwives
- NACPM Core Documents
- Rules and regulations governing the practice of licensed midwifery in the midwife’s state, if licensed

MANA documents can be found at www.mana.org.

ACNM (Certified Nurse-Midwife) documents can be found at www.acnm.org.

The Midwives Model of Care can be found at www.cfmidwifery.org.

Suggestions for Documentation of Clinical Experience

In response to multiple requests for clarification about the role of the Preceptor in the NARM application/certification process, NARM has developed the following step-by-step guidelines based on the instructions set forth in the Candidate Information Bulletin. These guidelines are suggestions for successful completion of the application documentation.

1. The preceptor and applicant together, should review the three (3) separate practice documents required by NARM—Practice Guidelines, Informed Consent, and Emergency Care Plan.

2. Review all client charts (or clinical verification forms from a MEAC accredited school) referenced on the NARM Application. Confirm that the preceptor and applicant names appear on each chart/form that is being referenced.

3. Confirm that the signatures initials of the applicant are on every chart/form for: initial exam, history and physical exam, complete prenatal exams, labor, birth and immediate postpartum exam, newborn exam, and complete follow-up post partum exams listed on the NARM Application. Be sure the numbers written on the application forms are the same number of signatures/initials on the charts/forms.

4. Check all birth dates and dates of all exams for accuracy

5. Check all codes to make sure there are no duplicate code numbers. Each client must have a unique code. If there is more than one birth with any given client there must be a different code assigned for each subsequent birth.

6. If a preceptor has more than one (1) student (applicant) each chart must have a code that all students will use. Students should not develop different codes for the same client.

7. Preceptors need to be sure their forms show that the student participated as primary under supervision and that the preceptor was present in the room for all items the preceptor signs. For example: the arrival and departure times at the birth should be documented on the chart for both the applicant and the preceptor. At the time of clinical experience preceptors and students should initial each visit.

8. Applicants should have access to or copies of any charts listed in the application, Form 112a-f and Form 200 with Code # in case of audit.

The Informed Consent document used by the apprentice/student should not indicate that she is a CPM, even if she is in the application process. The CPM designation may not be used until it is earned.

Preceptors who sign off on experiences they did not witness risk losing their ability to sign as a preceptor in the future and also risk losing their NARM certification.

JOIN THE GRASSROOTS NETWORK EMAIL LIST

Visit the Citizens for Midwifery website at www.cfmidwifery.org
Job Analysis

Job Analysis to be done in 2008

The knowledge and skills that must be demonstrated by each CPM candidate are determined by the Job Analysis, a survey of knowledge and skills that is done every 6-7 years. This is not unique to the CPM, but is a required step in the development of every certification credential. The first NARM Job Analysis was done in 1995, and the second in 2001. Now it is time to do it again. The purpose is to confirm the current knowledge and skills for the CPM credential and to ascertain if there have been any significant changes to the role of the CPM since the last analysis.

There are two steps to the NARM Job Analysis. The first step is to expand the list of possible tasks to include everything a midwife might need to do or know. The second step is to survey all CPMs and ask them to rate the list of tasks according to how important that task is to their job as a midwife. Tasks that rate high become part of the Knowledge and Skills Checklist that is the curriculum for apprentice education and are also the basis for the NARM exam, and tasks that rate low are not included. NARM does not state that the low-ranking tasks are not permitted, just that they are not required for the CPM.

To develop the 2008 survey, we have asked a focus group to look at the current job list and consider what might be added to the survey. The focus group was made up of CPMs who represent a variety of geographic locations, practice sites, and years of experience. The participants have added to the list of NARM knowledge and skills for the purpose of expanding the survey. All CPMs are invited to respond to the survey for the purpose of editing the list down to the knowledge considered essential for certification.

In 2001, the 50 page survey was printed and mailed to all CPMs with a pre-paid return envelope. The cost of printing and mailing was significant, as was the scoring of every page returned. In light of the tremendous advances in technology available to most midwives, we are going to do the 2008 Job Analysis electronically. Not only will that save the cost of printing and mailing, but it will allow the results to be tabulated by a survey program, thus eliminating the tedious hand-scoring. There will still be expenses involved in software and professional consultation and analysis, but the advantages will be significant.

As this newsletter goes to print, the electronic survey is still being formatted. Once we go live there will be a notice on our website. CPMs will be able to click a link to enter the survey site and will be asked for a membership passcode, which will be their CPM number. The best part is midwives will be able to fill out the survey at their own pace and then click submit when completed. Midwives who do not have access to the internet may request a printed copy. If you would like to receive the Job Analysis survey on paper rather than participate on the web, please e-mail testing@narm.org, or call 1-888-353-7089. Your participation in this survey is essential for the ongoing development of the NARM Certification Process. What makes NARM unique is that every CPM has the opportunity for input, in identifying the knowledge and skills that are mandatory components of midwifery training. The requirements for certification are based on what the midwives are actually doing in practice. We need for every CPM to fill out this survey so that it truly does reflect the knowledge and skills of the midwife.

Stay tuned for a formal announcement of the new, web-based NARM Job Analysis, or check the web regularly!

Legislative Tricks and Tips: lobbyist

Hiring a Professional Lobbyist

A professional lobbyist can be a great help, but is also very expensive. Fees vary from state to state, and are usually based on how much work you expect to get from your lobbyist. Most lobbyists expect a bill to take several years to pass. They may charge a smaller fee in the first year or two and then charge much more during the year you expect to really pass the bill. Even if you are raising some money, you won’t likely have enough to hire a lobbyist. But you can interview several lobbyists as though you were looking to hire, and then explain to you that you won’t have nearly that much money. Do these interviews well before the session, when they aren’t so busy. Most states require the lobbyists to register, so you can get a list and talk to some of them. Some do pro-bono work, and might meet with you several times to give advice before and during the session. Even if you can’t officially hire one, you might get a lot of benefit from talking with them. Write thank-you notes, even for a phone call, and ask them to keep your issues in mind even though you can’t hire them, and let them know you would welcome any advice at any time. Contact with lobbyists who have as clients other grass-roots organizations. Also, identify the medical lobbyists. You might not want to seek their advice the same way, but it could be helpful to talk to them once the real lobbying starts. Once the opposition starts to speak, you might want to catch their lobbyist in the halls and have impromptu chats about getting them to back down.
From Susan Hodges of Citizens for Midwifery:

My experience is that a professional lobbyist is similar to a contractor. When you are building a house and hiring a contractor, you are not only hiring his/her experience in construction, you are also hiring his/her relationships with subcontractors. The contractor knows who is good and who isn’t, and the subcontractor is more motivated to do good, timely work because future work with this contractor depends on doing a good job. Similarly, when you hire a lobbyist, you are not only hiring his/her expertise in finding the way around the capitol and just spending the time to go talk up your issue with the right people, you are also hiring that person’s relationships with the legislators and staff (aides, etc – very important). The legislators and staff are more likely to pay attention to someone they already know, who has provided trustworthy information before, etc, than someone new, coming in green. This may be especially significant for an issue that many will perceive as “fringe”. It may be that you can find someone who is already lobbying for similar causes that you can hire part time. It might be worthwhile asking a senator if there is a professional lobbyist they might suggest. Even if you can’t afford to hire a professional lobbyist, you might be able to consult with one who is sympathetic. If you can make friends with one of the regular lobbyists, one or more may keep an eye out for you; give you some useful information, etc.

After your bill passes it can also be very helpful to keep a professional lobbyist on a small retainer in order to get the service of a “watchdog” in the years to follow. Having an interested party who is already attending health related hearings at the Capital each year will help to ensure you stay aware of potential unfriendly legislation or new laws that licensed midwives must follow.

The National Conference of State Legislatures
Debbie Pulley, CPM, NARM Public Education & Advocacy

The National Conference of State Legislatures (NCSL) was held August 5-9 in Boston Massachusetts. Over 9,000 legislators and legislative staff attended the conference. Representatives from MANA and NARM working at the Midwives Model of Care booth were Carol Nelson, Miriam Atma Khalsa, Ida Darragh, and myself. Our goal was to talk with as many legislators from target states as possible, which was accomplished. Ida has sent follow-up letters to those who requested information. We have also put together a database of names and forwarded the information to state midwives for follow-up. The most exciting thing this year was how many legislators actually sought us out. Next year we plan to get one page FAQ sheets from each state to hand to legislators and staff so they can see what is happening locally.

Looking for Opportunities to Obtain CEU’s?

Don’t miss a great opportunity to earn CEU’s and have a great time doing it! Plan on attending MANA 2008 in Traverse City, MI October 16th through 19th.

Last year at MANA 2007 in Clearwater, FL, there were opportunities to earn contact hours during the regular conference plus additional contact hours if you attended a pre-conference workshop.

For more information, watch for announcements about the conference on Midwives Alliance’s website at www.mana.org.

*Come to NARM’s Workshops at MANA Conference!
- Legislative Workshop
- Charting Workshop
- QE Workshop
- Apprentice/Preceptor Relationships
  *Tentative
On-line Ordering for CfM Literature and Memberships

You can now order Midwives Model of Care brochures and other items at www.cfmidwifery.org using your own credit card, no PayPal account needed! Ordering is quick and convenient for you, and CfM can turn around your order more promptly. Brochures, videos and other items that can be ordered are all described at http://cfmidwifery.org/store.

If you have not visited the Citizens for Midwifery web site for awhile, go take a look! In addition items you can order, a variety of items are freely available: in “Resources” find a list of all our resource items, or you can scroll down below the list for categories, such as “Fact Sheets” or “CfM News Re-prints.” A recent fact sheet, “Out-of-hospital Midwifery Care: Much Lower Rates of Cesarean Sections for Low-risk Women” can be found at: http://www.cfmidwifery.org/pdf/cesarean2x.pdf. The results of several studies simply presented in a table, with citations, clearly demonstrate the title of the fact sheet. Many of these are useful for reaching out to potential clients, and for informing legislators and the press.

Citizens for Midwifery Announces New Fact Sheet

“Evidence Basis for the Ten Steps of Mother Friendly Care” was published last winter as a Supplement of the Journal of Perinatal Education (Vol 16, Supplement 1, Winter 2007).


Citizens for Midwifery (represented by Carolyn Keefe and Susan Hodges) and BirthNetwork National (represented by Victoria Macioce-Stumpf) together produced this fact sheet, with feedback from the authors of the study and board members of Lamaze International and the Coalition for Improving Maternity Services (CIMS). The 2-sided fact sheet summarizes the main findings for each of the steps and the appendix (“Birth can safely take place at home and in birthing centers”) with the intent of making the findings much more easily accessible to everyone. It includes a complete citation for the publication, as well as information on how to get copies (on-line and ordering a paper copy) and where to find out more about the Mother-Friendly Childbirth Initiative. If you want print a copy, you may find that your printer shrinks the file to make wider margins, causing the type size to be quite small. To avoid this, especially if you are making any quantity of copies, have your local copy store print directly from the pdf file (you can copy the file to a CD if needed).

Midwives Alliance

Find a Midwife

As part of the growing public education campaign, the Midwives Alliance of North America (MANA) has launched a consumer website: Mothers Naturally (mothersnaturally.org). This consumer-based site will serve as a valuable resource to mothers to be seeking natural advice. A big feature of the website is to connect these mothers to midwives. The mother will type in her location and get a list of midwives serving that area. Please help us provide resources for all these women. The cost is $50 for the first year for MANA members. If you are not a current member of MANA you may join up and ask to be listed all at the same time. With your participation we can connect women to the provider of their choice and move midwifery forward!

Contact Elizabeth Moore: region5@MANA.org

News from NACPM

The tide is turning at last in the United States for health care reform! Just in the last few months, a growing number of states have proposed or adopted plans to provide universal access to health care for their citizens, and several federal legislative proposals are on the table. It has become clear that national health care reform will be the number one domestic topic of the 2008 presidential campaign.

This rapidly rising tide of reform presents an immediate opportunity to Certified Professional Midwives to participate in the design of these reforms, to integrate CPMs into a reformed national maternity care system, and to radically increase women’s access to midwifery care. NACPM is working now to assemble the tools that will be needed to ensure that midwifery as practiced by CPMs will be viable into the future, and that it will hold a secure place in our health care system as it emerges from the current health care reform efforts.

To these ends, NACPM has launched the NACPM Strategy for Increased Access to Midwifery Care. We have fashioned bold initiatives to achieve the goals of increasing women’s access to the care of CPMs, and to supporting...
CPMs by removing barriers to our care. The key elements of this new strategy are to ensure that CPMs are at the table as the health care reform movement redefines health care in the U.S., and to achieve federal recognition of the CPM through our federal legislative agenda to support insurance reimbursement of CPMs. The first issue of our new newsletter describes this strategy and the work that is being done. We invite you to read the complete newsletter at www.nacpm.org. If you are not already an NACPM member, we invite you to join now at our website, and to become involved in this exciting work!

The NACPM Board believes that these are exciting times for midwifery, and that the health care reform movement presents a unique opportunity to bring the dream of a midwife for every mother closer to reality than ever before. We believe that Certified Professional Midwifery is poised to take its rightful place in our health care system and in the lives of the women and families in our states and our country. We welcome your ideas and your participation in this work of NACPM.

Mary Lawlor, CPM, LM, MA
President, NACPM

In Memoriam:
This column is intended to honor the passing of those people who have touched our community of midwives in some way.

Lora Burgess
April 2007
Lora Burgess was a 30 year old single mother of two beautiful young children. She was also a passionate home birth midwife candidate. She had planned to sit for the August 2007 NARM Exam. She was beloved by area midwives, birth professionals and birthing women for her passion and her humor.

Jennifer Wollheim, CPM
June 2007
On June 23, 2007, Jennifer gave birth to a healthy, beautiful baby girl, Lila Jennifer. She died on the same day of complications related to her pregnancy and her planned hospital delivery. Jennifer, a 2004 graduate of the Florida School of Traditional Midwifery, will be missed greatly by her husband Neal, her family, and many, many people whom she touched with her love, caring and beautiful soul.

Gail Mraz-Goddard
August 2007 at the age of 71
Gail was a lifelong Minneapolis resident and mother of nine, was a pioneer in home-birthing and helped reestablish the practice across Minnesota. She delivered more than 250 babies, two of them her own granddaughters. In 1975, Mraz co-founded Genesis, a Twin Cities midwifery group, and also helped to write the care standards used as midwives were again being licensed in the state. Her middle child, son Paul Mraz, said he remembers the basket of prenatal care equipment his mother would keep by their door, ready to grab and head out whenever she got the call from an expectant mother. "When my mom saw someone in need, that transcended all other things that she might see in that person," he said. Her desire to help others extended to her many years of work as a nurse at Mount Olivet Nursing Home in Minneapolis and to her volunteer efforts with the poor and homeless, which included several summers in Olivia, MN, working at a clinic for migrant farm workers.

Paula J Mandell
May 14, 1959 - January 4, 2008
Paula was involved with Citizens for Midwifery since 1996, when she volunteered to help with the CM News, a simple black and white photocopied publication at the time. She was involved with the development of the new logo, newsletter design and website design, and their implementation, in 2000. She also filled a vacancy on the Board of Directors in that year and served on the Board through 2005. Over all those years she continued to format the newsletter, keep the website updated, and administer the Grassroots Network. She also created ads, signs and fliers as needed.

Prior to 2000 Paula was an independent midwife for 12 years in Nebraska and Arkansas. She also did volunteer work for a local domestic violence shelter for 6 years, and later volunteered with a home-hospice care organization.

NARM Updates

Anytime there are any changes or announcements, the information is immediately posted to the web. Be sure to check it regularly.

www.narm.org

CPM News Alerts

NARM now offers you the option of receiving the newsletter via the internet to save financial and environmental resources.

If you would like to try this out, go to www.narm.org/cpmnews.html and open the PDF file. You can print it or save it.

If you would like to receive an email notifying you that a new issue of the CPM News is now available online in lieu of a paper copy, send your name, mailing address and email address to cpmnews@narm.org.
Get started with Stats!
Peggy Garland, Midwives Alliance Division of Research

MANAStats has been online now since 2004 and gets easier and easier to use, due to awesome software upgrades and helpful feedback from users. If you haven’t joined, ask someone who uses it to show you how, and show you how you get your own stats back instantly. You can use these numbers for your clients’ informed consent, for your own practice improvement, for pooling with other midwives in your practice or your state. It’s up to you. Soon you will be able to customize the reports you see, by limiting the fields or the time frames. For example, you could see only your transfers for a certain two year period, or all your births between April and June. And then change the menu and get a different report – say the same information for another year. You can comply with state regulations using this information. You could even get your own raw data and design a small study for your own practice.

Another new feature is a midwifery organizational account. There are quite a few states now that have so many members collecting their stats with this system that they want to pool them automatically. So now, any midwifery organization can decide to obtain an account to view the aggregate stats of its contributing members. This is anonymous data that is added up by the software. Imagine the usefulness of being able to go to your state Medicaid office with your state CPM transfer, induction and c-section rates! Negotiate a place at the table for your group in a public health commission on breastfeeding by showing your breastfeeding rates! The sky’s the limit!

We do not want our contributors’ data to be used without their consent, so we’ve developed a fair process by which organizations can decide and obtain an account. That’s the easy part. The more important part is to get your members to become contributors and to support them to stay current. The more contributions we get, the higher quality of data because it becomes more representative of practice. Also, the more births in the system, the more significant the rates and percentages, especially for outcomes that don’t happen very often.

As if that weren’t reason enough, there is going to be more and more emphasis on transparency and quality measurement in health care as we barrel headlong toward health care reform. With MANAStats you will be in the forefront of this important trend.

"To enroll in MANAStats, go to www.manastats.org
To inquire about organizational accounts, email Peggy Garland at research@mana.org

Stats Report
Ken Johnson and Betty-Anne Daviss

Educating Legislators and Providing Testimony for Midwives
In Court

The CPM2000 study continues to be accessed from the BMJ website by more than 1,000 different individuals every month. With Wisconsin using the BMJ article in their legislative effort to make the case for the safety of CPM attended out-of-hospital births.

1. A record number of states have turned towards legislation (11 at last count) We have produced documentation to educate agency staff and policymakers for South Dakota, Wisconsin, Indiana, California, Missouri, New York, Minnesota, and Maine so far, and will continue to develop and make presentations when requested.

2. At least 10 midwives are presently under investigation. We have provided testimony for four court cases over the last two years.


We want CPMs to know that we are available for presenting state-focused statistics for the purpose of educating agency staff and policy makers and for testimony for individual midwives. We do not charge for this service. It is important to understand that meaningful statistics require more than a simple tabulation of births. They require comparison to a control group and for midwives attending home births, the CPM2000 study serves as the best comparison group for either the individual midwife or for the state as a whole. Thus we are able to provide the midwife and the courts with high quality, statistically valid information on birth outcomes from a highly reputable source that any judge/prosecutor/lawyer can download from the BMJ

MANA
Statistics Address

MANA Statistics
P.O. Box 6310
Charlottesville, VA 22906
statistics@mana.org
website. We realize that there are few epidemiologists who can offer this type of support to midwives who are on trial because it is time consuming, generally involves dropping everything else when suddenly asked to produce a report in a very tight time frame on the specific case, and requires specific expertise.

**Other Collaborators**

CPMs who are doing research in Florida, Michigan, Oregon have approached us about collaborating with them. They are obtaining their own grants.

The website (*understandingbirthbetter.com*) has an updated home page, an improved data entry system in three languages, and the BMJ article has been translated into Spanish, German, and French. The Spanish one has been uploaded to the BMJ site and we are working on uploading French and German versions.

**Questions About BMJ Article**

Some of you have written emails to us asking questions about the BMJ study. We have responded to these questions by placing a section called “Answers to Questions” on our website at UnderstandingBirthBetter.com. Jennifer Block also consults with us periodically, as we were quoted frequently in her new book “Pushed.” Because of her popularity, we are posting answers to questions coming to her on the website as well.

The best way to find the article quickly is to Google “BMJ Daviss”. Shortly after our attendance at the NIH conference in 2006, the CPM2000 study began to be used as a benchmark for rates of cesarean sections and other interventions, in particular by Childbirth Connections.

For those who are interested in finding out more about what we are doing, you can email us at cpmstats@rogers.com to sign up to received periodic news emails from the Midwives, Mothers, and Researchers Network.

**Legislative Updates**

**Iowa**

Melanie Moore, a CPM in Iowa, was arrested in May and charged with practicing medicine without a license. She was scheduled to go to trial in August (a very long, expensive process, and very difficult to win). Three days before the trial, she was offered a plea bargain: no jail or trial in exchange for a guilty plea, fines of over $700, and 25 hours of community service. She must also, of course, discontinue working as a midwife. Considering the alternative, she made the prudent decision and accepted the offer. Midwives and consumers in Iowa are working to change the laws and make midwifery legal. A Legislative Workshop was held September 22 to prepare for the process of proposing legislation. Led by Ida Darragh from NARM, the workshop helped participants to organize both the tasks and the volunteers that will be necessary for work this fall, and to learn effective lobbying techniques, including speaking and letter writing.

**Maine**

The midwives of Maine presented arguments in favor of a voluntary licensure bill for CPMs in a sunrise hearing at the Department of Professional Regulation in August. The Department’s focus was to assess whether the public interest would be served by licensing direct-entry midwives. DEMs are unregulated, but considered legal in Maine. The proposed bill would allow licensed CPMs to carry and administer medications, but would not alter the legal status of midwives who remain unlicensed. Several CPMs spoke of their hope that licensure would improve relationships with doctors and hospitals when advanced medical care became necessary, and that the availability of medications could make home birth safer. Ida Darragh, from NARM, testified to the training and education of the CPM and to the advantages of licensing midwives as evidenced in other states with licensure programs. The DPR will continue to gather information and will make a recommendation on the proposed bill this fall.

**Massachusetts**

A bill to license CPMs and CNMs under a joint board has made progress again during the 2007-2008 legislative session. The bill was approved in November by the House and Senate Joint Committee on Public Health. More legislative hearings will occur in January.

In addition to the states listed above, midwives and midwifery supporters are working toward or considering legislation to license midwives in these states: Alabama, Georgia, Delaware, Illinois, Kentucky, Indiana, North Dakota, and Idaho. Friends of Midwives in these states have continued to meet with legislators during the summer, but the rally for legal midwifery will peak again this winter as the legislatures consider proposals to license direct-entry midwives.

**Missouri**

August 23, 2007 Press Release from Missouri: Midwifery supporters join Attorney General’s Office and file appeal to Missouri Supreme Court on midwifery law. Missouri Supreme Court on midwifery law

(Jefferson City, Mo.) – Missouri’s midwifery supporters today joined with the Office of the Missouri Attorney General to file an appeal to the Missouri Supreme Court in order to reconsider the permanent injunction on the state’s new midwifery law. The coalition of Missouri homebirth families and their midwives said they are mobilizing for the appeals process and praised the actions of Attorney General Jay Nixon’s office.

“Our members very much appreciate the decision of the Attorney General to appeal this injunction to the Supreme
Court,” said Mary Ueland, Grassroots Coordinator for the Friends of Missouri Midwives. “We are hopeful that the Supreme Court will reverse this unfortunate judicial ruling, and Missouri will at long last decriminalize the practice of Certified Professional Midwifery, doing away with the threat of felony charges and seven years in prison for practicing midwifery.”

On August 8 Circuit Court Judge Patricia Joyce disallowed the Certified Professional Midwives provision contained within HB818 regarding portability and accessibility of health insurance. Judge Joyce ruled the provision was unconstitutional and unrelated to health insurance.

Assistant Attorney General John K. McManus and Midwifery Coalition attorney Jim Deutsch argued in circuit court less than one month ago that decriminalizing midwifery does indeed relate to health insurance, recalling that the Missouri Supreme Court has already ruled health insurance is interdependent on health services, and the two subjects are related. Deutsch cited nine other states where Medicaid covers homebirths attended by Certified Professional Midwives and many others where CPMs receive private insurance reimbursement. Both McManus and Deutsch argued that families obviously cannot get health insurance reimbursement for their midwives if their providers are considered felons by the state. They agreed that legalizing Certified Professional Midwives is a first step to homebirth families being able to have their maternity care providers covered by insurance. They also cited the lower cost of midwifery care, which in turn could encourage insurance companies to lower their rates for healthy women.

Allan Schwarb, father to five children born at home and a Boeing employee, is glad for the news of the appeal. “The judge was wrong to decide that legal midwifery is not part of access to health insurance,” he said. “While safety is the number one reason my wife and I chose homebirths, money is also a factor. While living in other states where midwifery is a legally recognized healthcare profession, our care was covered by my Boeing insurance with $5 co-pays. But when we relocated to Missouri, we discovered that since midwives are felons here my insurance was useless.”

Jessica Mattingly is a Blue Springs, MO mother due in September who wanted the midwifery law to stand as she had hoped to use a Certified Professional Midwife to deliver her baby. She cites skyrocketing c-section rates as one of the primary reasons that mothers like her are looking for alternatives. “Right now, if you are a pregnant woman delivering at a hospital, you have a 1 in 3 chance that you will come out of that hospital having had major abdominal surgery. Beyond the additional risks for mothers and babies that c-sections create, what does a c-section rate of more than 30 percent do to our insurance rates, and how reliant are doctors and hospitals on these increasing revenues?”

The decision to go to the Supreme Court is also strongly supported by Laurel Smith, President of Friends of Missouri Midwives. “Physicians’ groups don’t seem to realize that families today are not willing to suffer on the battlefield of their turf wars,” she said. “The days of medical groups pouring money in to ensure that other health professionals cannot perform services for which they are trained are coming to an end.”

Ueland agreed with the notion that organized medicine’s misuse of “Scope of Practice” laws impairs healthcare access and increases costs to consumers, especially those who reside in rural areas or who are disadvantaged. “Missouri families who want safe, healthy, and economical healthcare have long been frustrated by the choke-hold that organized medicine has maintained on childbirth in our state. At a time when the majority of the country – and the world – allow midwives to practice as professionals rather than felons, Missouri is strangely out of step with the rest of civilized society.”

She added that people move to Missouri from states like California, Florida, or Tennessee where Certified Professional Midwives are in the Yellow Pages and ask her what the problem is with Missouri and midwives.

“The root problem is tough to pinpoint. One could criticize the state legislature for cowering to the threats of organized medicine for several decades so that they never passed midwifery legislation before now,” Ueland said. “Or one could make a fairly compelling argument that Judge Joyce’s service on the Board of Directors for St. Mary’s Health Center in Jefferson City is a mighty conflict of interest given her ruling on the case. But instead of focusing on this water under the bridge, we are looking forward to having the Supreme Court recognize not only the constitutionality of the midwifery provision, but also the value of midwives to the public good and their significant contributions to more consumer choice, increased healthcare access and decreased costs within a top-tier healthcare system.”

As national attention to the Missouri midwifery case grows, midwifery supporters from across the country are getting involved to show their support of the Supreme Court appeal. A recent study on direct-entry midwifery prepared by the Georgia legislature reported that, “When a state has an underground network of healthcare providers, it has a responsibility to deal with the problem through regulation rather than prosecution.”

Ueland said she agrees with the Georgia study and that the time is now for Missouri to deal with midwifery and decriminalize the profession. “We are hopeful the Supreme Court will rule that legal access to midwives relates to access to health insurance. And with this ruling that will decriminalize Certified Professional Midwives and remove the threat of prosecution, Missouri finally will join the 40 other
states where professional midwives are allowed to assist homebirth families.”

The Certified Professional Midwifery defendants and midwifery supporters who are listed on the appeal to the Missouri Supreme Court include: • Friends of Missouri Midwives (FoMM). A non-profit organization representing the interests of Missouri families who choose to have safe, alternative, out-of-hospital childbirth options. FoMM was created to support, promote and protect the rights of Missouri families to make choices about how, where, and with whom their babies will be born and to promote access to the midwifery model of care. • Kelly & Dallion Rehm, and Eric & Jessica Kerr. Two families expecting babies to be born after August 28th, the day the new law was to take effect. They were planning home births with legal, well-trained CPM’s. Now the new law has been struck down, they will have to choose between breaking the law, birthing at home without a trained attendant or the expense and interventions of a hospital birth.

• Columbia Community Birth Center, Kim James, CPM; Ivy White, CPM; and Dr. Elizabeth Allemann, MD. Columbia Community Birth Center is the only licensed birth center in the state of Missouri. The Center is a place where families give birth in a comfortable home-like setting. James and White received their CPM credentials in 1995, Dr. Elizabeth Allemann is Medical Director of the birth center. • Missouri Midwives Association. An organization dedicated to promotion, protection, support and education for midwives in Missouri.

North Carolina
The North Carolina Friends of Midwives has been very active this summer, producing the play, BIRTH and hosting a Red Tent event on labor day. They are organizing for legislative activity this fall, and will have a study bill in the legislature this year since 2008 is the “short” session. Led by the rousing new voice of Russ Fawcett (husband of North Carolina CPM Lisa Fawcett) – who goes by the moniker “midhubby”, the consumer group is coming up with many amazing ideas, from speaking to the Women’s Studies programs at the local university to urging the Dept of Emergency Management to recognize the value of CPMs in attending births outside of hospitals in the event of hurricanes or epidemics. In December, their request for a legislative Study Committee was granted, and work in that area will begin in January, 2008.

Pennsylvania
Diane Goslin, a CPM in Pennsylvania, was charged last year with practicing medicine without a license and practicing midwifery without a license.
Her legal process was an administrative hearing by the Board of Medicine in September. The Pennsylvania Board of Medicine has found Diane to be in violation of the Medical Practice Act of 1985 by practicing medicine without a license and practicing midwifery without a license. She has been ordered to Cease and Desist from midwifery and from attending births and has been fined $11,000.
She has closed her clinic and hopes to attend births as a doula while she appeals this decision to the Pennsylvania Supreme Court.
This outcome combined with the Cease & Desist orders and fines applied to two other Pennsylvania CPMs last year, set an unfavorable precedent for the midwives in that state. A legislative workshop was held in Harrisburg last March, and a Friends of Midwives group is organizing to support legislative efforts.
NARM signed on to an Amicus Curia brief in support of Diane’s appeal in November of 2007

South Dakota
The South Dakota Safe Childbirth Options group organized a group of speakers this summer to go around the state bringing together groups of consumers and legislators to talk about midwifery legislation. This was a very successful way to get more consumers involved in the legislative issues since many can’t travel across the state to a meeting held in only one location.
A two-hour workshop was held on legislative strategies, followed by a dinner and public session to which the legislators were invited. The more formal program included presentations by Dr. Heather Margaret about the safety of home birth from a physician’s point of view, and by Ida Darragh of NARM about the CPM credential. Debbie Pease, president of SDSCO, and Paul Levi Jesse, home birth dad of 9 children, spoke about the consumer’s interest in birth options. Several legislators attended the meetings, and the dialogue was very productive.
This very organized and active group of consumers has continued to visit with legislators and organize letter writing campaigns all summer, topping it off with a state birthing conference in September. They are proposing a licensure bill for CPMs in the 2008 legislative session.

Virginia
As of October 1, 2007, CPMs will be eligible to be enrolled as Medicaid providers. Contact Brynne Potter CPM, Policy Coordinator for Commonwealth Midwives Alliance, for more information on the enrollment process.

Wyoming
A midwife in Wyoming was charged in June with involuntary manslaughter and practicing medicine without a license following the death of a newborn in 2006. She pled not guilty in August. In November, she pled guilty and received probation and a $3,000 fine in exchange for agreeing not to practice in the future.
NARM NEEDS YOU

Questions for the NARM exam are written and reviewed by teams of Item Writers who take a training workshop. In the 2-day workshop, we learn how to write good multiple-choice questions and then spend time writing questions.

NARM would like to have several Item Writing workshops in 2008. If your state organization will sponsor an Item Writing Workshop for CPMs, NARM will provide a trainer, CEUs, and prizes for participation. For more information, contact Ida Darragh at testing@narm.org.