Chairman Manchester, Vice-Chair Cutrona, Ranking Member Denton, and Member of the of the House, Families, Aging, and Human Services Committee, thank you for the opportunity to provide interested party testimony on Sub-HB496.

My name is Jennifer Bain, MD and I am writing as an interested party to Sub-HB 496. I have been practicing as a family medicine physician including obstetrics for over 23 years and have worked closely in a team including certified nurse midwives (CNMs). I am currently a director of women's health services and Clinical Professor of Family Medicine at a large academic health center.

There are approximately 450 CNMs in Ohio. CNMs are federally-designated primary health care clinicians who provide evidence-based midwifery care for women and gender nonconforming people throughout the lifespan, with an emphasis on pregnancy, childbirth, gynecologic, and reproductive health care. CNMs support shared decision-making with patients and work to promote access to care to ensure better healthcare outcomes for the people they serve. While midwives are well-known for pregnancy and birth, CNMs are additionally educated and trained to provide a full range of primary health care services for women from adolescence throughout the lifespan. These services include the independent provision of primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of partners for sexually transmitted infections.

Sub-HB496 introduces two other types of midwives who have varying preparation and training requirements: 1) Certified Midwives (CMs) and 2) Certified Professional Midwives (CPMs). CMs are similar to CNMs in that their midwifery educational programs are at the graduate level and are accredited by the same accrediting body as CNMs, the Accreditation Commission for Midwifery Education (ACME). Additionally, graduates of CM Programs are eligible to sit for the same exam certification examination (boards) as CNMs through the American Midwifery Certification Board (AMCB). The difference is that CMs come to midwifery from disciplines other than nursing (e.g., public health, social work, etc.).

The preparation and training requirements for Certified Professional Midwives (CPMs) differs from CMs and CNMs and is not as standardized. The main focus of CPMs is care of pregnant people and attending home births. They are not nurses and are not federally-designed primary care providers. There are two optional routes to becoming a CPM. First all applicants must be at least 18 years old and have a high school diploma or equivalent. The first route for becoming a CPM is to attend an accredited program to be eligible to sit for a certification exam through the North American Registry of Midwives (NARM). This exam is very different from that of CNMs and CMs. The second optional route is to go through an apprenticeship and verification of knowledge and skills is done by another "qualified" CPM preceptor (known as the NARN Portfolio Evaluation Process [PEP] program).

As a family physician, I am strongly committed to evidence-based practices and safety in birth settings. I fully support a woman's right to choose her birth setting and for midwives to choose where they will attend births. Many CNMs, CMs, and CPMs attend home births in other states for low-risk birthing people. The key word here are LOW-RISK people. The way sub-HB496 is currently written, CPMs can attend home births of breech, twins and people who have had previous cesarean/birth/s, which are definitely NOT low-risk conditions. These are very high-risk conditions that have potential to significantly contribute to maternal and infant morbidity and mortality in Ohio.

According to Section 4723.581 of Sub-HB 496, CPMs will be able to manage birth of twins, breech, and vaginal birth after cesarean (VBACs) in the home setting without oversight or physician care agreements. CNMs and CMs, who must have standard care agreements with physicians are not permitted in OH to manage birth of twins, breech, and in most cases VBACs in the hospital setting where access to an obstetrician and operating room are immediately accessible. If these kinds of high-risk births are not deemed safe in the hospital, why would these high-risk births with a CPM in a home be acceptable? The American College of Obstetricians and Gynecologist (ACOG) reports a fetal death rate of 13.51 deaths/1,000 for people attempting vaginal breech births compared to 1.09 deaths/1,000 for people attending vaginal vertex (headfirst) births (ACOG, 2018). Furthermore, babies less than one month old born vaginally in the breech position are much more likely to die than neonates born vaginally in the vertex position (see appendix A). I am extremely concerned that others with less education and training requirements than CNMs and CMs will be allowed to perform these high-risk births in homes. The U.S. already has one of the highest infant and maternal mortality rates than other developed countries. Allowing these types of deliveries at home will further contribute to our infant and maternal morbidity and mortality. Initial and ongoing risk assessment must occur for people who choose homebirth to ensure that they are and remain low-risk. I believe that homebirth for low-risk people is a good option with CNMs, CMs, and CPMs. However, there must be a very clear mechanism in place for people who "risk out" of homebirth due to high risk conditions to prevent maternal and neonatal morbidity and mortality. Clearly, this mechanism is not in place with this sub-HB which would allow CPMs to attend high-risk births in the home.

Additionally, as the bill is currently written, a Midwifery Council to the Ohio Board of Nursing (OBN) will be established. The majority of midwifery seats on this counsel will be CPMs (3 guaranteed seats), only one CNM and only one CM or CNM seat. The vast majority of midwifery-attended births in Ohio are by CNMs. According to the bill the midwifery council will make recommendations about practice and regulation to the OBN about CNM and CM practice and sanctions for their practice, in spite of CNMs being the ONLY nurses of all the midwives and the majority of midwifery-attended births. CNMs are advanced practice registered nurses, trained, educated, certified, and licensed in two disciplines, nursing and midwifery. For these reasons, I believe that CNM should have equal if not majority of seats on the Midwifery Council to the Ohio Board of Nursing.

Thank you for your time in reading my concerns. Again, I am in favor of regulation of CPMs and introduction and licensure of CMs in OH. As sub-HB496 is currently written, I have serious reservations this bill will support safe care for pregnant people and infants in Ohio.

Sincerely,

Jennifer Bain, MD

Appendix A: Home Births

	Intrapartum death	Early Neonatal Death	Late Neonatal Death
Breech Vaginal Birth	13.51/1000 births	4.57/1000	4.59/1000
Vertex Births	1.09/1000	0.36/1000	0.3/1000

Source: ACOG, 2017; ACOG, 2018; Cheney et al., 2014

References:

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