Regarding Sub HB 496

Chairwoman Manchester, Vice Chair Cutrona, Ranking Member Denson, and esteemed Representatives and members of the House Families, & Human Services Committee

Thank you for opportunity to give testimony regarding HB 496, the " Regulate the practice of certain categories of midwives. "

I am Michelle Zamudio and I am a Certified Nurse Midwife (CNM) in Cincinnati OH. I currently work as an Associate Professor for the College of Medicine at the University of Cincinnati and practice as a CNM at The Christ Hospital in Cincinnati. I have been an RN for 37 years and a Board Certified Nurse Midwife for 27 years. I am also a retired Lt Colonel in the United States Air Force and I serve on several OH Boards of Directors for Health organizations. I have delivered over 2000 babies and have served families in many different environments and different situations. I also currently teach Advance Life Support in Obstetrics for physicians and CNMs in several parts of Ohio. This course includes obstetrical-related life saving skills which address the current Joint Commission requirements for maternity staff. I'm what you would likely call a safety focused provider. Additionally, I organized and helped develop our local Ujima Project to actively address health disparities experienced by persons of color in our current health care system. We certainly need to do better.

I am here today as an individual and an Interested Party to HB 496. As you may recall from the end of 2021, the American College of Nurse Midwives (ACNM) Ohio Affiliate came forth in Opposition to HB 496. I agreed with that position. We were supported by our national office as well and I have attached that letter of support to this testimony. We have since worked diligently in collaboration with several Representatives and the Bill Sponsor. I want to express my most sincere appreciation to **Rep Koehler** for his support for the Midwifery model of care and his willingness to hear our concerns and make several amendments to his Bill in order to protect the practice of CNMs. I also want to clearly emphasize that we FULLY support the licensure and regulation of the CPM role in Ohio. The absence of legislative authority has created an underground practice situation which is dangerous for Ohio mothers and babies.

We are well aware that home birth spiked during the Pandemic, and the majority of home births are attended by CPMs. A current review by CDC and National Center for Vital Statistics was published on November 17th, 2022. A copy is attached for your review. We know that currently over 52,000 home births occur in the US and about ONE FOURTH of those are unplanned or unattended. For example, this is the third time mom who wakes up with strong contractions, her water breaks while preparing to head to the hospital, but the baby makes a surprise entrance in the driveway. Unfortunately there is also a current movement of " free birthers," who choose to deliver without a trained provider present. Those stories are commonly found on social media sites. But let's look at the published data for Ohio.

Home births increase from 2019 to 2021 : 1,599 to 2,099, OR from 1.19 % of all Ohio births to 1.62%

That is a percent increase of 21 %, then 13% from 2019 to 2021. These are not small numbers we are discussing.

I do work collaboratively with CPMs in my area who are excellent home birth midwives. However, I have also known of injured women and babies who present for emergent hospital care, some even as a " drop-off." The lack of integration of CPMs and regulation of home birth and birth center midwives into

our US hospital model of care perpetuates this dangerous situation. Please remember, when you hear statistics on the rising maternal and infant mortality rates, that when a home birth patient is transferred to a hospital, or the newborn who is in need of heroic measures is taken to a hospital, if the mother or newborn subsequently dies, that is counted for the receiving hospital statistics and is reflected in overall rates. I believe HB 496 can address some of these concerns and presents an excellent opportunity to improve maternity care in Ohio.

However, there remains several areas of concern re: SubBill 496 which you have heard from my colleagues. They prevent me from moving to a position of support and proponent of this Bill.

First , we know clearly that licensure improves Public and Consumer protection. It also should include mechansims for accountability (including in my opinion insurance to remedy any negative outcomes and care for the injured newborn or mother) . HB 496 appropriately includes the requirement for CPMs to report outcomes. However, it places a duplicate burden on CNMs when we already have strict mechanisms in place. I do NOT support a reporting requirement for CNMs to the Ohio Dept of Health.

CNMs have had licensure and regulation for decades in OH Revised Codes and under the OH Board of Nursing (BON). Until recently I served on an Advisory Committee to that Board. They protect the public health and take that charge very seriously. Most of the research showing improved birth outcomes and safe options for healthy birth outcomes in midwifery are actually based upon CNM statistics and their reported outcomes. For example, this includes lower rates of interventions such as less use of interventions in normal physiologic birth and fewer cesarean deliveries. This is important because some of the leading causes of maternal morbidity and mortality in the US are related to postpartum hemorrhage, blood clots forming in the veins, and infection. Cesarean births increase those factors. There is a national movement to decrease the surgical delivery rate and CNMs have become a well integrated, valued team member in the maternity care environment. This joint approach to team based care is well documented in both the midwifery and obstetrical literature. The research from other countries that you have been presented can ***not*** be generalized to the US because we lack the same integration for midwives, restrictions for LOW RISK care at home, and consistent educational standards for midwifery preparation.

Second, Licensure and regulation supports quality assurance.

Ohio families deserve satisfying and SAFE maternity care. HB 496 allows for the acceptance of out-of-state licensure of CPMs with reciprocity in Ohio. This could include a license, no matter how long ago it was acquired, from states that simply accept Apprentice model licensing of CPMs. That should be changed to protect safe practice. The Bridge Certificate (a profile review of cases and 50 hours of continuing education) should not be allowed. Part of those CEUs may be obtained by simply logging delivery outcomes with NARM. HB 496 should be clear on our high standards for licensure of CPMs similarly to other health care providers. I disagree completely with accepting a Bridge certificate or out of state license for CPM care in Ohio.

Of note, as of 2021, 36 states have licensure or legal recognition of CPMs. 31 of those require full credentials and education preparation and I support that for OH CPMs. 4 require only that they pass the NARM exam. This can be self study, requiring no formal education. 1 has legal authority for CPM practice but no licensing mechanism.

Third, I believe and the research supports the delivery of babies in the home should be limited to TERM, low-risk women and babies. As you will hear from other testimony, the delivery of babies who are Breech, Twins, or in a mother with a prior cesarean is recommended to be conducted in a hospital setting. I have assisted in the cesarean delivery of a pt with a prior cesarean birth. Although it can sometimes be silent, there can be subtle signs that the uterine scar is thinning out. After noting these, I notified my collaborating physician and we proceeded immediately to the Operating Room. Upon reaching the uterine layer, it was thinned out that I could see the baby through a thin window of tissue, it's hair waving in the amniotic fluid. I will not forget that sight and it gave me a healthy respect for the uterus and it's limitations. We do deliver many women in our practice via Vaginal Birth after Cesarean (VBAC). But this is done in a hospital with a team based approach.

With regard to breech delivery, when the baby is coming out bottom first, or foot first, there is a significantly increased risk of loss of life or other impairments. CNMs in Ohio are currently forbidden in the ORC from attending Breech birth even in a hospital setting, unless in an emergency situation. The risk I have NOT heard addressed in relationship to HB 496 risks is one of the more common causes of fetal death in breech or other malpositioned babies due to a cord prolapse. That is when the umbilical cord falls out of the uterus or even out of the woman's body before the baby delivers. This is an obstetrical emergency.

So how often does it happen? In a normal, head down delivery, the incidence is 0.2-0.5%. With a breech baby, it is as high 10% depending on whether a foot is hanging down or the baby arrives early. I have experienced this with a patient who had no risk factors and the baby was head down. You immediately place your hand inside the woman and elevate the fetal part off of the cord, allowing some blood flow and oxygen to still reach the baby. In this case I rode to the OR on the stretcher with the patient, reassuring her as we put her to sleep for an emergency birth. I kept my hand in place as they placed sterile drapes over top of me and remained there until a surgeon colleague of mine touched my hand from above, as she lifted the baby safely out of the uterus. It took just over 4 minutes in total. I learned a healthy respect for the unexpected nature of birth. We recently took photos together at my office for his second birthday.

Fourth, House Sub Bill 496 does not require that out-of-hospital births occur in Accredited Free Standing Birth Centers. I believe this is a safety risk and not any self-described birth centers should be included.

The remaining items of concern which prevent me from becoming a Proponent to HB 496 include :

The wide, mostly unlimited scope of practice for CPMs to care for the entire family until 6-8 weeks postpartum. They are not educated, examined, or nor licensed to do that.

The wide scope of practice with regard to CPMs ordering ultrasound, labs, etc. without any counseling or oversight. This should definitely be limited to maternity and newborn care of term pregnancies, LOW RISK, healthy mothers and babies, and in a collaborative model with physicians or CNMs/CMs.

Thank you - I am quite grateful for your valuable time and attention. I am passionate about improving access to safe maternity care for all Ohio families. While I support the licensing and regulation of CPM practice, it can't be without guardrails and should not be untaken at any cost. Although uncommon, the high risk births requested in HB 496 can be catastrophic. I suppose the final question is this : What is your level of acceptable risk. Mine is zero. I am happy to answer any questions you may have.