RE: Sub.H.B.496
Ohio Affiliate of ACNM Interested Party

Dear Honorable Susan Manchester (Chair), Vice-Chair Cutrona, Ranking Member Denton and Members of the House, Families, Aging, and Human Services Committee,

My name is Lisa Hachey and I am writing as an interested party to Sub-HB 496. I have been a practicing registered nurse for 38 years and a certified nurse-midwife (CNM) for the past 23 years. I am the interim director of a nurse-midwifery program and an Associate Professor for the Nurse-Midwifery and WHNP Program at a large academic institution in Ohio. Prior to my position in academia, I practiced as a NICU nurse, a perinatal ICU and flight nurse for a large academic referral center, and in Level II and III hospitals. After becoming a CNM I worked in large volume practices at the Cleveland Clinic Foundation, the Detroit Medical Center and Perinatal Research Branch of the NIH, health departments, and community health centers. Throughout my 16-year full-scope career, I have attended over 2,200 births with an 11% C-section and 64% successful VBAC rates.

On behalf of the Board of Directors (BODs) of the Ohio Affiliate of the American College of Nurse-Midwives (OAACNM), I want to thank you for the opportunity to provide *interested party* testimony regarding our position on HB496 and the subsequent modifications noted in SUB-HB496. We support the positive changes in SUB-HB496 and applaud the Representative Koehler's efforts to address our concerns for access to safe midwifery care for all women and newborns. As Certified Nurse-Midwives (CNMs), we want to reiterate our support for the licensure and regulation of the Certified Midwives (CMs) and the Certified Professional Midwives (CPMs) in Ohio. Based on the changes in SUB-HB496, the OAACNM has modified our position from "opposed" to "interested party". With that said, we would be remiss in our professional and Board of Director obligations to support SUB-HB496 as written with the unchanged safety concerns for maternal and newborn care.

With over 462 CNMs in Ohio, the OAACNM BOD's represent the largest category of midwives. Our rigorous educational requirements include advanced health assessment and physical examination, advanced physiology and pathophysiology, advanced pharmacology, differential diagnosis, and management of both normal and abnormal primary care, gynecological, and obstetrical conditions within our scope of practice (including ordering, interpreting laboratory and diagnostic studies, and performing limited ultrasounds. Many CNMs continue their education by obtaining terminal degrees within research or clinical practice tracks. It is through this lens of differing educational preparation that we address the issue of absolute contraindications for the management of "out of hospital" high-risk conditions, financial cost of neonatal hypoxic-ischemic encephalopathy (HIE), and professional accountability necessitating liability coverage in the event of adverse outcomes.

The American College of Obstetricians and Gynecologists (ACOG) committee opinion #497 on planned home birth states that "...planned home birth is associated with a twofold increased risk of neonatal death and threefold increased risk in neonatal seizures or serious neurological dysfunction when compared with planned hospital birth (ACOG, 2017). While ACOG recognizes a woman's right to make informed medical decisions, they need to be informed that the appropriate selection of candidates to reduce perinatal morbidity and mortality for planned home birth include the avoidance of *"the absolute contraindications of fetal malpresentation (ie breech), multiple gestation (twins) and prior cesarean section".* Increased adverse outcomes associated with planned home births are likely due to high-risk patient profiles, inability to adequately monitor during labor, and additional risks encountered during transfer to the hospital (Grunebaum et al, 2020). Homebirth outcomes data often cited from the United

Kingdom, the Netherlands and other European countries explicitly exclude these risk factors in their low-risk management guidelines for homebirth. According to Section 4723.581 of HB 496, CPMs will be able to manage the birth of twins, breech, and VBACs. Point 12: Section 4723.581 (A), page 85, line 2430. This was unchanged in SUB-HB496.

A major contributor to the underlying causes of neonatal mortality and morbidity during home births include intrapartum complications due to oxygen deprivation before or at the time of birth (Grunebaum et al, 2017). Neonatal hypoxic ischemic encephalopathy (HIE) is an injury to the brain caused by acute perinatal asphyxia, which can lead to seizures, permanent neurodevelopmental deficits, and death. In a case-controlled analysis, neonates with HIE were 21 times more likely to have a planned homebirth compared to neonates without HIE (Buchanan, 2022). The economic costs of medical care averages 10 - 15 million, but the indirect costs to the child, the family, and the associated life-long services and educational needs are substantially greater. In Ohio, the largest reported settlement was over 37 million. If a homebirth provider carries liability insurance, it is not inconceivable that one adverse perinatal outcome would cap the policy, at which point the economic burden would be transferred to taxpayers for Medicaid and/or Medicare coverage.

While we support a woman's right to choose her birth site for low-risk pregnancies. Today my testimony gives a voice to the unborn fetus.

Respectfully,

Lisa M. Hachey, DNP, APRN-CNM
President of the Ohio Affiliate of the ACNM/ The Board of Directors

Appendix A: Change in SUB-HB496

Positive Changes:

Section 4723.43 (A), page 52, Line 1499
…care of the newborn during the first 28 days of life, consistent with the nurse's education and certification, nationally established scope of practice, and in accordance with rules adopted by the Board of Nursing.
Specifically authorizes a certified nurse-midwife to provide care for normal newborns during the first 28 days of life *(R.C. 4723.43)*.

Section 4723.57 (C), page 81, line 2328
Similar, but specifies that the permitted repairs are of the first and second degree only and also allows a certified professional midwife to perform frenotomies

Section 4723.58, page 83, beginning on line 2374: Consenting all patients
Instead outlines the circumstances in which a midwife must obtain informed consent in the manner required by the bill, which for a certified professional midwife must occur when providing any treatment to a patient and for a certified nurse-midwife or certified midwife must occur when providing treatment in a setting other than a hospital or facility (*R.C. 4723.58*).

Section 4723.583
provides services or care following an adverse incident or transfer of care is not liable in damages in a tort or other civil action for injury or loss to person or property allegedly arising from the services or care, unless provided in a manner that constitutes willful or wanton misconduct

Also applies to an advanced practice registered nurse or certified midwife providing services or care after an adverse incident or transfer *(R.C.).*

Section 4723.60 (A) page 92, line 2634: Board of Nursing Midwifery Advisory Council
Added 2 CNMs. We need to revisit the composition of the midwifery board for CPM practice

Not Addressed
Section 4723.43 (A), page 53-line 1515
Not addressed

Section 4723.50(B) (1), page 73: Line 2091
Not addressed
We agree with this section but request clarification of definitions for rule consistency
Suggested change: The formulary shall not permit the prescribing or furnishing of any of the following:

(1) A drug or device to perform or induce an abortion IAW 2919.11

Rationale: add statutory definition of abortion to allow for prescribing of cytotec to induce labor or treat miscarriage only. This reflects the OBON APRN FAQ clarification for prescribing of medications for non-abortifacient indications.

Section 4723.57, page 80, line 2310: CPM practice

(1) certified professional midwives can care for the family, which is not included in their educational preparation. Instead, the intent is they provided family-centered care.
(2) Suggested Change: “Attend births in homes, accredited birth centers, and offices.”

(6) “Ordering and interpreting laboratory and diagnostic tests, including without a physician’s order.”

CPM education does not teach interpretation of diagnostic test, including ultrasounds. For nurse-midwifery, performing ultrasounds is an advanced skill that requires additional education aside from basic midwifery education. In addition, laboratory interpretation is a complex skill and not within NARMs guidelines.

Section 4723.581 (A), page 85, line 2430 (This is a red line)

(B) of this section are satisfied: a vaginal birth after cesarean, birth of twins, or breech birth.”