Quickening

OFFICIAL NEWSLETTER OF THE AMERICAN COLLEGE OF NURSE-MIDWIVES

Fall 2017

VOLUME 48 | NUMBER 4

Reclaiming Indigenous Midwifery

p. 12

ACNM Elections, p. 14

Savannah Sneak Peak, p. 24

ACNM at the UN, p. 32

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CONTENTS

ACNM NEWS

4 **Message from the Interim CEO**
5 **President's Pen**
6 **Leadership in Action**
7 **Financial Report**
8 **Regional and Student Updates**
12 **Ex Officio Report:** Reclaiming Indigenous Midwifery
14 **ACNM 2018 Elections**
16 **ACNM Forum**
17 Inside the *Journal of Midwifery & Women's Health*
17 ACNM Releases 3 New Position Statements

ADVOCACY

18 **Advocacy:** Maternal Mortality Review Committees
20 **Affiliate Spotlight:** The Oregon Model
22 **Midwives-PAC:** Please Step Up...
23 **Certified Midwives Path:** Embracing Certified Midwives

MIDWIFERY MEETINGS

24 **Annual Meeting Preview:** Savannah Sneak Peak
26 **Volunteer Spotlight:** Interview with Letitia Sullivan and Pam Reis

CLINICAL FOCUS & MIDWIFERY PRACTICE & EDUCATION

27 **Professional Connection:** Preventing Alcohol-Exposed Pregnancies
28 **Professional Connection:** After the Bruise Fade
29 **Clinical Notes**
30 **Midwifery Education:** The Macy Grant: Developing an Innovative Model
31 **Preceptor's Pointers:** Will Precepting Slow Me Down?
32 **Global Health:** At the UN, ACNM Highlights Team-Based Approaches

FROM MY PERSPECTIVE

33 Steps on a Journey to Improving Midwifery Education

PARTNERS & PEOPLE

34 **Membership:** Building a Bright Future Together
35 **A.C.N.M. Foundation Update**
39 **Bulletin Board**
40 **AMCB Certification Awardees:** July–September 2017
41 **Keeping in Touch**

A few weeks ago I agreed to serve as the Interim CEO of ACNM while the Board of Directors initiates a search for a permanent CEO. I am honored that they trust me to continue the work of rebuilding ACNM, which started after our financial crisis in 2015. My professional background includes leadership of midwifery practices and educational programs as well as time in the corporate world. I have worked for ACNM in the Department of Global Outreach (now the Department of Midwifery Practice, Education and Global Outreach) since 2015. My background includes a term on the Board of Directors from 2010-2013. In some ways, I feel prepared for this new role, but I rely on your goodwill and support!

Let me offer some reflections on where we are and where I would like to move ACNM in the next few months. Since October 2015, when we realized the magnitude of our financial crisis, ACNM has gone through multiple phases. The ACNM Board has worked with endless energy to rectify the financial issues. In the past 2 years, ACNM has moved from crisis mode to restructuring and now onto a rebuilding phase. This progress needs to be recognized and appreciated. My immediate priorities are related to next year's budget, full utilization of the talents of our department directors, and decisive action to increase efficient operation of the national office. My overall commitment is to increased responsiveness to you, our members!

"We are rebuilding, and the national office staff is optimistic and ready to help."

Help reset the tone of the discourse about ACNM. We are rebuilding, and the national office staff is optimistic and ready to help. Our fiscal situation is being repaired and we are rebuilding our savings. Let's update the conversation to 2017 realities and focus positive energy forward!

Some recent improvements have included the new ACNM Connect, which replaces the old email listservs with a dynamic platform for groups and affiliates. (Please sign up at: http://connect.midwife.org/home.)

How can you help? Some midwives need to be convinced to join ACNM… so I'd like to ask each of you to act like a NPR fundraiser! Our activities are totally dependent on having the maximum number of engaged members. Relentlessly but pleasantly, ask every midwife you know (your students, your partners, your faculty) if they have "paid their 'Midwife Bill.'" ***Accept no excuses.*** The $1 a day they pay for national membership finances our collective lifeline to activities and representation in Washington and nationally.

Kate McHugh, CNM, MSN, FACNM
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Moving through Change to Advance Midwifery

There is a song by Bob Dylan called "The Times They Are a Changin'" that has been echoing in my mind these past couple of months. As we transition through the fall, the Board of Directors continues to take up the charge to move ACNM forward to create a more solid financial foundation for the organization while meeting our mission to advance midwifery and promote optimal health outcomes for those we serve. As announced in October, we are moving through a change in our national office leadership with the appointment of Kate McHugh, MSN, CNM as interim chief executive officer. With Kate in this role and in combination with a growing national office staff with expanded skills and vision to meet ACNM member needs, I have confidence in the changes you will see. We will not lose momentum as we move through the leadership transition and secure a new, permanent CEO before the Annual Meeting in May. So while change is never simple, this change is part of the process of our learning, growing, and progressing in the right direction. There are several updates in this issue of *Quickening* that highlight some of these directions, including a message from Kate as well as an update on our financial status from our treasurer, Joani Slager, CNM, DNP, CPC, FACNM and actions from the September board meeting from our Secretary Stephanie Tillman, CNM, MSN. ACNM is on more solid financial footing at this point in the calendar year than we have been in several years.

"We have the ability to push forward to take center stage in the public conversations to create the changes we hope to see for midwives and those we serve."

Calls for Action

Outside of the national office, the Dylan song also has meaning as I look across the national landscape and consider the many conversations that are happening in which an obvious response is "we need more midwives." The national media is calling attention to the rising maternal mortality rates in the United States with a close lens being placed on the impact racism and health disparities have on maternity care outcomes. We are seeing calls for action to address the maternity care workforce shortage, particularly in rural communities where "maternity-care deserts" exist without any hospital or maternity care provider to meet local needs. We continue to see national attention focused on the high cesarean birth rates in conjunction with questions being raised about the best place for birth: hospital, birth center, or home.

After more than 30 years as a midwife, it seems as if there are some positive winds of change for midwives and midwifery practice that we can now harness. In response to the national conversations and questions, in particular, about our current system of maternity care, ACNM stands ready. While we continue the many projects we have in place, which were ahead of the curve in promoting midwifery care, we are also launching new initiatives to support the advance of midwifery. We have increased support to our affiliates to secure full practice authority in their states through the formation of a State Government Affairs Committee and affiliate development support. We are expanding our national advocacy work to remove barriers to credentialing, privileging, and full medical staff status in health systems and hospitals. We are also convening larger multi-stakeholder groups to look at ways we can expand recognition of the CM credential in a growing number of states. All of these are key ways to advocate for midwives and expand midwifery practice in the provision of both maternity care and primary care. Between the expertise of our national office staff and the strength, experience, and wisdom of our volunteer leaders who serve on committees and divisions, we have the ability to push forward to take center stage in the public conversations to create the changes we hope to see for midwives and those we serve. As president, I am committed to taking the steps we need to help us secure the strength of ACNM as an organization so we can build the future we want and need to advance midwifery.

Strengthening Our Position

I will be providing updates in emails on the CEO search process as a first part of those steps and will be announcing some new leadership development opportunities in the spring. Please don't hesitate to reach out and let me hear your ideas regarding how ACNM can strengthen our national position in these conversations so we truly realize change.

By Lisa Kane Low, CNM, PhD, FACNM, FAAN
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Inside the September 2017 Board Meeting

A packed agenda included a review of volunteer membership restructuring, efforts to address the maternity care shortage, and much more.

Members of the Board, 2017-2018.

The September 2017 meeting of the ACNM Board of Directors exceeded our expectations: The work of our membership and staff led to such a packed agenda that we had to meet for a third day! The board discussed and revised position statements to add to our College's resources (see p. 17 for Ruth Zielinski's update); our regional representatives continued their fantastic work supporting members and affiliates; and staff reported on their advances in communications, membership support, advocacy, and global health. (See the minutes from the open session and consent agenda online at the board meeting webpage—http://bit.ly/2gy2FQl). The following is a brief review of specific projects.

The 2018 Annual Meeting in Savannah, GA has ACNM's national offices and program committee hard at work. With the theme "Giving Voice to the Soul of Midwifery," the meeting will give credence to and discuss the history of grand midwives in Georgia and the South. Staff and leadership have been paying close attention to member requests for accessible transportation from the hotel to the conference venue and for gender-inclusive bathrooms. A motion from the floor at the 2017 Chicago meeting resulted in a new track entitled "Racism and Disparities," and the program committee is reviewing 18 abstracts submitted under this topic.

The board reviewed a proposal for ACNM to create a position statement related to racial bias after reviewing ACOG's organizational statement. While ACNM will nominate its own representative onto ACOG's Committee, Care for Underserved Women, the board also asked the Midwives of Color Committee to create an inclusive process to develop a midwifery-focused statement on racial bias, due by the beginning of the ACNM Annual Meeting in May 2018.

ACNM continues its efforts to address the maternity care shortage in the United States. ACOG and ACNM have been partnering in work on the Maternity Care Shortage Bill (HR 315), and in November, ACNM and ACOG staff will be working collaboratively on a related strategic plan. Amy Kohl, ACNM's director of advocacy and government affairs, in conjunction with volunteer leadership, has also updated a comparison chart (http://bit.ly/2zJdXwl) of all midwifery professionals, and their education and scopes of practice to support work in full practice authority nationwide. A group in volunteer leadership will be leading the charge to work with state boards of nursing and ACOG to address the maternity workforce shortage. Their work includes drafting a survey regarding collaborative agreements and convening a meeting to discuss the maternity provider crisis and health outcomes to spark conversations around using licensing and regulation laws to improve health care delivery and foster interprofessional education strategies and funding.

The Volunteer Structure Re-Alignment Task Force is concluding its work of reviewing the college's current workflow and creating improved processes. After diligent review of feedback from volunteer members during and since the leadership meeting in Chicago, the task force created and offered its final recommended structure and suggested a plan for rolling out this structure in May 2018. A new team will be appointed to outline the steps for implementation with an initial report due by the December 2017 board meeting.

Did you know that you can participate in the ACNM Board of Directors meetings? You can 1) submit an agenda item by the deadline, usually a month prior to the meeting itself; 2) call in or attend in person during the open session, which you can find out about by reviewing the agenda on the board's ACNM webpage, posted a couple of weeks prior to the meeting; and 3) by reading the minutes from the meeting, posted on the board's ACNM webpage about a month after the meeting. Stay up to date and involved between meetings by reaching out to board members and letting us know your thoughts and experiences as a member!

By Stephanie Tillman, CNM, MSN
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ACNM Treasurer Reports Year-to-Date Positive Financials

In April of 2017, the ACNM Board of Directors hired a financial consulting firm, Vault Consulting, LLC, to complete preparations for the 2016 audit and to bring the 2017 financial reports up to date while we had a vacancy in the director of finance role. At our September Board of Directors meeting, the Finance and Audit Committee was able to report to the Board of Directors that a clean 2016 audit was completed, and the year-end budget deficit for 2016 was $33,000. This was significantly lower than original 2016 projections and what was preliminarily reported at the ACNM Annual Meeting. This positive outcome represents the collective efforts of national office staff and volunteer leadership to reduce spending and align resources carefully and conservatively with our strategic plan.

"We must also focus on member recruitment and retention to address the revenue side of the budget equation."

At its December 2016 meeting, the Board of Directors approved a balanced budget for 2017. An anticipated draw on reserves late in 2016 to manage cash flow was not necessary, resulting in a Short Term Reserve account balance of just over $538,000. Our Long Term Reserves have realized interest gains of $134,000 through August 2017. The full result is that our investment portfolio is stable with current balances just under $2,000,000. The ACNM 2017 Operations preliminary budget analysis through August 31, 2017 reports year-to-date expenses greater than revenue of $70,465, yet the change in net assets for the organization are +11% or $391,994.

The most significant revenue shortfall is in membership dues revenue, which is $204,529 (16%) below budget. If this deficit were cut by 50% we would have an operations budget that was $30,000 revenue greater than expenses. As mentioned above, efforts to reduce spending have contributed markedly to bringing the budget closer to alignment with our financial goals, yet we must also focus on member recruitment and retention to address the revenue side of the budget equation. Each of us can contribute to this by inviting at least one new or lapsed member to join us in our mission to advocate for the profession and of serving our members.

Next Steps

The ACNM Board of Directors and national office staff continue to focus on ways to improve our infrastructure and grow the organization. We have completed installation and implementation of a new association management system (AMS), which among other things includes a database that allows us to communicate with our affiliates and members in new and efficient ways. Meeting members' needs is our highest priority as we begin budget planning for 2018.

On behalf of the ACNM Board of Directors, I wish to express my profound gratitude for members' loyalty and support as we continue to move toward increased financial stability for the organization.

By Joan Slager
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Region I Update

CT, MA, ME, NH, NY, RI, VT, Non-US Locations

Honoring Our Late Grand Midwife Colleagues

In her 1984 article published in the *Journal of Nurse-Midwifery*, "A Historical Development of Midwifery in the Black Community: 1600–1940," Sharon Robinson, CNM illuminated the fascinating history of midwifery in black communities of the rural Southeastern states. The article traces the arrival of grand midwives on the first ships carrying enslaved Africans in 1619 and examines how even as late as the 1940s, midwives attended more than 75% of the births of black women in Mississippi, South Carolina, Arkansas, Georgia, Florida, Alabama, and Louisiana (Robinson, 1984).

The ACNM Annual Meeting, May 20-24, 2018, in Savannah, Georgia offers an opportunity to honor the legacy of our late midwife colleagues, to learn about their humanity, and to say their names, as well as to appreciate African American history in and around Savannah:

- Visit the White Oak Baptist Church in Monteith, just outside of Savannah. Here, Sallie Blount and 18 of her colleagues were among the first African American women in the state of Georgia to receive their state-issued midwifery licenses on June 14, 1938 (see photo above). It is said that Ms. Blount attended about half of the African American births in Savannah during the 1930s.
- Learn about the "weeping time" in March of 1857 when the largest sale of human beings in the United States took place in Savannah.
- Go see First African Baptist Church where the first all-black Baptist congregation is said to have prayed.
- Stop by the Beach Institute African American Cultural Center in downtown Savannah (http://www.beachinstitute.org/) to learn more about the historic works of Ulysses Davis and W.W. Law.
- Discover Savannah's Gullah Geechee community. Gullah is the language and Geechee are the people. Gullah is an African-English Creole formed to prevent slave owners from understanding what was being said.
- Inform yourself by picking up *Slavery and Freedom in Savannah,* Daina Berry and Leslie Harris's book on urban slavery in Savannah.

By Kathryn Kravetz Carr, CNM, MSN
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Region II Update

DC, DE, MD, NJ, PA, WV, International Addresses

A Maternal Health Crisis in the Nation's Capital

Washington, DC, a district created by Congress to provide a neutral zone for the work of the federal government, today leaves almost a million people without representation. As a result, things can slip through the cracks, and lately the health care of mothers and babies is one of them. We recently saw, in close succession, the closure of the labor and delivery units of United Medical Center (UMC), a hospital that primarily serves African American Medicaid recipients and is the only one with maternity beds in the southern half of the city, and Providence Hospital, which primarily serves Hispanic Medicaid recipients. This has distressed midwives and patients alike, but there is no legislator to turn to, no one to write a letter to, no statehouse to march to. DC funding comes from the federal government, and the DC representative to Congress, despite her heroic work in the House, has no vote.

This has left midwives and physicians scrambling to contain the fallout. A preliminary plan calls for transporting women from DC Wards 7 and 8 to 2 other hospitals not easily accessible by public transportation. If this plan does not get funded, simply to get to their prenatal visits, the women would have to take a couple of buses and a subway. Once they are in labor, they would most likely need to call 911—to then be transported to the nearest hospital, which only accepts one of the many types of Medicaid women have.

Critically, DC already has the highest maternal mortality rate in the nation at 38.8 per 100,000, and its infant mortality rate of 7.9/1000 is much higher than the national average of 6.1/1000. Between 2011 and 2013, for example, mothers in Ward 8, where UMC recently closed its maternity care doors, lost 24 babies, compared with the death of a single baby in wealthier Ward 3.

The DC City Council is considering a bill to establish a mortality and morbidity review committee to address this problem, and long-term solutions are being debated. Meanwhile, the district's maternal and infant mortality rates could spike from their already unconscionably high levels. For now, let those of us who *are* represented in the federal government ask our legislators to introduce emergency legislation to fund the interim solution. The women in our nation's capital are among the most disenfranchised in our nation. Let's lend our voices to theirs!

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Region III Update

AL, FL, GA, LA, MS, NC, SC, TN

Helping in the Aftermath of Recent Hurricanes

Hello everyone in Region III! The biggest current events for our region are the devastating effects of Hurricane Harvey on **Louisiana** and **Alabama**, and Hurricane Irma on **Florida**, **Georgia**, and **South Carolina.** The affiliate leaders have been participating in ongoing conference calls with the national office and with CNM experts in disaster preparedness **Robbie Prepas, CNM** and **Karen Hays, CNM**. So many people want to reach out and help. Note, what Karen Hays explained to us:

"Evidence from previous studies and observations shows that it's actually mentally healthy for people to be able to get back to their jobs and careers as soon as possible during and after a disaster, instead of being bumped aside by well-meaning volunteers who want to go provide services. Let's think about a way we can support the midwives once recovery can actually start—by donating money or labor to help rebuild their houses, get them a new car, restock their ruined or irreplaceable birth supplies, support a voucher program for clients to be able to pay for maternity and reproductive health care, sending respite midwives down there to cover some clinic and call, at their request, while they do what they need to do to put their lives back together."

Please do not hesitate to use the new ACNM Connect feature of our website to reach out for needs and opportunities to help. Meanwhile, the long-term needs of mothers and babies in our region continue to persist. On September 21, prior to the fall board meeting of September 22-24, Pat Loftman, CNM, ML, MS, FANM (ex-officio member of the Board of Directors) and I went to the Capitol Hill offices of both Georgia senators Isakson and Purdue to request that they co-sponsor the Improving Access to Maternity Care Act, which passed the House of Representatives in January and is in the Committee on Health, Education, Labor and Pensions in the Senate. We will ceaselessly press for this important legislation, which is a budget-neutral bill!

Just as our fall board meeting was taking place in Washington, **North Carolina** was hosting a regional conference at Lake Junaluska for the North Carolina, South Carolina, and Georgia and **Virginia** affiliates. Meanwhile the Louisiana Affiliate was hosting a retreat in New Orleans for the Gulf states of Alabama, **Mississippi**, and Louisiana. I wish I could have been 3 places at once!

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Region IV Update

AR, IL, IN, KY, MI, MO, OH, VA

Shared Camaraderie, Opportunities, and Goals

Hello Region IV! I am writing this as we all celebrate National Midwifery Week. We are headed into the season of autumn affiliate meetings and preparing for retreats and forwards and continuing educational events. I just returned from the **Lillian Runnerstrom Fall Affiliate Meeting** in Chicago. The affiliate hosted a fabulous gathering with students and new midwives in attendance along with midwifery service members, service directors, faculty, and a few fabulous babies! **Sabina Dambrauskas, CNM** shared some of the history behind this 46-year annual event, recounting gatherings in Lillian's home hosted over a shared meal, just like it was this year. The event has always been a time to embrace each other with shared camaraderie and opportunities for networking as we move our midwifery goals forward. Beginning with my midwifery student days at the University of Illinois at Chicago, I have been blessed to attend this fall gathering many times. Back in the day, it was often referred to as "the lasagna dinner." I felt proud to be taking part again, sharing this meal, engaging in conversations, hearing issues of concern, and celebrating the multiple wins and progressions. Full practice authority is cause for celebration. As we went around the room and individuals reported out on their leadership work and recounted their colleagues' successes, I repeatedly heard our core commitments of diversification and inclusion, leadership development, research, inter-professionalism, and communication shining through. We also discussed the launching of the ACNM Connect—our new forum hosting platform, which replaces eMidwife discussion groups, and I feel excited as it will be more mobile friendly, accessible, and have enhanced capabilities with much faster search results. Thanks **Carrie Klima, CNM, FACNM** for being my first contact request! Chicago has had great cause for happiness as they hosted an amazing annual meeting, and it was great to be back in the Windy City and to be hosted at their fall meeting.

Region IV is gearing up for many more events:

Michigan Affiliate fall event will take place on November 14, 2017 with a meeting in Detroit and also in Grand Rapids.

Arkansas Affiliate will be hosting a virtual meeting on November 18 at 10 am.

Ohio Affiliate is busy planning their Forward, which will be held at the Kalihari Resort in Sandusky, OH on February 2-4, 2018.

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Region V Update

IA, KS, MN, ND, NE, OK, SD, WI

It's Time to Plan for Legislative Season

Fall always reminds me to enjoy a bit of leaf peeping and get ready for the legislative season, which in most states starts in January. In Region V, we have several states that are working on legislation for the new year. After 8 years or so, **Wisconsin** has some acceptable draft language for an APRN full practice authority bill that includes nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, and certified nurse specialists with consensus model language. **Nebraska** had a CNM full practice authority bill introduced last year and will be working to move it forward in 2018. **Kansas** has had some challenges with the Board of Healing Arts (BOHA) Midwifery Advisory Council promulgating regulations for their "independent practice" legislation. This legislation would require an APRN license from the Board of Nursing in addition to the license for independent practice limited to pregnancy and family planning services from the BOHA. Currently Kansas has joined the coalition of Kansas Advanced Practice Nurses to work on a full practice authority bill, and affiliate members have been discussing trying to repeal the "independent practice" legislation. **Minnesota** is considering working on CM licensure. **Iowa** has not had a functional state organization in over a decade. Recently, it elected a board of directors that has been working hard to get the affiliate organized. They are proud to announce the first Iowa Affiliate membership meeting in years will be November 15 in Des Moines.

For any affiliates that are working on or planning to work on legislation for 2018, now is the time to start planning, and ACNM has an advocacy team to assist you! In the national office is our Director of Advocacy and Government Affairs Amy Kohl and our State Affiliate Support Specialist Barbara Woolley. On the volunteer side is the newly formed State Government Affairs Committee (SGAC). Every state affiliate has a member of the SGAC assigned to them for midwife-to-midwife support. The committee is a repository of midwives with experience in state legislative initiatives, so can respond with suggestions for overcoming those pesky challenges we all have in working legislation. You can reach our advocacy team at govaffairs@acnm.org

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Region VI Update

AZ, CO, MT, NM, UT, TX, WY, IHS/Tribal

A Midwife at Every Table

Hello Region VI! I have had the opportunity to travel fulfilling my representative duties at the ACNM board meeting, ACOG District XI meeting, and most recently at the Arizona Affiliate midwifery week festivities. It is clear to me that we have a group of midwives and staff who are passionate, dedicated, and eager to move midwifery to the next level. We have an opportune time to address some of the workforce issues our obstetrics and gynecology physician colleagues have projected, that the national demand for women's health care is forecast to grow by 6% by 2020. It is time for us to think outside the box to develop creative care delivery models, expand midwifery to areas that lack access, and to be part of the solution to the workforce challenges that are right around the corner. *How do we do this?* Collaboration, collaboration, collaboration! We must first start by collaborating with all entities at all levels, share our expertise, display our superb outcome data, and focus on the value we bring to health care. The time is now as 2020 is fast approaching! We need a midwife at every table and a midwife for every woman!

A couple of shout-outs to our affiliates doing great things!

Colorado recently held their 14th Annual Nurse-Midwifery Symposium in Denver. They also helped develop and institute new regulations for free-standing birth centers. In 2018, Colorado will have 2 more free-standing birth centers, totaling 7.

Arizona recently hosted a successful affiliate symposium: Overcoming Challenges in Pregnancy, Birth, and Women's Health.

Utah: The University of Utah hospital is now offering nitrous oxide after 2 years of interdisciplinary collaboration that began as a DNP project by **Danica Loveridge, CNM. Gwen Latendresse, CNM, FACNM** was awarded a 2-year grant of $298,459 from the Utah Department of Health for her project titled "Telehealth: A Promising Approach to Reducing Perinatal Depression in Utah's Rural and Frontier Communities."

Texas has a new birth center, the Birthing Spot & Wellness Center, started by **Christine Stuart, DNP, CNM, WHNP.**

By Jessica Anderson, CMP, DNP, WHNP
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Region VII Update

AK, CA, HI, ID, OR, WA, Uniformd Services, Samoa, Guam

Care and Integration with Community-Based Birth

One of our practice's former Ob/Gyn residents, now a maternal fetal medicine fellow, sent me a recent *JAMA* editorial, "Hospital-Affiliated Outpatient Birth Centers: A Possible Model for Helping to Achieve the Triple Aim in Obstetrics." The triple aim refers to: a) decreased cost, b) better outcomes, and c) better integration of levels of care. The proposed solution is the establishment of hospital-associated birth centers based on the belief that existing, privately owned birth centers are not adequately accredited or regulated, and the authors' experiences with "devastating delayed transfer experiences" from such centers. The editorial reports facts, but also has critical omissions.

Fact: "Patients in the United States are increasingly demanding a birth experience that provides interventions only when necessary." The current ability of US hospitals to offer low-risk women protection from unnecessary interventions and procedures is the impetus for initiatives at state levels: e.g. the California Maternal Quality Care Collaborative and nationally: the Healthy Birth Initiative (ACNM) and Safe Reduction of Primary Cesarean Births and AIM (Council on Patient Safety in Women's Health Care). The elephant in the room is that US maternity care is driven by the medical model that does not trust birth–even in low-risk women.

Omission: Re: "The United States could improve outcomes and decrease costs by reconsidering where low-risk deliveries take place." It is not the where, but the who. The excellent outcomes of community-based birth (at home and in birth centers) are because of midwifery-led care. The editorial did not reference the "Outcomes of Care in Birth Centers: Demonstration of a Durable Model" (Stapleton and colleagues, 2013), the prospective study of 15,574 US women in American Association of Birth Centers that reported excellent outcomes commensurate with those in Netherlands, Scotland, United Kingdom.

Thoughts for the future: Re: "In some existing (birth) centers, variability in education and licensure among midwives, the primary caregivers, creates potential concern about the quality of care provided." The birth cohort in the Stapleton study was attended by certified nurse-midwives, certified professional midwives, and licensed midwives. At our recent board meeting, the National Association of Certified Professional Midwives (NACPM) outlined their momentum to promote licensure of midwives based on formal education (largely in accredited education programs) or by formalized routes of certification.

Hospital-centricity is not the solution. There must be efforts to integrate the existing infrastructure of community-based birth with hospital maternity care.

By Ruth Mielke, CNM, PhD, FACNM, WHNP-BC
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Student Update

Mark Your Calendars

Back to school! If you were lucky enough to have a break last summer, I hope you enjoyed it and got time to relax and recharge. The fall brings a lot of exciting new programs and activities at ACNM, and I hope you take advantage of them. The Students and New Midwives Section is planning a mentorship program, in which students will have the opportunity to be mentored by an ACNM fellow. Learn more here.

On October 11, we will be hosting a New Midwives Webinar, a place to ask any questions you have about being new to practice. More information can be found on the SANMS page on the ACNM website and the Students Facebook page (www.facebook.com/groups/acnmstudent). We are also coordinating with committee leaders to make more volunteer opportunities available to students. Watch for updates over the next few months!

On September 21, the Students and New Midwives Section hosted a "You Are ACNM!" webinar. It was great to join with almost 50 other students to connect during this event, ask questions, and hear from leaders! Of note, there are still several schools that are not represented by a student liaison. This is a great way to be involved in ACNM, represent your classmates at the national level, and help make positive change for the people we care for. If you are interested, email your program director for more information. If you missed this webinar, check out the recording here, (www.midwife.org/Midwifery-Students) and look for postings of other webinars throughout the year!

I recently visited the ACNM national office for the fall Board of Directors meeting. These meetings are open to any member—students are welcome and encouraged to join in via conference call or in person if you are local. *It is so important for students and new midwives to share our unique views and help guide decisions!*

One of the topics we discussed was the student report. We are addressing the suggestions, so watch for and the board response on the website and students' Facebook page! Lastly, we heard an exciting report from the ACNM Annual Meeting Planning Committee. Lots of exciting things planned for students. So mark your calendars for Savannah, Georgia for May 2018!

By Lillian Medhus, SNM
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Indigenous Midwifery: Reclaiming, Restoring, and Rebuilding

To help give voice to the breath of midwives of color, Patricia Loftman turns to Nicolle Gonzales, a Navajo and leader of Indigenous midwives.

At the Indigenous Midwives Gathering in Anchorage, Alaska, attendees planned to advance Indigenous midwifery.

The breadth of midwives of color includes the sisterhood of African American, Latina, Asian, and Native American midwives. The health disparities for African American women have been widely documented. However, even more distressing are the health disparities for Native American women. Today there are a total of 14 Native American ACNM midwives. We celebrate the 22 Native American students currently enrolled in certified midwifery educational programs. These midwives and students will merge their midwifery knowledge, traditional customs, and mores as they care for Native American women and families. Their presence in ACNM has gone unnoticed.

Navajo Midwife: From Displacement to Reclamation

I reached out to Nicolle Gonzales, CNM, MSN, and asked her to share her vision and goals for Native American and Indigenous midwives. Nicolle, a Navajo, is founder of the Changing Woman Initiative, a Native American-centered women's health collective. Her thoughtful response follows:

Today, as Indigenous midwives, we are all reconstructing our roles in our communities, reconstructing frameworks that reflect our methodologies, reconstructing our governance, even reconstructing ourselves as we have each survived deliberate separation from our matriarchal life teachings and have unknowingly integrated into a colonial system that does not value us as knowledge keepers. We have seen how intellectualism, over the centuries, was used to validate and legitimize reproductive knowledge and displace us from our place in our communities. Examining the process of elimination of our native teachings around puberty rites, birth, and motherhood is where many of us begin the journey of reclaiming our place in our communities.

Sharing Our Collective Indigenous Knowledge

Over 30 Indigenous birth workers in 2015 attended the first Indigenous Midwifery: Ancestral Knowledge Keepers Gathering in Albuquerque, New Mexico. The 2-day gathering included topics about ancestral land and body sovereignty issues, the landscape of midwifery today, the lack of Native American representation within our respective organizations, and the inability of many of us to serve women on our own reservations due to policy restrictions. These conversations were already happening in our communities long before this event and, in coming together, the importance of our gathering was realized. Between 2015 and 2017, 3 Indigenous midwives hosted 3 more Indigenous Midwifery gatherings, in Atlanta, Georgia; Bemidji, Minnesota; and Anchorage, Alaska.

We saw new faces, new birth workers, and new Indigenous midwives looking for community each time we gathered. The last gathering, in Anchorage, was different in that as we shared our collective Indigenous women's knowledge about plant medicines, songs, and stories of hardship, our conversations shifted to discussions about "How do we restore this in our communities?" "What is Indigenous midwifery?" "What are the pathways to midwifery for me?" "What are our social and political rights as Indigenous birth workers in our territory?" and "What does midwifery sovereignty look like for us?"

Our collective work together, after 3 years of gathering, has shifted from learning about our past to working toward our future. Until now, we have individually shouldered the reproductive justice work in our communities. We have attended organizational gatherings alone searching for a Native Sister in hopes of finding our community. Many of us who have attended larger organizational gatherings like MANA or ACNM, left wondering if they really represented our interest.

Indigenous midwives have outlined ways to support Indigenous midwifery.

Creating Partnerships with Us

Two other Native American midwives and myself attended the ICM gathering in Toronto, in June 2017 where we listened to the same stories of hardship due to the impacts of colonization from our Indigenous relatives in New Zealand, Australia, Canada, and Mexico. We recognized that we are not alone. Following this monumental gathering, we traveled north of Toronto to spend the weekend at a retreat with our Canadian Aboriginal midwifery sisters. Here we exchanged sacred traditional women's knowledge and offered our tobacco and our prayers before beginning our work of editing a position statement that was drafted by the National Aboriginal Council of Midwives (NACM). This position statement outlines the important role Indigenous midwives hold in their communities and listed recommendations about the ways non-indigenous midwives and associations could create partnerships with us. Recommendations drafted by the NACM at the 2017 ICM gathering include the following:

- Promoting the voices of Indigenous midwives and recognizing their unique contributions.
- Building linkages between Indigenous birth attendants and the midwifery community so that all reproductive health contributions are valued and enhanced.
- Supporting community self-determination in all aspects of reproductive health, including education, regulation, and care delivery. The return of birth, for some Indigenous communities, is vital to their autonomy, health, and connection to land and place.
- Recognizing the systemic effects of colonization and make measurable goals to identify and close the gaps in health outcomes for Indigenous communities.
- Promoting cultural safety training for midwives, other health providers, and educators.
- Recognizing that Indigenous midwives are uniquely positioned to provide high-quality care to Indigenous peoples to improve the health and well-being of Indigenous communities.
- Sharing appropriate administrative and organizational support for the development of autonomous Indigenous midwifery associations.
- Recognizing the role of Indigenous midwives as stewards of knowledge regarding traditions and rites within their communities, which support healthier communities over generations.

Closing the Gaps in Health Outcomes

As we position ourselves to rebuild Indigenous midwifery through our collective efforts in the social and political realms of birth work, we seek the support of ACNM and our allies to close the gaps in health outcomes between Indigenous and non-indigenous communities. We are fully invested in rebuilding our communities through the lens of Indigenous midwifery that takes into account Indigenous collective trauma at the hands of our colonizers and supports real Indigenous community autonomy as well as knowledge systems that promote healing through reclaiming Indigenous spaces in the current landscape of midwifery.

Rebuilding Indigenous midwifery in our communities means weaving together the knowledge systems that support our cultural, spiritual, emotional, and physiological well-being as Indigenous peoples.

Revitalizing Deeply Rooted Traditions

"We all carry a piece of the puzzle. If we come together, we can piece together the puzzle that was scattered by colonization. There is no such thing as no culture, story, or language. It's not lost; it's out there, and everyone has a piece of it."
–Maria Campbell

Excerpted from: *Indigenous Midwifery as an Expression of Sovereignty Mothers of the Nations: Indigenous Mothering as Global Resistance, Reclaiming and Recovery, 2014.*

By Patricia O. Loftman, CNM, ML, MS, FANM
Board of Directors, Midwife of Color Ex Officio
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By Nicolle Gonzales, CNM, BSN, RN, MSN
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Actively Choose Your ACNM Leaders

Help determine ACNM's path by casting your vote for the leadership.

In January, voting opens for the upcoming ACNM election. On the ballot will be candidates for secretary, and for Region 2 and Region 5 representatives, as well as Nominating Committee positions. Here we introduce you to the candidates by sharing their answers to the question, "What do you see as the most important task at hand for the person elected to this position?" Additional answers, candidate CVs, and more will be posted on the election website, open in January. Stay tuned!

CANDIDATE FOR SECRETARY

Bridget O. Howard, CNM, MSN
Erial, NJ

I see the secretary as a point of contact, a person who actively communicates with the board and the members, and one who is committed to the strategic goals of ACNM, communication as a key activity, and embracing change within our leadership. Service to the membership is the next commitment I want to extend. I have been an active member of ACNM since 1999. During that time, I have grown up at ACNM and would like to extend the same kindness that I encountered to our returning and new members. As a strong advocate for women, I have that same passion to advocate for our membership, and as your secretary, I promise to serve this board and its membership.

CANDIDATE FOR SECRETARY

Ruth Zielinski, PhD, CNM, FACNM
Ann Arbor, MI

I see one of the most important roles of the secretary to be that of facilitating transparency within ACNM and the executive leadership. Organizations work best when members are aware of decisions as they happen, and if they are provided with information about how those decisions are made. The board must respond to the needs of members as well as the health and well-being of those persons, families, and communities in our care. Responding to these challenges requires the board to make timely and often difficult decisions. One of the secretarial roles is to provide "accurate, timely, and appropriate distribution of the minutes," and dissemination of this information provides transparency regarding what happens during board meetings to the members of ACNM.

CANDIDATE FOR REGION II

Jeanne Murphy, PhD, CNM
Rockville, MD

The most important task for the next Region II representative is to communicate to the ACNM executive board the needs and current practice situations of midwives across the varied Region II area. I believe the most important current issues include those related to the stress and uncertainty of practice in the current political climate and insurance market. Obstetrical units are being closed in many rural and even urban areas, as hospitals try to manage uncertainty; this obviously affects the careers of hospital-based midwives profoundly and endangers the health of many medically underserved women.

In addition, the growing tragedy of opioid addiction has hit Region II hard, as midwives are being asked to care for more and more pregnant women with opioid use disorder. This will be a challenge for the foreseeable future, and midwives in this region will face demands to learn new skills in helping women living with addiction. The next Region II representative must understand these challenges and help mobilize national ACNM office assistance to address them.

CANDIDATE FOR REGION II

Clarice Nichole Childs Wardlaw, CNM
Chesapeake, VA

The most important task at hand for being the Region II representative is being able to properly represent the concerns of members as they relate to the top goals laid out by ACNM. Supporting our members is the first goal that has been identified, and the person elected to this position has to be able to coordinate the recruitment and retention

of the members in our region. By supporting our members, we can in turn show the value of membership to the organization. We have a host of working midwives that are not a part of our professional organization. It is time to bring those members back and continue to show the value of membership to current members. Members are an integral part of the affiliate, and as a regional representative, one must be able to have a working relationship with the affiliate officers and identify what the needs and accomplishments are in the state. The regional representative has a responsibility to the commitment to the advancement of midwifery and women's health. It can be done by reaching across the table to other providers of maternal child care. As the past president of the South Carolina Affiliate, I was able to reach out to a cross section of different interest groups and consumers. Of note, as a member of the Midwives of Color Committee and past chair of the Friends of Midwives of Color and Ethnic Diversity Caucus, I am also sensitive to the voices of an underrepresented group.

CANDIDATE FOR REGION V

Ann L. Forster Page, DNP, CNM, APRN, FACNM
Golden Valley, MN

We are in a health care crisis with worsening outcomes in maternity care and a maternity care shortage. We need more midwives in the workforce and more midwives with a voice at the table driving change. The voice of the midwife needs to be the foundation of not only clinical work, but also research and policy initiatives to improve outcomes. Strengthening each and every affiliate will make us more effective locally and nationally to meet that goal. I would make that my top priority. We all share in the need to increase membership and engagement at the local level. Strategizing the best ways to reach out to practicing midwives to share the benefits of both local and national membership in ACNM is ongoing. Local efforts can garner great results. Working with active members to develop creative approaches to expand membership locally is key and may very well be different state to state. Just as ACNM national works to improve interprofessional relationships, we need to grow and deepen our relationships with other professional organizations locally. At the affiliate level, it is also important to reach out to our students early in their educational track. Working with educational institutions and preceptors creates opportunities for engagement and formal roles. I see the work of the Region V representative as helping with affiliate growth and serving as a conduit for sharing successes, ideas, and strategies between affiliates.

CANDIDATE FOR REGION V

LT Latrice Martin, FNP-C, CNM, MSN
Papillion, NE

The most important task at hand for the person elected to this position is availability. First, the elected official should set aside designated time to become intimate with the mission, vision, and goals of each affiliate. This information will be used to ensure each affiliate is aligned with the core values of the national organization. Next, the responsibility of the person is to be available to listen, reflect, and synthesize the needs of each individual affiliate. This step will be critical to the success of the individual affiliate and ultimately contribute to the success of the national organization. Lastly, the person should have a spirit of servitude and should be accessible to facilitate connections to local and national resources and together develop creative solutions to meet their identified needs.

NOMINATING COMMITTEE MEMBER

Celina del Carmen Cunanan, CNM, MSN
Shaker Heights, OH

I see my role on the Nominating Committee to be one of networking, mentoring, and building relationships within the organization and to identify up-and-coming leaders and innovators that are poised for success in a national officer role. (This, of course, is how I ended up on this ballot to begin with…. Thanks, Angy Nixon.) In my current role as system chief for nurse-midwifery at University Hospitals in Cleveland, I manage 26 midwives at 4 different hospital locations with the plans for expansion to 3 additional sites in the next 3 to 5 years. I am in charge of leading our practice directors at these sites and mentoring junior faculty as leaders and to position them for opportunities in our University Hospital system. I think a good part of my success as a leader has been my ability to network, build relationships, and nurture others. So I believe that this position on the Nominating Committee would certainly play to these strengths. One of the challenges in this role would be to know that I am finding all of the great leaders and hidden talent within our organization from all over the country. While I would certainly want to identify and network with people face to face, I hope to use virtual platforms for networking opportunities if those in-person opportunities are not available or feasible.

NOMINATING COMMITTEE MEMBER

Terri Clark, PhD, CNM, ARNP, RN, FACNM
Seattle, WA

It is of paramount importance to develop a diverse slate of candidates. In addition to ACNM members who have long and distinguished careers as midwives that prepare them for office—many of today's young or newer CNMs/CMs have other relevant strengths and qualifications that could strengthen the work of the board. They should also be considered. I am truly inspired by the many young (and not so young) people with unique and unexpected backgrounds who choose today to become CNMs/CMs. They bring unimaginable career histories, skills, and leadership experiences with them to midwifery. It is critical for the Nominating Committee to recognize members with both conventional and unconventional abilities and to solicit their interest in running for elected ACNM offices along with more established candidates.

Nominating Committee members must know a lot of CNMs/CMs to function effectively, in my view. I have been actively involved in the work of ACNM for almost 40 years. I have met hundreds of CNMs/CMs in the years from being a midwifery student and midwifery faculty at Yale, staff CNM and preceptor at UCSD, CNM service director and

preceptor in the Bronx, and now as Seattle University midwifery education program director. Short version: I know a large and incredibly diverse group of CNMs/CMs, both young and well-seasoned, and those whom I don't know directly, I often know indirectly through their good works, reputation, and publications. I would use that knowledge to help develop the strongest, broadest possible slate of candidates.

NOMINATING COMMITTEE MEMBER
Colleen Donovan-Batson MS, CNM, ARNP
Port Angeles, WA

I believe having a geographically diverse group of Nominating Committee members is one of the first ways to increase the diversity of the candidate pool. Having connections around the country allows Nomination Committee members to reach out to their networks and expands the opportunity to find those exceptional candidates. More importantly, the Nominating Committee itself needs to be diverse as well, including gender, racial, and cultural diversity. Maintaining a balance in board composition mix is also key, recognizing the benefits new members and their fresh insight bring, as well as the institutional knowledge that seasoned members retain.

The most important task for the person elected to this position is to be committed to the inclusion of people not in the majority when making recommendations for candidates. The Nominating Committee member should consider leadership ability, flexibility and willingness to serve, diversity and board balance, as well as evolving organizational needs when making recommendations for candidates.

ACME Responds to a Call for Action on Midwifery Fellowships

The Accreditation Commission for Midwifery Education (ACME) Board of Commissioners (BOC) welcomes the opportunity to respond to UCSF Nurse-Midwifery Education Program Director Kim Q. Dau's article, "Call to Action: Midwifery Fellowships: Addressing the Trend" (http://bit.ly/2AaN6JW). The call to ACNM to define and accredit post-graduate midwifery programs" ran in *Quickening's* ACNM Forum, Summer 2017.

The ACME BOC recognizes the rising popularity of educational programs being referred to as midwifery fellowships and has been discussing accreditation's proper role with these emerging programs. ACME has a responsibility to the public, midwifery students, and midwifery programs to review whatever constitutes an educational program and to consider creating accreditation criteria for such programs.

ACME's mission is to advance excellence in midwifery education. ACME was recognized in 1982 by the US Department of Education (under "Health Care") as a programmatic accrediting agency for midwifery education programs. The accreditation process is a voluntary quality assurance activity conducted jointly by the education institution and ACME that combines self-assessment and peer evaluation. ACME establishes criteria and processes for assessing the quality of midwifery education programs. ACME fosters continuous development and quality improvement in midwifery education programs to assure the institution, education program, administration, faculty, students, and the public that high standards of education in programs are maintained and professional competence of graduates is attained. Administratively and financially autonomous from the American College of Nurse-Midwives (ACNM), ACME's unique responsibilities are to develop, approve, implement, and evaluate criteria for midwifery education programs and to establish policies and procedures to guide the accreditation process.

ACME's Initial Actions

The ACME BOC formed a Subcommittee on Fellowships in August 2017 to begin assessing the current climate of fellowships, residencies, and other transition-to-practice programs. The BOC believes the term "fellowship" best fits the emerging programs and will be drafting a definition of the term and a rationale for its use. The BOC seeks to learn the number, type, and other characteristics of existing fellowships. Upon completion of this climate research, the ACME BOC will consider the appropriateness of developing a set of accreditation criteria for midwifery fellowships. If criteria are developed, ACME will welcome comment from ACME stakeholders.

By the ACME Board of Commissioners:
Peter Johnson, CNM, PhD, FACNM (chair); Melissa Avery, CNM, PhD, FAAN, FACNM; Suzanne Schechter, CNM, MS, FACNM; Irene de la Torre, CNM, MSH; Pamela Reis, CNM, PhD, NNP-BC, FACNM; Ann Cockerham, PhD, CNM, WHNP-BC, CNE; Ronald Hunt, DDS, MS

In the Nov./Dec. Mental Health Continuing Education Theme Issue

Mental health care is an important component of the women's health care that midwives provide and is a focus of many articles published in the *Journal of Midwifery & Women's Health (JMWH).* The 2017 November/December *JMWH* continuing education theme issue is dedicated to women's mental health: illness and wellness. The articles in the issue address mental health across the lifespan. An editorial by *JMWH* Deputy Editor Patricia Aikins Murphy begins the issue with a cogent look at the state of mental health care in the United States, including an overview of the prevalence of mental illness, a discussion of where the health care system falls short in meeting the mental health care needs of women, and a call to action for midwives to be advocates for mental health care. The articles within this issue demonstrate the breadth of ways mental health and illness can affect women throughout their lives. Several articles review the challenges that arise when mental health intersects with pregnancy and birth and discuss bipolar disorder in pregnancy, the impact of stress on pregnancy outcomes, and psychological interventions for postnatal depression.

Contributing authors also address mental health as a component of the primary care midwives provide in articles on attention-deficit hyperactivity disorder in women and screening women at risk for alcohol misuse. Articles additionally describe the impact that traumas experienced earlier in life can have on women from the antepartum to postpartum periods and the need for midwives to integrate trauma-informed care into clinical practice. Additionally, the mental health of midwives themselves cannot be overlooked, and this issue includes a scoping review of the literature that seeks information on the methods midwives employ to alleviate stress and increase their resilience when dealing with the normal stresses of the profession as well as traumatic situations. Four Share with Women patient education handouts related to mental health round out the issue. Topics of these handouts include intimate partner abuse, posttraumatic stress disorder, depression during pregnancy, and counseling for mental health and illness. Another handout relevant to mental health, *Resilience: Bouncing Back from Hard Times,* can be found in the July/August 2017 issue of *JMWH.* With mental illness affecting nearly 20% of the US population, we hope this issue of *JMWH* is a timely resource for midwives seeking more information about mental health and illness as well as an inspiration to continue the hard work already being done to advocate for women affected by these illnesses.

By Brittany Swett
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ACNM Releases 3 New Position Statements

Circumcision and infant sleep positions are the subjects of 2 of 3 new statements.

I am pleased to bring to your attention several new position statements as well as some recently revised ACNM documents. The most recently issued position statements—concise documents articulating a position taken by ACNM and the evidence supporting that position–are:

- **Active Management of the Third Stage of Labor.** ACNM recommends that midwives discuss the benefits and potential risks of active management of the third stage of labor with women and their families.
- **Newborn Male Circumcision.** ACNM advocates that newborn male circumcision not be routinely recommended, but be considered on an individual basis within the context of risks compared with the potential benefits of the procedure while also considering the cultural and religious preferences of the family.
- **Safe Infant Sleep Practices.** The best practice is to place an infant on his or her back, sleeping in the same room as the parent (co-sleeping), but not in the same bed. During prenatal and postpartum visits, midwives should provide clear, evidence-based, non-biased information and elicit parental and cultural preferences regarding infant sleep environment.

Updated Position Statements

- Collaborative Agreement between Certified Nurse-Midwives/Certified Midwives and Physicians or Other Health Care Providers;
- Vaginal Birth after Cesarean.

Position statements are available to everyone at: http://bit.ly/2nWLGsx

By Ruth Zielinski, CNM, PhD, FACNM
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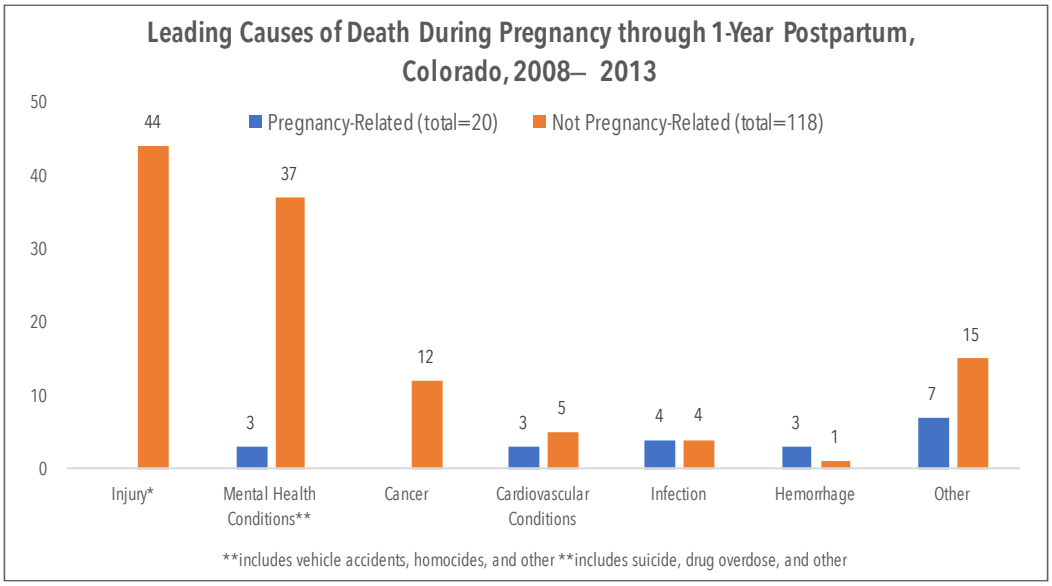
Maternal Mortality Review Committees: Essential Players

As a look at the Colorado experience shows, developing a full picture of states' maternal mortalities depends on MMRCs. Here's how midwives can help.

Maternal mortality has recently emerged as a hot topic in the news. The United States ranks 37th in the world in this regard, and rising maternal mortality rates in all states—except California—have been an eye-opener for our entire nation.[1] In response, many organizations, including ACNM, have announced a call to action, and as states have examined their data, they are asking penetrating questions. Maternal mortality review committees (MMRCs) are essential players in this process. MMRCs are interdisciplinary teams of experts in maternal, infant, public health, and other disciplines who fully examine cases of death during pregnancy and the postpartum period and identify causes, risk factors, and trends, as well as recommend actionable prevention strategies.

Over half of US states have well-established MMRCs; others are working to coordinate MMRCs.[1] To assist their efforts, in March members of Congress introduced bipartisan legislation to enable states to effectively establish MMRCs or improve existing committees. The bill also calls for MMRCs to collect critical information related to alarming disparities in maternal mortality rates among white women and women of color and mandates that a certified nurse-midwife (CNM) or certified midwife (CM) serve on each state committee.



Adapted from "Understanding Maternal Deaths in Colorado: An Analysis of Mortality from 2008 to 2013," A report from the Colorado Center for Health and Environmental Statistics, October 2017.

The Colorado Experience

Colorado's MMRC dates to 1998 when an ob-gyn, Harvey Cohen, MD, noticed rising numbers of pregnant women in the state were dying from certain conditions and brought together a group of obstetrical providers, nurses, and public health officials who were inspired to investigate these deaths. The committee has evolved over the years to include a variety of team members and the incorporation of different processes to explore case reports and data. For instance, between 2004 and 2012, a leading category of maternal mortality in Colorado was "self-harm," largely through accidental and intentional overdose.[2] Once it became clear that there was a mental health component to maternal deaths, the Colorado MMRC made a conscious effort to incorporate mental health care professionals onto the team to gain a better understanding and more accurate evaluation of the cases.

Combating the Causes

The complexity of data can be a complicating factor both in evaluating the cases and in identifying effective measures to combat their individual causes of maternal mortality. In the case of Colorado's self-harm numbers, for example, deaths were evenly distributed over the first year postpartum, the most common drug identified in the cases were opioids, approximately 50% of women had a previous psychiatric diagnosis, and approximately 48% of women had stopped their medications during pregnancy. Some states are in their infancy in this work. Others are further along. Colorado's efforts include educational efforts such as the Annual Harvey Cohen, MD Maternal Morbidity and Mortality Symposium, which presents a public review of cases, trends, and interventions. The committee also provides some on-site education to providers in hospitals and other facilities.

How Midwives Can Help

How can we help as midwives? First, we can encourage our states to develop, revive, or strengthen a MMRC. A recently launched resource, Review to Action (reviewtoaction.org), produced by the Association of Maternal and Child Health Programs, the CDC Foundation, and the CDC Division of Reproductive Health, offers a snapshot of what's happening in each state, along with MMRC models, an implementation guide, and other material.

Secondly, midwives need to ensure that they are represented on these committees. It is crucial for midwives to be included in the state discovery process and intervention development. Midwives bring a unique perspective to the process, asking questions that other members might not address. Additionally, the midwifery model of care has associated with reduced maternal mortality.[3]

From a personal perspective, having served on the Colorado MMRC for more than 5 years and seeing the profound impacts of a maternal death, being at the table as a midwife is a way of giving that mother a voice to help prevent other mothers from dying.

It is crucial for midwives to be included in the state discovery process ...

Lastly, our organization needs to continue involvement and collaboration both in every state and nationally. At the federal level, urge your representatives and senators to support the Preventing Maternal Deaths Act (H.R.1318) in the House and the Maternal Health Accountability Act (S.1112) in the Senate. All health care workers and organizations are needed in order to address today's monumental maternal mortality challenges.

By Jessica Anderson, DNP, CNM, WHNP
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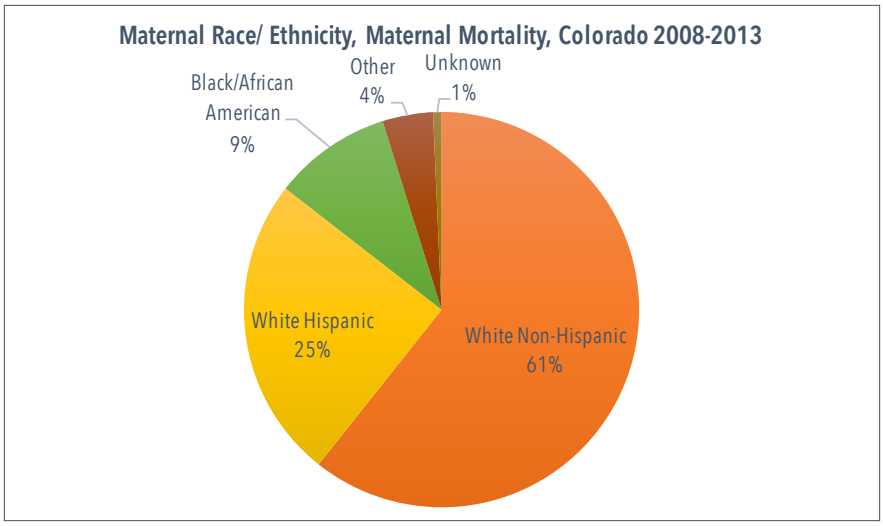

Adapted from "Understanding Maternal Deaths in Colorado: An Analysis of Mortality from 2008 to 2013," A report from the Colorado Center for Health and Environmental Statistics, October 2017.

[1]Review to Action. (n.d). Fast Facts. Retrieved from: http://www.reviewtoaction.org/learn/fast-facts.
[2]Metz, T.D., Rovner, P., Hoffman, M.C., Allshouse, A.A., Beckwith, K.M., & Binswanger, I.A. (2016). Maternal deaths from suicide and overdose in Colorado, 2004-2012. Obstetrics & Gynecology, 128(6), 1233-1240.
[3]Midwifery: Evidence Based Practice, A Summary of Research on Midwifery Practice in the United States (2012), American College of Nurse-Midwives.

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The Oregon Model

An inside look at how Oregon achieved a non-restrictive practice environment and payment parity.

Oregon Affiliate members advocating in the US Senate.

The Pacific Northwest might be known for its wet winters and gray days, but Oregon's midwifery practice climate shines bright. Certified nurse-midwives (CNMs) attend approximately 18% of all births in Oregon, and there are 357 certified nurse-midwives licensed by the Oregon State Board of Nursing (OSBN) as nurse-midwife nurse practitioners (NMNPs). Certified midwives (CMs) are not yet recognized. The Oregon Board of Direct Entry Midwifery licenses midwives who are not CNMs/NMNPs. CNMs in Oregon practice as licensed independent practitioners, and Oregon law mandates that if a CNM is approved to practice in a particular hospital, then that CNM will also have admitting privileges and membership on medical staff with voting rights. The collaboration we have with our physician, nursing, and midwifery colleagues in both clinical and legislative settings is what makes the environment remarkable.

During the 1970s, nurse-midwives became recognized as licensed independent practitioners (nurse practitioners) with prescriptive privileges. In the early 1990s, Oregon CNMs worked closely with the Oregon Nursing Association (ONA) and a variety of legislators and stakeholders to pass legislation that addressed admitting privileges, with the law stating any hospital in the state *may* grant admitting privileges to nurse practitioners (emphasis added). Many institutions adopted medical staff bylaws that included admitting privileges for CNMs, but this was not universal.

Ensuring Healthy Home Births

Also unique to Oregon is the home birth rate. Per the CDC's National Vital Statistics System, in 2015, 2.2% of all babies born vaginally in Oregon were born at home compared with a national average for home birth of about 1%. Solid systems must be in place to support collaboration between providers attending pregnant and birthing women in hospitals, in birth centers, and at home; optimal outcomes for moms and babies depend on open communication and appropriate and timely transfers. Oregon legislators and obstetric providers recognize this, and in 2013, Oregon CNMs collaborated to pass HB 2997, which, with few exceptions, required licensure for direct-entry midwives (midwives who are not certified by AMCB) and tied reimbursement to licensure. A remarkable coalition of more than 90 individuals, including CNMs, RNs, MDs, and public citizens, formed to support the bill and submit written testimony in its favor. Several CNMs also testified, as did the Oregon Affiliate. The bill was not without controversy, but in general, the cooperation between obstetric providers and legislators resulted in a progressive bill that supports direct-entry midwives and, ultimately, a safer infrastructure for mothers who wish to have options for their birthing environment.

Now, it was time to revisit admitting privileges. Prior to 2015, hospitals were mandated to grant CNMs admitting privileges only in Washington, DC. The ACNM Advocacy and Government Affairs Department hosted an affiliate brainstorming conference call to identify which state legislation regarding admitting privileges might be passed—and potentially serve as a model. This led to efforts that resulted in Oregon HB 2930 in the 2015 legislative session.

A Compromise Agreement

The affiliate worked with the Oregon ACOG, the ONA, the Oregon Medical Association, the Oregon Association of Hospitals and Health Systems, the medical staff of local hospitals, and legislators to bring all Oregon hospitals in alignment regarding CNMs' independent admitting privileges and membership on medical staff with voting rights. Initially, the bill included admitting privileges for all nurse practitioners, but this proved to be too controversial. In the end, a compromise extended this mandate to CNMs only; the ONA remained neutral on the bill with the understanding that in the future, we could seek this mandate for all nurse practitioners in Oregon. Of interest, emphasis was placed on avoidance of vicarious liability to support CNMs' independent admitting privileges. The state house and senate passed the bill unanimously. Since then, the work to implement the legislation has continued as hospitals' bylaws have come up for review.

"Initially, the bill included admitting privileges for all nurse practitioners, but this proved to be too controversial."

Oregon midwives have the immense privilege of a non-restrictive practice environment and payment parity and are therefore available to advocate for a variety of issues to support the health and well-being of our communities. This ranges from our official support of Oregon's Reproductive Health Equity Act, which mandates coverage for a variety of reproductive health needs—the bill passed—and a bill that addressed prescription drug pricing, which died in session. Inspiration is at every turn, and the collaborative environment makes advocacy fun and exciting!

By Laura Jenson, MPH, MS, CNM, CPH
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Please Step Up …

In Support of Advocacy for Midwives and the Families We Serve.

"Raising the Voice of Midwives, One Donation at a Time"—this is our motto in the Midwives-Political Action Committee (PAC), and this fall, we continue the hard work of raising money on behalf of midwives, women, and babies. Our funds ensure that supportive legislators from both sides of the aisle are able to get into office and stay there. Although the bulk of our contributions come during the PAC Rally at ACNM Annual Meeting, the fall is when we make our final push to meet our $75,000 goal through the Student PAC-athon and the Fall Affiliate Challenge.

So far only 5% of members have given to the PAC. Help us do better. Even $5 makes a difference.

So far this year, only 5% of ACNM members have given to the Midwives-PAC. We hope to see more than 25% of ACNM members contribute! It does not matter how much you give. Whether you give $5 or $200, you will help us to meet our goal of $75,000 in 2017! Each year, we try to increase the proportion of midwives in ACNM who contribute. Our hard-working ACNM members provide the only source of funding for the contributions made to federal legislators from the Midwives-PAC. We cannot solicit money from any other groups or individuals, so—no matter the amount—your donation is important! *Will you step up now in support of advocacy for midwives and the families we serve (http://www.midwife.org/Donate)?*

Say "Yes" to Students

During the Fall Affiliate Challenge, we have been asking affiliates to designate a portion of their budget to the Midwives-PAC. Additionally, some states challenge their membership with a matching contribution. Please encourage your affiliate to consider making a fall contribution to the Midwives-PAC if it is able. Challenge the membership to make individual donations as well! The PAC-athon is an event during which student midwives donate their time to call ACNM members who have yet to make a donation this year. If you hear from one of these amazing students, please say yes to their request for a donation. Better yet, save them a call by donating online today (www.midwife.org/Donate).

Federal legislators who have the ability to influence and support legislation related to midwifery and women's health receive the vast majority of funds donated to the Midwives-PAC. We work with the Government Affairs Committee on advocacy targeting specific legislation, such as the Preventing Maternal Deaths Act, which ACNM's advocacy and government affairs team is working to support right now. This legislation helps to establish maternal morbidity and mortality review boards in every state. We are also continuing efforts to pass the Maternity Care Shortage Act, which aims to designate specific areas in need of additional maternal health care providers nationally. We often collaborate with ACOG, AWHONN, and other professional organizations as we select legislation to support. At the Midwives-PAC, we do our best to maximize your contributions!

Productive Conversations

This summer, members of the Midwives-PAC accompanied Georgetown student midwives to Capitol Hill in Washington, DC. We had many productive conversations with legislators regarding the Maternity Care Shortage Act and the Preventing Maternal Deaths Act. Our lobbyist Patrick Cooney and Amy Kohl, director of advocacy and government affairs, are now following up on those meetings.

To expand our impact, the Midwives-PAC is growing! We added several new members to our board this summer and have expanded our number of at-large board members from 6 to 8. If you are interested in advocating with us, learn more about the Midwives-PAC by visiting our website (http://www.midwife.org/Midwives-PAC). We can always use the help of midwives who are passionate about advocacy in support of our profession and the families we serve.

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Access to Midwifery Means Embracing Certified Midwives

Answers to these 6 common questions will help all midwives gain a clearer picture of the importance of certified midwives (CMs).

With the United States in the midst of a growing maternal health crisis, it is essential that we foster a national recognition of high quality midwifery care as an important solution. Yet limited seats in prerequisite nursing programs mean many US midwifery programs turn away qualified students. The certified midwife (CM) pathway is an important way to overcome this roadblock, and we as a profession must advocate for states to open their regulations to full practice authority for certified midwives. To help midwives advocate on behalf of expanding access to care through inclusion of the CM credential in state licensure, below are answers to frequently asked questions.

1. Who are CMs?

Just like CNMs, CMs are midwives who have graduated from programs accredited by the Accreditation Commission for Midwifery Education (ACME), with a master's in science or post-graduate certificate. CMs enter midwifery with a science background, study side-by-side with RN colleagues, and sit for the identical American Midwifery Certification Board (AMCB) exam. CMs enter midwifery from many other professions such as physical therapy, lactation consulting, physician's assistant, doula, public health, and massage therapy to name a few. Like physician colleagues, some CMs enter midwifery school right after their undergraduate education.

2. How do CMs become midwives without a foundation in nursing?

Nursing and midwifery share basic health skills, and CMs either bring these skills from another profession or acquire them within the midwifery education program. All graduates of accredited midwifery education programs meet two criteria: They acquire 1) the knowledge, skills, and behaviors prerequisite to midwifery clinical education, and 2) the core competencies for basic midwifery practice.

3. Where can a prospective CM study midwifery?

Currently, two programs, SUNY Downstate, where the first class of CMs graduated in 1996, and the Midwifery Institute at Jefferson (Philadelphia University and Thomas Jefferson University) educate both CNMs and CMs. Internal studies and published work have demonstrated no differences in attainment of core competencies for basic midwifery practice or board pass rates. Alumni work in all of the places where CNMs work including hospitals, birth centers, homes, and federally qualified health centers (FQHCs), and in global health and academia.

4. What is the current state of CM licensure?

Most CMs work in New York State, where they have full practice authority, including prescriptive authority and access to hospital privileges. CMs are now working in 30 hospitals around the state. CMs can also be licensed in Rhode Island, New Jersey, Delaware, and Maine. Several states are actively strategizing to bring about CM licensure in the future.

CMs and CNMs celebrate their graduation from SUNY Downstate.

5. Why is it so important to have multiple pathways to accredited, graduate midwifery education?

Over 75,000 qualified applicants to nursing programs in the United States are turned away each year because of a lack of nurse faculty and clinical sites, and inadequate education budgets, according to the American Association of Colleges of Nursing. Interest in midwifery is very strong from applicants with college degrees in disciplines other than nursing. In 2015 ACNM reported that there were 100 unfilled seats in midwifery education programs, primarily in programs that require the RN for admission. Compound this with aging nursing, obstetric, and midwifery workforces, an aging baby-boom generation, a projected shortfall of maternity care providers, and the situation urgently highlights the need for multiple routes of entry to accredited midwifery education.

6. What can ACNM affiliates do to increase access to midwives?

First, help us bust the myths: Devise ways to inform affiliate members about CMs and overcome stereotypes. Next, take part in strategic planning: Envision near-, mid-, and long-term strategies to license CMs in your state. Third, contact us: if you're ready to act to promote access to high value, high quality midwifery care, we have committee members engaged in this work across the country and are happy to speak with your practice, affiliate, or other interest group.

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Savannah Sneak Peak!

There is a lot to look forward to at the 63rd ACNM Annual Meeting & Convention from a world-class location and a stunning venue to a theme—carried throughout the meeting—that honors the legacy of the grand midwives.

A Picture-Perfect Meeting Space and Hotel

Our headquarters hotel is the beautiful Westin Savannah Harbor Golf Resort and Spa located along the banks of the Savannah River just steps from the Savannah Convention Center. Many of the evening activities for the 2018 Annual Meeting will be held at the Westin. Both the convention center and the Westin are a 2-minute ferry ride from historic downtown Savannah. You can explore the area via one of the bicycles that are parked at the front of the hotel for all guests to use. The Westin also offers 3- and 5-mile RunWESTIN running routes, designed in partnership with New Balance. Take off on your own, or join a group run led by their Run Concierge.

Just across the river, ACNM will have additional sleeping rooms contracted with other hotels to accommodate a variety of tastes and budgets (details coming soon). Enjoy a beautiful and relaxing trip on one of Savannah's 4 water taxis. They are officially named "the Belles," to honor 4 strong women—Juliette Gordon Low, Susie King Taylor, Florence Martus, and Mary Musgrove—who shaped the city's history. These ferries operate 7 a weeks, from 7 am to midnight.

The Savannah International Trade & Convention Center is a superbly functional, architecturally stunning waterfront complex also on the Savannah River. The venue offers large meeting spaces and an easy-to-navigate layout, and is a perfect fit for the ACNM Annual Meeting. The majority of the Annual Meeting events will be held at the convention center, including all workshops, sessions, general sessions, exhibits and the midwifery awards dinner. Looking forward to seeing you there!

By Tana Stellato
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Welcome to My Hometown!

Discover soulful music, amazing food, a powerful midwifery heritage, and Savannah's unique culture.

Savannah is one of the oldest and most haunted cities in America. Founded in 1733, this city is what we describe as being in the "low country," because it is located at sea-level or below. It is also one of the first master-planned communities. Interwoven within its expansive downtown historic district are 22 Spanish moss-lined and manicured-azalea city squares and an abundance of picturesque historic homes, churches, and cemeteries. This makes Savannah perfect for a nice afternoon stroll, or I highly recommend booking a trolley tour where you can hop on and off to visit points of interest, including some of these city squares. However you get around, you'll find much to explore such as forts, the home of the founder of the Girl Scouts (Juliette Gordon Low), the Telfair Academy of Arts and Sciences, City Market for music and nightlife, Forsyth Park Fountain, Wormsloe Plantation remains, the Mercer-Williams house from *Midnight in the Garden of Good and Evil,* and famous cobblestoned River Street. The city is also home to one of the most prestigious art schools in the country, Savannah College of Art and Design, which revitalized nearby buildings and streets and helped give rise to a thriving cultural and music scene. Interestingly, Savannah hosts the second largest St. Patrick's Day parade in the country and celebrates by turning its river, fountains, and food green. This hometown of mine is truly a gem of the South.

The city is surrounded by smaller inlets and islands, including Wilmington, Skidaway, Whitemarsh, Talahi, and Dutch, and has its own beach, Tybee Island, which is about 15 minutes from downtown. Tybee Island lighthouse and pier are popular attractions in their own right. Of course, Savannah is also notable for its scrumptious culinary delights, including Byrd's Cookie Company's key lime cooler cookies, Savannah Bee Company honey, and Paula Deen's restaurants.

Moreover, Savannah has a long history of midwifery with its free-standing birth center and rich heritage of grand midwives of the South who took care of countless women and infants in the low country and coastal regions. This gives rise to a great reason to celebrate our profession from our past into present as midwifery in our area continues to thrive. Therefore, I welcome you to my hometown of Savannah, a city with soulful music, amazing food, a powerful midwifery heritage, and a culture that all of us Savannahians embrace.

By Desireé Mullis Clement, DNP, APRN, CNM, FNP-BC,
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Honoring Grand Midwives with This Year's Theme

For the 2018 Annual Meeting & Exhibition, the Program Committee has selected a memorable, well-deserved, and timely theme: Giving Birth to the Soul of Midwifery. It's designed to celebrate the women who were central, honored figures in their communities, who in the segregated South provided care to legions of pregnant women of color. Grand midwives developed their midwifery skill and knowledge over the years through practice, observation, apprentice training, and oral tradition. They passed down not only their knowledge, but also important cultural traditions and values. Their contributions as pioneers in the care of women cement the legacy of our profession of midwifery. Look for presentations and sessions on their foundational role. You won't want to miss them.

Clockwise from left: Grand midwives Onnie Logan, Margaret Charles Smith, and Mary Coley.

Daring to Chair the Program Committee

Here's a look at 2 dynamic volunteers—Letitia Sullivan and Pamela Reis—working to showcase ACNM and the midwifery profession via the ACNM Annual Meeting & Exhibition.

Letitia "Tish" Sullivan, CNM, MS, FACNM (right) and Pamela Reis, CNM, PhD, NNP-BC, FACNM arrange session locations in Savannah, GA.

For Letitia "Tish" Sullivan, CNM, MS, FACNM, constantly juggling a myriad of moving parts comes with the territory of being the National Program Committee chair for the ACNM Annual Meeting. For the past 6 years, she has overseen multiple facets of each year's meeting, such as organizing the review of the abstracts, ensuring they reflect the membership and its interests, managing stakeholders and their needs, and organizing a never-ending workflow. In 2018, she'll step down after completing her second 3-year term. To keep the process running smoothly, in 2015, she asked the board to approve a chair-elect role enable the incoming program chair to on-board more successfully. The position is now held by Pamela Reis, CNM, PhD, NNP-BC, FACNM, who works closely with Tish in this highly involved endeavor. (For a closer look at the role of the program committee, visit www.midwife.org/Program-Committee.)

Q: What motivated you to step up as program chair and chair-elect?

Tish: Hearing other midwives say they were getting more information from attending other types of meetings was the motivating factor for me. Our clinicians were seeking results elsewhere, and this weakened our meeting. My goal was to work to improve the ACNM Annual Meeting to be the go-to meeting for midwives, and I hope I have. Keeping the meeting current, keeping it visionary, and keeping it viable, those were my primary goals.

Pam: I wouldn't have been motivated to step into this role had it had not been for Tish and her commitment to diversity and inclusion in the Annual Meeting—from seeking out speakers to making sure there are enough abstracts that include diversity and inclusion content.

Q: What has been a reward of your role?

Tish: The reward has been seeing that the meeting has grown, that we've increased our numbers of attendees, and that we've tried to bring along content that addresses the range of settings our midwives work in, although not always successfully. I don't think we have nearly enough content for the midwives who work in the rural areas or who are in some other categories. But the meeting is always a work in progress.

Pam: In addition, what has been the most rewarding to me is working with the local committee at each of the Annual Meetings we've done. I've just been really impressed with how they've stepped up to the task and assumed a lot of responsibility to make sure that we've had a really rewarding experience.

Q: What are you looking forward to for the 2018 Annual Meeting?

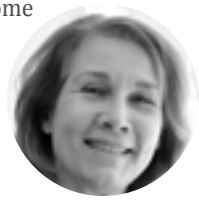
Tish: We're rolling out a new Racism and Disparities track, and we've had a good response in the number of abstracts for it. I'm also looking forward to the energy that happens when you get together 1,500 to 2,000 midwives and people who care about women's health.

Pam: I think the fact that we're in Savannah and have some activities to celebrate the contributions of grand midwives is exciting this year. Savannah is a wonderful location. It's the home of the Girl Scouts, and we're looking at activities to involve them.

Q: Why should our members attend the Annual Meeting?

Tish: When you're at a professional meeting that is just for your group, you do share a sort of intuitiveness about things, and you also have a lot of opportunities to develop relationships, to support each other, and to put forth challenges to each other as well. What's more, this is our professional organization, and if we don't stand together we will fall divided.

Pam: In addition to earning continuing education credits in a variety of ways, the Annual Meeting is an opportunity to network with our colleagues and the vendors who are there supporting us and to learn about the new products on the market. It's also an opportunity to model behaviors and expectations for students and to show up for them. For many, it's their first exposure to what their professional role is going to look like when they graduate, so it is important for the members to show up in a positive light in that role and welcome students into the profession.



By Maura Christopher
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Preventing Alcohol-Exposed Pregnancies

By applying the "gold standard" of alcohol screening and brief intervention, midwives can guide women toward reducing or stopping drinking to nurture a healthy pregnancy.

Alcohol use and misuse is increasing in the United States, especially among reproductive-age women who are college educated, middle-class, and white (http://bit.ly/2uMmatU). This trend combined with high unintended pregnancy rates (http://bit.ly/2wbpuCf) indicates increasing risk for alcohol-exposed pregnancies and, therefore, has serious implications for midwives. The 2015–2020 US Dietary Guidelines for Americans state that if women choose to consume alcohol they do so in moderation—up to 1 drink per day or up to 7 drinks per week (http://bit.ly/2oiFuM7). Alcohol abstinence is recommended for pregnant women. For women who consume alcohol, are sexually active, and either planning pregnancy or not using contraception consistently or correctly, avoiding drinking from preconception throughout pregnancy is optimal. A recent study published in the *Journal of the American Medical Association* (http://bit.ly/2vGi080) documents that consuming alcohol during pregnancy, even at low levels prior to pregnancy recognition, can influence fetal development, resulting in lifelong impairments associated with fetal alcohol spectrum disorder (FASD). An estimated 2%-5% of children in the United States are affected by this disorder, making it more common than autism (http://bit.ly/2wkJYIG). Thus, midwives' abilities to identify, inform, and advise women who are at risk for an alcohol-exposed pregnancy is an essential practice.

Adopting a Strategy of Screening

The US Preventive Services Task Force recommends alcohol screening and brief intervention (SBI) as a population-wide preventive service used to identify excessive use followed by a brief counseling intervention (http://bit.ly/2wND1xQ). Clinical trials support this approach in adults reporting unhealthy alcohol use, but not necessarily a moderate-to-severe alcohol use disorder (http://bit.ly/2uZDjzj). Practicing alcohol SBI is a strategy midwives can routinely adopt with all women as this approach aligns with the midwifery role to encourage improvement in clients' overall health status. Alcohol SBI is especially important for use with women of reproductive age to support optimal preconception and pregnancy health, regardless of pregnancy intention, to prevent FASDs. This year, two thirds (65.8%) of ACNM members who participated in an online survey indicated being comfortable talking with women about alcohol use. Although 73% work in practices where an alcohol screening protocol is incorporated into care, fewer than 1 out of 5 (16.5%) use a validated alcohol screening instrument. Using a validated screening instrument is key to enabling the clinician to objectively determine whether a woman's drinking is excessive. Additionally, awareness of personal biases and brief intervention training, especially related to pregnant women with a positive alcohol screen, allows providers to better respond, rather than react, to women who are forthcoming about alcohol use. Additionally, a validated instrument that assesses alcohol consumption patterns provides a quantifiable level of use for comparison during follow-up visits.

Applying the "Gold Standard" SBI

The 10-item AUDIT (US), developed by the World Health Organization, is the gold standard of alcohol screening instruments (http://bit.ly/2k6ZEt6). A midwife can administer the screener, AUDIT 1-3 (US), which is the first 3 questions of the AUDIT (US), in 1 minute and can include it as part of a longer health questionnaire. The AUDIT 1-3 (US) (see chart) identifies clients who consume more than the recommended alcohol limits both on 1 occasion (or day) and weekly. For those who screen positive, the remaining 7 items can be answered in 2 to 3 minutes. Cut-off scores provide midwives with guidance to offer brief counseling with a goal of enhancing clients' motivation to reduce or stop drinking (depending on circumstances). The intervention emphasizes the message of no safe type, time, or amount of alcohol use in pregnancy because of the powerful structural and behavioral teratogenic effects of alcohol. These include unpredictable impacts associated with maternal and fetal genetics, maternal nutritional status and stress level, and other combined substance use or environmental exposures. For reproductive-age women who do not wish to abstain from alcohol or become pregnant, consistent contraception is an option. We urge all midwives to incorporate FASD prevention into their routine practice through the use of alcohol SBI. Continuing education resources that include brief intervention options for selected scenarios are available (www.npwh.org/courses). As providers on the front lines of women's health care, we can make a difference!

By Marilyn Pierce-Bulger MN, CNM, FNP-BC
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After the Bruises Fade

Survivors of intimate partner violence face the potential for long-term effects that can mask themselves in many ways.

As midwives, we are acutely aware of the prevalence of intimate partner violence (IPV) and sexual violence, and understand these are health care issues. We recognize many of the more immediate effects on the health of the women we care for, including STIs, unplanned pregnancies, discomfort with exams, bruises, broken bones and teeth, and preterm labor. Less apparent may be the potential for long-term effects on both physical and mental health.

Not only is IPV a primary cause of traumatic injury to women, but according to a 2016 report by the organization Futures without Violence, experiencing domestic or sexual violence correlates with increased rates of a variety of health and behavioral health co-morbidities over the long term. These include: arthritis, asthma, migraines and other headache syndromes, back pain, chronic pain syndromes, genitourinary problems, metabolic problems and obesity, heart disease, stroke, depressed immune system, irritable bowel syndrome and other GI problems, depressive symptoms, substance abuse, anxiety/panic attacks, sleep problems, memory loss, PTSD, poor self-esteem, insomnia, and suicide ideation or gestures. Although we can recognize some of these comorbidities in our patients, we may not have considered them in the context of a history of violence.

Many survivors say their providers haven't made any connection between their symptoms and the traumatic experience.

A Cumulative Effect

For example, most (81%-94%) survivors of intimate partner violence or sexual violence have had injuries to head, face, or neck, and more than two thirds have been strangled at least once. Additionally, many survivors report repeat episodes, which have a cumulative effect, and many do not seek emergency room care, even when strangulation—"being choked"—causes them to black out. What they and some health care providers may not realize is the oxygen deprivation that occurs during strangulation can affect the pituitary gland, leading to alterations in hormones impacted by the pituitary and, in turn, symptoms such as menstrual irregularity.

Similarly, as many as 71% of survivors who have experienced head trauma may have incurred at least mild traumatic brain injury (TBI), a syndrome more typically linked with combat veterans or football players. The long-term effects of TBI can include memory loss, difficulty thinking clearly, problems concentrating or absorbing new information, headache, visual problems, problems with balance, dizziness, lack of energy, sound or light sensitivity, irritability, sadness, mood lability, sleep issues or feeling slowed. Significantly, the majority of IPV or SV survivors say their health care providers have not made any connection between their health symptoms and the traumatic experience.

Overlapping Symptoms

How does this understanding impact our care for women? It is essential that we not only screen our patients for both current and past violence (USPTF, 2013), but that we also incorporate awareness of the potential long-term impact in our practice. This awareness includes an understanding of the potential overlap of trauma symptoms and sequelae with symptoms usually associated with other conditions. Once example is the overlap of sequelae of TBI and symptoms of depression:

TBI Symptoms:	PHQ-9 Depression Screen:
• Difficulty thinking clearly and concentrating; feeling slowed	• Trouble concentrating on things
• Sleeping more or less than ususal; trouble falling asleep	• Trouble falling or staying asleep, sleeping too much
• Irritability, lability, anxiety	• Being fidgety or restless
• Depression, sadness	• Feeling down, depressed

Framing a SAFE Approach

Utilizing this knowledge, we can not only be compassionate providers of care to the women we serve, but "SAFE" ones as well. The "SAFE" acronym, developed by the New Jersey Cares about Domestic and Sexual Violence collaborative, frames how we can put this information into practice:

- **S–Screen** all women for a history of violence or current violence.
- **A–Assess** for current safety and needs, including physical assessment and documentation of clinical signs (see sidebar) and for impact of trauma on her health.
- **F–Facilitate** referrals as appropriate, not only to domestic violence or sexual violence services, counseling, resources, and support groups, but also to specialists to address the possible long-term impact of violence on health (neurology, physical therapy, endocrine).
- **E–Educate and Empower** to validate her experience. Give information on prevalence (that she is unique, but not alone); provide information about the relationships between violence and health, connecting symptoms and responses to history of violence.

As midwives, we are already experts in helping women feel safe and comfortable in situations that can include discomfort and pain, and in assisting and supporting them to help them achieve the best possible outcomes. By including this approach, we can take another step in being "partners with women in their health care" when they need us the most.

By Linda Sloan Locke, CNM, MPH, LSW, FACNM
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A New Model of Care for (IPV) Victims

The International Association of Forensic Nursing (the certifying body for forensic nurses) recently has established a systematic, coordinated model for the care of intimate partner violence (bit.ly/2kRsX4S), which is based on the model for victims of sexual assault. The model calls for the injuries to be evaluated by a forensic nurse examiner and for him or her to document them appropriately, collect potential evidence, use a trauma-informed approach, and refer the survivor to appropriate support systems. Previously in emergency rooms, victims of IPV were often seen by regular ER clinicians or others who may or may not, for instance, have collected evidence.

For midwives, the upshot is if someone appears to be a fresh or recent survivor of IPV, strongly encourage an ER visit. Even if the survivor tries to brush off what happened, explain that we now have more information and know there can be immediate and delayed impacts, and that it's best to be carefully assessed. At the same time, understand that this is not an evaluation that you can do in the office. --LSL

CLINICAL NOTES

SCREEN ALL PREGNANT WOMEN FOR OPIOID USE

ACOG has updated **guidelines** on treating opioid use during pregnancy to call for universal screening beginning at the first prenatal visit, with referral to treatment if needed. While medication-assisted treatment remains the recommended therapy, ACOG said medically supervised withdrawal could be considered in some cases. **(http://bit.ly/2y7cWsR)**

PRENATAL MULTIVITAMINS MAY REDUCE ASD RISK

Youths whose mothers took multivitamins during pregnancy were nearly 50% less likely to develop autism spectrum disorders, compared with those whose mothers didn't, researchers reported in *The BMJ*, based on data involved 274,107 mother-child pairs.

MORE WOMEN SAY NO RISK TO REGULAR MARIJUANA USE

The average number of women who said there was no health risk from smoking marijuana once or twice a week increased from 4.6% in 2005 to 19% in 2015, according to a study in the Green Journal.

MATERNAL PSYCHIATRIC DISORDERS DON'T AFFECT BIRTH OUTCOMES

Pregnant women with anxiety disorder, depression, and panic disorder had similar maternal and neonatal outcomes to those without mental disorders, according to a study in *JAMA Psychiatry*. However, benzodiazepine treatment during pregnancy was tied to slightly lower birth weights, while serotonin reuptake inhibitors were associated with 1.8 days shorter gestation.

FDA ENCOURAGES DRUG EXPOSURE REGISTRATION

The FDA encourages pregnant women who take a prescription medication to enroll in a pregnancy exposure registry, which can provide information on the effects of prescription drugs and vaccine exposures on the health of women during pregnancy and on their babies after birth. **(http://bit.ly/2xhlixN)**

Developing an Innovative Model to Grow the Provider Workforce

An exciting new project—ACNM-ACOG Maternity Care Education and Practice Redesign—aims to increase numbers of midwives through interprofessional education, thanks to the Macy Foundation.

The American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists in collaboration with 4 demonstration sites are designing and implementing an interprofessional education (IPE) curriculum for graduate midwifery students and ob-gyn residents. The 3-year project, which is funded by a grant from the Josiah Macy Jr. Foundation, builds on the work of a 2014 ACNM-ACOG Interprofessional Education Workgroup to redesign clinical care for women into a collaborative model between obstetrician-gynecologists and midwives to lead to an increase in the number of midwifery graduates.

Leading the project to develop this model are past ACNM and ACOG presidents, Melissa Avery, PhD, CNM, FACNM, FAAN and John C. Jennings MD, as well as ACNM special projects technical advisor, Elaine Germano, CNM, DrPH, FACNM. A midwife and ob-gyn physician from each of the 4 sites—Baystate Medical Center/Tufts University School of Medicine (Baystate), Drexel University/Frontier Nursing University/Reading Health Systems (Frontier), the University of California at San Francisco (UCFS), and the University of Minnesota (UNM)—will co-lead the development and implementation of an IPE curriculum at their sites. Didactic, laboratory simulation, and clinical practice experiences for graduate midwifery students and ob-gyn residents will all be included, and the learning materials will be shared among the sites. By the project's conclusion, a model IPE curriculum will be accessible for use by other educators and institutions.

Developing Core Modules

The group met this past June at UNM where they participated in TeamSTEPPS training and planned modules through Spring 2018. Now each of the sites is simultaneously creating opportunities to teach these 2 groups of learners together while developing the core modules that cover basic IPE principles including "Role Clarification," "Difficult Conversations," and "Introduction to Guiding Principles." Many midwifery education programs are already engaged in interprofessional education to diverse groups of learners, as described in the November 2015 issue of *JMWH* (http://bit.ly/2yJKP7x). At that time, UCSF identified challenges of IPE including the residents and midwifery students having different academic calendars. Residency training is primarily clinical and operates on a year-round July 1 to June 30 schedule, while midwifery education is based on an academic calendar and is focused on both didactic and clinical education. Another challenge that has emerged at UCSF and elsewhere relates to residents being licensed physicians and thus able to sign health records and orders, whereas the midwifery students, while licensed as RNs, must have their notes and orders in health records co-signed, usually by their midwifery faculty member. This problem reflects much larger systemic issues that most midwifery education programs grapple with, and although the IPE project cannot solve the broader challenges behind these discrepancies, we hope to contribute to possible solutions to some of these barriers.

Professor Melissa Avery, CNM, PhD, FACNM, FAAN, assists midwfery students and residents practicing assessing labor progress and placing an intrauterine pressure catheter.

Adjusting for these challenges, the programs are moving forward with interprofessional activities. Baystate, for example, which has had a collaborative midwifery and ob-gyn practice for years, but had not engaged in extensive IPE, now has embarked on an outpatient communications simulation tailored for first- and third-year residents and midwifery students who are halfway through their program. The initial simulation involves a contraception visit, which starts with a midwifery student counseling a 20-year-old woman requesting a bilateral tubal ligation while residents observe the interaction. Interestingly, during a debriefing after this first half of the simulation, the residents remarked on the thoroughness of the midwife's patient education. This led them to reconsider their counseling during the second half of the sim to avoid repetition, to the benefit of the patient. A third-year resident and midwifery faculty member evaluate the students' communication styles for eye contact, reflexive listening, and asking open-ended questions.

Partnered Placement Opportunities

UMN recently implemented a well-received 3-hour skills lab session for second-year midwifery students and first-year ob-gyn residents. The 4 stations, each facilitated by a midwifery or ob-gyn faculty member, included labor support techniques; manual removal of the placenta; amniotomy and applying a fetal scalp electrode; and cervical dilation, effacement, station assessment along with placement of an intrauterine pressure catheter. The project team also will be developing additional simulations and partnered clinical placement opportunities along with the didactic modules. Frontier University and UCSF have likewise moved forward with IPE simulations and activities.

The Macy grant is also bringing together the accreditation agencies for the two professions to develop joint IPE criteria. The standards they develop may assist in expanding maternity workforce numbers. For instance, if the 85 medical centers where midwives are now teaching medical students and residents were to include even 1 or 2 midwifery students at their sites, this could significantly boost CNM/CM numbers over time. For now the project promises a modest increase in graduates by its wrap-up in 2020, but looking ahead, the potential is enormous.

By Elaine Germano, CNM, DrPH, FACNM
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Preceptor's Pointers

Will Precepting Affect My Clinic Productivity?

Welcome to our new column by and for preceptors (and for midwives considering precepting). Please think of it as your forum for sharing expertise, ideas, questions, and concerns.

Q: I'm thinking about precepting a midwifery student. The catch is that I'm worried that precepting will slow me down and negatively affect my clinic productivity. Thoughts?

A: This is a common response and can be a challenging issue. At our site, we are given 2 fewer patients on our schedule per half day, slots blocked as "mentor time for SNM," so it helps a bit. However, that being said, I find the "burden" of having a new student really only lasts a couple of days. I have them shadow me for the first day or half day depending on how quickly the student is catching on and how confident he or she is. After that, there is always something they can do, e.g. go in and do the patient's history and start the physical. Then I will join them and answer any questions the student or the patient has. Or for OB patients, the students can almost always do fundal height and FHR. Allowing them to do this starts to give them a feel for independence and builds their confidence. We review the chart together so the student knows what's expected in the visit, and they just start doing more and more on their own. I also ask them to do the patient teaching and go over what I usually cover. Before you know it, they are really sharing the workload with me, and I hate the days when I don't have a "helper"!

A: Precepting is trying, frustruating and very rewarding. There are days the student slows you down, and days when your patients get some much needed one-on-one because the student spends time with them while you see other patients. There are days you learn something from the student and ones when externalizing all of your thoughts, so the students gets why you are doing what you are doing, is exhausting. Sometimes the patients get annoyed, but most like participating in the learning process and helping the student learn.
A: I did have reservations, and I discussed them with the obstetrician with whom I worked. He said let us try to assist the students, and he also supported us. I was fortunate to have a student who was eager to learn, and who did not mind coming out at night and being on call. It was a rewarding experience for her and me. She eventually worked in the same clinic that I did and was a great midwife, safe practitioner, and a joy to her patients. Give the students a chance. Become a preceptor.

Question for Winter 2018 Quickening

Q: I'll soon be precepting a student who is very different from me culturally. How do I establish a relationship with her that is culturally sensitive and minimize the potential for conflicts or misunderstandings?

Responses should be no more than 250 words (they may be edited) and can be submitted to quick@acnm.org.

At the UN, ACNM Highlights Team-based Approaches

Global leaders and stakeholders should look to professional associations as an essential partner in the advancement of the health of women and families.

ACNM was prominently featured in a side event entitled "Team-based Approaches to Newborn Survival: Lessons from Africa and Mexico" during the 72nd Regular Session of the UN General Assembly in New York City in September. ACNM, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, Johnson and Johnson, and the Survive & Thrive Global Development Alliance all jointly hosted the event, which included a seated dinner, panel presentation, and fireside conversation.

The Importance of Global Partnerships

The activities engaged General Assembly attendees and members of NGOs and philanthropic and private sector organizations in discussing the importance of global partnerships to achieving sustainable development goals regarding maternal, newborn, and child survival. A panel of speakers from Nigeria, Uganda, and Mexico highlighted newborn survival successes and challenges, and showcased team-based approaches that encompass partnerships among pediatricians, midwives, obstetricians, and other key birth attendants. During a fireside chat, Chunmei "Mei" Li, director of global community impact at Johnson & Johnson and I discussed the unique capabilities of professional organizations and the ways global health partners can best engage with them to address maternal, newborn, and child health needs.

United Nations Sustainable Development Goal 3—"Good Health and Well-being"—includes charges to: ensure universal health coverage and access to sexual and reproductive health care; reduce global maternal mortality; end preventable newborn deaths; and increase the recruitment, development, training, and retention of the health workforce by 2030. Strong professional associations are the backbone of an optimal health care workforce and are critical to ensuring the health of the public. In particular, associations:

- set professional and practice quality and safety standards,
- advocate for health and human rights,
- promote awareness of the latest research and health information,
- mobilize during crises, and
- engage in development of educational and professional career pathways.

Chunmei "Mei" Li, of Johnson & Johnson and the author discuss ways associations can help advance global maternal health at a UN side event.

Strong professional associations are the backbone of an optimal health care workforce.

Associations also provide avenues for global, national, and local implementation of best practices, self-assessment and peer review, continuing education, and professional growth and mentorship opportunities. We hear the voices of our members and understand their needs, struggles, and victories as they work in partnership with the people they serve. We have our finger on the pulse of the profession.

A Fully Educated Midwifery Workforce

The theme of this year's UN General Debate was "Focusing on People: Striving for Peace and a Decent Life for All on a Sustainable Planet." The Secretary General's report stressed that eradication of poverty in all its forms, everywhere, cannot be realized without achieving gender equality and women's empowerment. These goals cannot be achieved without the contributions of a fully educated, widely deployed midwifery workforce worldwide. Global development leaders and health care stakeholders everywhere look to associations like ACNM to articulate the clinical, socioeconomic, political, and cultural context in which people access the care our members provide. ACNM is recognized as a world leader among professional midwifery associations and as an essential national and global partner in work to advance the health of women and families. We harness the power of our treasure trove of members—midwifery clinical experts, researchers, educators, volunteers, and thought leaders—to inspire, innovate, and chart the course to shape a sustainable future. When all health care providers partner together, we can do even more to build sustainable systems of care that can deliver high-quality maternal, newborn, and child health interventions that save lives, promote healthy development, and strengthen children, families, and communities.

By Tina Johnson, CNM, MS, FACNM
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Steps on a Journey to Improving Midwifery Education in Liberia

Serving as a volunteer instructor with the Global Health Service Partnership meant calling on inner resources and professional support.

The author (center, last row) with student midwives in the Suakoko District, Liberia.

I did not hesitate to accept an invitation to serve as visiting midwifery faculty in Liberia with the Global Health Service Partnership (GHSP), a public-private collaboration with Seed Global Health, the Peace Corps, and the President's Emergency Plan for AIDS Relief. For me, it was a dream come true to be able to support the goal of strengthening health education and delivery in Africa.

My year of service as a GHSP volunteer, which began in July 2016, proved to be a transformational one; it gave me a candid understanding of what is required to practice as a competent and efficient professional midwife in a resource-limited country. This insight has inspired me to raise the collective awareness of our midwifery community for the need to strengthen midwifery education in resource-limited training institutions.

A Reservoir of Knowledge

As I boarded a plane for Monrovia, the capital of this small West African country, my feelings seesawed between confidence in my abilities as an educator and anxiety about what this would be like in a nation still recovering from 2 civil wars and, more recently, the Ebola crisis. The confidence I felt had grown organically over the past 4 decades. Being of African/Caribbean ancestry, I had consistently experienced international journeys since the impressionable age of 3, and my understanding of what it means to be culturally competent had similarly evolved. I also knew I would be able to teach the next generation of Liberian midwives by drawing on my reservoir of 22 years of knowledge as a health care professional, with 8 of those years practicing full scope midwifery in fast-paced settings.

Once I began my position, my anxiety proved to be equally warranted. Try to imagine: 1) becoming a professional midwife in a setting where neither you nor your instructor have access to current midwifery training materials and resources; 2) learning from midwifery curriculum sequencing that does not fully support your ability to achieve clinical competency; and 3) having to learn in clinical settings that do not support evidence-based practice. I found these scenarios and more in my midwifery training setting. For example, my Liberian counterparts are forced to use textbooks that are literally decades old. Our school library had only 1 copy of *Varney's Midwifery* (and it was the first edition)! The school campus lacked wifi access, which presented an almost insurmountable barrier to accessing the online resources needed to teach evidence-based practice. Additionally, the dense midwifery curriculum made it extremely challenging for the administration to schedule classes and clinical time in a way that permits students to acquire clinical competency as well as maintain their health and well-being.

Professional Support

Although I often had to be creative and flexible in dealing with the challenges I encountered, the Global Health Service Partnership, fortunately, provided me with many valuable resources that helped me to be successful in the field. This included important pre-service training and orientation that Seed Global Health offered to prepare me for global clinical instruction. I was grateful for the professional support and resources, which certainly enhanced my work as a midwifery instructor. Further, in-country partnerships and collaboration with the Maternal Child Survival Program provided me with the opportunity to participate in workshops alongside Liberian educators to improve midwifery instruction in training institutions. I just hope that I made a substantial contribution in educating the next generation of professional midwives for Liberia.

In July, I boarded a plane for home. My heart felt burdened by the scope of challenges facing global midwifery. I wondered how the profession could thrive if we couldn't provide the highest quality of midwifery training we have to offer to the next generation.

Overcoming some of the challenges to providing high quality midwifery education in countries such as Liberia, I believe, requires establishing effective collaborations with local and global partners and optimizing current technology to break down the significant barriers associated with providing quality midwifery training. These, in my opinion, are the first necessary steps to ultimately supporting the commitment of the global health movement to eliminate the preventable maternal and newborn deaths, which plague many resource-limited, developing countries.

By Shakira Franklyn, CNM, MPH, MS
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Building a Bright Future Together

In August, ACNM welcomed a new director of membership and publications, Hedy Ross. Here, she offers her vision and perspective on making the most of your membership.

As your new ACNM director of membership and publications, it is my goal to continue building an ACNM that has value for you at every stage of your career. Every member, at every career phase from student to retired midwife, makes a unique contribution and strengthens our community. Together, we grow and enhance the midwifery profession and provide support to fellow midwives. This, in turn, helps the women who depend on midwives for care throughout their lives. Diversity and inclusion add to our strength, and I will actively participate in our efforts to create a diverse and inclusive midwifery community and address disparities in the delivery of women's health care.

Getting Involved

The more you engage with ACNM, the more value you receive from your membership—you develop professionally; learn from our educational offerings, peers, and mentors; benefit from our advocacy activities; ensure women's access to care; and support the entire midwifery profession. Here are some ways to get involved:

- **Demonstrate Pride in Your ACNM Membership.** Include your ACNM membership on your resume, LinkedIn profile, and on graduate school and job applications; include it as a qualification during interviews with media; and visit www.acnmstore.com for items to proudly display your ACNM affiliation. Ask your employer to pay for your membership as essential to your career.
- **Learn and Network.** Attend the ACNM Annual Meeting & Exhibition and Midwifery Works. These gatherings are not only educational opportunities; they give you a unique setting in which to network with other midwives socially and professionally, and to establish and revisit lasting relationships that enhance your career. Join ACNM Connect, our improved online member-only community. Join an ACNM caucus (special interest group for midwives who share a particular passion).
- **Volunteer**. Help build the ACNM of tomorrow. Volunteer to serve on an ACNM division or committee. Find applications on "Volunteer Community" on ACNM Connect. Consider running for a leadership position with your state affiliate and develop your leadership skills. We also have a limited number of volunteer opportunities available for members at the 63rd Annual Meeting & Exhibition in May 2018. Stay tuned for more information by year's end.
- **Provide Feedback and Information**. We depend on your valuable feedback—complete membership and other ACNM surveys when you receive them. Please also contact me anytime; you don't have to wait for a survey to communicate your opinions and ideas. Update your profile information at ACNM.org/MyACNM, our new association management system (AMS). Keeping your profile current enables us to send you appropriate and timely communications.
- **Stay Informed and Advocate**. Read our bi-weekly policy updates and act to support legislation advancing women's health. Visit our Action Center at www.votervoice.net/ACNM/Campaigns. There is strength in numbers and we accomplish more important work together.
- **Be Involved with Your State Affiliate**. Stay involved with your local affiliate activities to facilitate relationships with midwives in your area, and collaborate on health care issues pertinent to your state. Easily communicate with affiliate members via ACNM Connect.

A Bright Future

During my brief time at ACNM, I have already connected with many of our members. I have witnessed dedication and compassion as our members prepared for numerous hurricane disasters to support maternal and child health. I am inspired by your passion and professionalism. I see a bright future ahead for the midwifery profession and for ACNM. Your participation is vital as we work together to grow our ACNM midwifery community. You are ACNM! Please keep your membership current. Your dues enable us to continue our mission. Engage with ACNM in the ways that fit with your lifestyle. We can't do this without you! I look forward to our exciting future and to supporting you and your fellow midwives, as you serve the women and families who so greatly need you.

By Hedy J. Ross, MS, MBA
ACNM Director of Membership and Publications
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Attention Federal and Military Employees who Participate in the Combined Federal Campaign!

Federal and military employees can now support the A.C.N.M. Foundation, Inc. with their donations to the 2018 Combined Federal Campaign (CFC). Simply choose CFC charity code #43413! (Note: In the previous issue of *Quickening*, the charity code was noted incorrectly. Please use #43413.)

Foundation's 50th Anniversary "Hall of Fame" Awards

During the May 2017 ACNM Annual Meeting, the Foundation presented special recognition awards to individuals and groups that have made historical contributions to the Foundation's 50-year legacy. Hall of Fame Award recipients either established or advanced one of our endowed scholarships and awards, or helped grow our endowment. The names and contributions of all awardees will be enshrined on a plaque at the ACNM national office as follows:

- Midwifery Legacy Circle, 2002
- All donors of unrestricted legacy gifts of $20,000 or more
- Therese Dondero Lecture Series, 1986
- Charlotte (Pixie) Elsberry, CNM, MSN, FACNM
- W. Newton Long Award, 1990
- Elaine Moore, CNM, MSN, FACNM
- Mary Breckinridge Founder's Club, 1995
- Suzanne M. Smith, CNM, MS, MPH, FACNM
- Basic Scholarships for Midwives of Color, 1995
- ACNM Midwifery of Color Committee
- Edith B. Wonnell CNM Scholarship, 1996
- Edith B. Wonnell, CNMM, MSN, FACNM
- Bonnie Westenberg Pedersen International Midwife Award, 1999
- ACNM Division of Global Health
- Varney Participant Award, 2000
- Helen Varney Burst, CNM, MSN, DHL (Hon.) FACNM
- MBN Midwifery Leadership Fellowship, 2001
- Midwifery Business Network
- Foundation's Leadership Development Program, 2002
- Sally Engelhard Pingree and The Charles Engelhard Foundation
- Dorothea M. Lang Pioneer Award, 2002
- Dorothea M. Lang, CNM, MPH, FACNM
- Teresa Marsico Memorial Endowment, 2006
- Deanne R. Williams, CNM, MS, FACNM
- Jeanne Raisler Award for International Midwifery, 2007
- The Raisler-Cohn Family & The Harold K. Raisler Foundation
- Frances T. Thacher Midwifery Leadership Endowment, 2008
- Frances T. and Thomas D. "Toby" Thacher, II
- Ongoing Group (now Midwifery Legacies Project), 2009
- Royda Ballard, CNM, BSN, FACNM
- Louis M. Hellman MD Midwifery Partnership Award, 2010
- Midwifery Business Network
- Doctoral Scholarship for Midwives of Color, 2015
- ACNM Midwives of Color Committee
- Texas Midwifery Creation Scholarship, 2016
- Consortium of Texas Certified Nurse-Midwives
- Dianne S. Moore Midwifery Research Endowment, 2017
- Sean Moore Gonzalez and Ryan Moore Gonzalez

In the next several issues of *Quickening*, we will feature a few of the individuals and groups that were entered into our Hall of Fame during our 50th Anniversary Celebration in Chicago last May. In this issue we highlight those who have strengthened the Foundation's scholarship and awards programs, as well as our infrastructure, through legacy and estate gifts.

Midwifery Legacy Circle (MLC), Est. 2002

The Midwifery Legacy Circle was established with 34 charter members who had planned gifts to the Foundation upon their death. Several of those entered into the Foundation's Hall of Fame were celebrated because they specified (or "restricted") the use of their legacy gifts. While we are very proud to honor them in our Hall of Fame, we must first honor and memorialize those who deserve a special place in the Foundation's Hall of Fame because of their "unrestricted" legacy gifts, which serve to support a strong infrastructure, so vital to a nonprofit charitable organization the size of the A.C.N.M. Foundation, Inc. Listed below are those who have left to the Foundation unrestricted legacy gifts of $20,000 or more—collectively contributing close to half a million dollars in support over the past 25 years. A special plaque will hang at the ACNM national office with an ongoing list of those who have made invaluable unrestricted legacy gifts.

- 2015, Johanna Borsellega, CNM
- 2007, Patricia Duffy, CNM
- 2006, Jane Wiggins, CNM
- 1998, Ernestine Weidenbach, CNM
- 1998, Thelma Finch, CNM
- 1995, Agnes Reinders, CNM
- 1992, Ruth Doran, CNM

For more information about the Midwifery Legacy Circle, please visit: www.acnmf.org

Therese Dondero

Pixie Elsberry

Therese Dondero Lecture Series, Est. 1986

PRESENTED TO: Charlotte "Pixie" Elsberry, CNM, MSN, FACNM, and the longest-serving member of the Dondero Fund Committee.

Therese Dondero, CNM who founded the Midwifery Service at North Central Bronx Hospital Montefiore Medical Center in 1977 with the help of Ob/Gyn Samuel Oberlander, MD, and Charlotte (Pixie) Elsberry, CNM. In 1986, Dr. Oberlander, family members, and friends established the Therese Dondero Memorial Fund to honor and preserve Therese's remarkable legacy after she died from breast cancer at age 40. Since then, the Dondero Lecture Series has been featured at 31 consecutive ACNM Annual Meetings. The series

enables midwives to benefit from renowned invited speakers who possess a remarkable record of achievement in maternal and infant health and a deep commitment to Therese's ideals of excellence in clinical care, excellence in midwifery education, and advocacy for the rights of all childbearing women to responsive personalized care, regardless of economic or obstetric risk status.

Bonnie Westenberg Pedersen International Midwife Award, Est. 1999

Robyn Churchill, CNM, DGH chair (right) with Mistress of Ceremonies Dr. Jo-Anna Rorie, CNM.

PRESENTED TO: The ACNM Division of Global Health

Established in memory of Bonnie Westenberg Pedersen, CNM, founder and director of ACNM's Special Projects Section, this award has enabled 8 international midwives from economically developing nations to attend the ACNM Annual Meeting as an honored guest. All have been recognized for outstanding work in their home country to make birth safe for mothers and babies. The goal of the Pedersen Award is to encourage them to take Bonnie's path of leadership, vision, and significant contributions to the profession of midwifery and international health. From its inception, the ACNM Division of Global Health has worked energetically to support recipients and raise funds for this biannual award.

Teresa Marsico Memorial Endowment, Est. 2006

Deanne Williams, CNM (left) with Elaine Moore, CNM, foundation president.

PRESENTED TO: Deanne R. Williams, CNM, MS, FACNM

The Teresa Marsico Memorial Endowment was established with a legacy gift by ACNM's beloved past-president, Teresa Marsico, CNM, MEd, FACNM. Teresa envisioned the endowment's purposes to be twofold: support for basic and graduate student scholarships, especially for students whose intention is to serve vulnerable populations, and support for the missions of both the ACNM and the Foundation. While Teresa's vision guided plans, it was ACNM's then Executive Director Deanne Williams who drafted (and crafted) the fund's purposes and guidelines. The result was that half of the Memorial Fund resources would be used to support activities that expand the capacity of ACNM to meet the needs of the midwifery profession, while the other half would be used to support operating expenses or other activities as determined by the Foundation Board. This forward-thinking dual purpose has strengthened the Foundation's operations and capacity while at the same time funding projects prioritized by ACNM, especially those that fall outside of the ordinary budgeting, making Teresa's an invaluable gift to both organizations!

Jeanne Raisler Award for International Midwifery, 2007

PRESENTED TO: The Raisler-Cohn Family and The Harold K. Raisler Foundation.

This award honors the memory of Jeanne Raisler, CNM, DrPH, FACNM, a distinguished and internationally known and respected nurse-midwife, scholar, and champion of women's health whose work had broad impact on students, fellow researchers, and global HIV/AIDS policy. The Jeanne Raisler Award for International Midwifery was established in 2007 by Jeanne's family, with funding directed by Jeanne prior to her death and sustained through regular contributions from the Raisler family foundation. The award enables ACNM members or student members with an expressed interest in a career in global health to gain experience in international midwifery through participation in a project designed to improve the health of women in an economically developing country.

The Raisler-Cohn Family with Dr. Jeanne Raisler in 2005.

Dianne S. Moore Midwifery Research Endowment, 2017

PRESENTED TO: Sean Moore Gonzalez and Ryan Moore Gonzalez

The Foundation's most recent endowed fund arose from the estate of midwife researcher, entrepreneur, educator, and practice director, Dianne Moore, PhD, MN, MPH, CNM, who made legacy plans to establish a fund to support midwifery and public health research. After her death in 2015, Dianne's sons Sean and Ryan made sizable donations designed to honor their mother's wishes, thereby establishing the Foundation's first endowed fund for research, something we are certain would have greatly pleased her. Dianne was a truly visionary change agent who tirelessly aimed to improve maternal and child health, often advancing innovative and unconventional approaches. Her professional legacy within midwifery, nursing, and public health is characterized by the promotion of evidence-based clinical practice, innovation in health care service delivery and financing, and excellence in education. She held particular interests in the use of computer technology in health care and education, including medical informatics and artificial intelligence. She also promoted the concept of birth centers as a viable option for childbearing women.

ACNM President Elect Susan Stone and Sean Moore Gonzalez, celebrating signing of the endowment agreement.

In keeping with her remarkable legacy in research, the purpose of the Dianne S. Moore Research Endowment Fund is to advance innovative research designed to improve maternal and child health. The Fund's purpose will be achieved by providing:

- Scholarships and grants to individual researchers;
- Research-related grants to organizations that aim to improve maternal and child health, with priority to ACNM and its strategic priorities; and,
- Grants and awards for projects and initiatives that advance the Fund purpose and Dr. Moore's legacy.

While the Fund will be managed by the Foundation Board, it will be advised and guided by a Foundation-ACNM committee that will include Diane's sons and her dear friend and colleague, Maureen Rayson, CNM. Sean and Ryan have already launched plans for growth of the fund that honors their mother's professional passions in perpetuity, specifically using social media marketing and fundraising that will extend well beyond our usual donor base. Stay tuned for more news about this exciting fund!

UPCOMING APPLICATION DEADLINES:

Note new deadlines for several 2018 Awards and Scholarships!

All applications are available at: http://www.midwife.org/Foundation-Scholarships-and-Awards

January 15, 2018

- Louis M Hellman, MD, Midwifery Partnership Award

QUESTIONS ABOUT DONATIONS OR AWARDS?

Lisa L. Paine, CNM, DrPH, FACNM, CEO
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E:fdn@acnm.org

To make a tax-deductible donation in support of the Foundation mission, go to: http://www.midwife.org/Charitable-Contributions

February 1, 2018 (EARLIER DEADLINES)

- Basic Midwifery Student Scholarships, including:
  - Midwives of Color-Watson Scholarship
  - Edith B. Wonnell CNM Scholarship
- Varney Participant Award **(STUDENTS ONLY)**

February 15, 2018

- 20th Century Midwife Student Interview Project
- Graduate Education Fellowship **(EARLIER DEADLINE)**

March 1, 2018

- W. Newton Long Award **(EARLIER DEADLINE)**

Gifts to The A.C.N.M. Foundation
May 16, 2017 to August 31, 2017

UNRESTRICTED GIFTS
Mary Breckinridge Club ($1000 or more) since 1/1/17:
Melissa D. Avery
Rebeca Barroso
Ginger K. Breedlove
Katherine Camacho Carr, *in memory of Dorothea M. Lang*
Mary Kaye Collins
Leslie Cragin
Susan DeJoy
Jean Downie
Kathryn Eck *(Student)*
Judith T. Fullerton
Carolyn Gegor
Laraine H. Guyette
Denise J. Henning
Elizabeth Hill-Karbowski, *in memory of Russell Hill*
Lynne Himmelreich
Bridget Howard
Barbara Hughes
Marsha E. Jackson
Peter & Tina Johnson
Timothy R.B. Johnson, Jr.
Holly Powell Kennedy
Julia Lange Kessler
Jan Kriebs
Cara Krulewitch
Mary Jane Lewitt
Francie Likis
Lisa Kane Low
Ellen Martin
Michael M. McCann
Denise McLaughlin
Elaine Moore
Tonia Moore-Davis
Lonnie Morris
Patricia Aikins Murphy
Linda Nanni
Kathryn Osborne
Lisa Paine, *in honor of Frances T. Thacher, 2017 'Hattie'*
Karen Perdion
Nancy Jo Reedy
Pamela Reis
Ximena Rossato-Bennett *(Student)*
Mavis N. Schorn
Kerri D. Schuiling
Rebecca Smiddy *(Student), in honor of Elizabeth Minton & Clarissa Carbo*
Suzanne & Brian Smith, *in memory of Dorothea M. Lang*
Susan E. Stone
Letitia Sullivan
Frances T. Thacher
Joyce E. Thompson, *in memory of Glen & Ida Beebe*
Deborah S. Walker, *in memory of Mary Anne & Wilbur Walker*
A .M. Wilson-Livermore
John Andrew Youmans *(Student)*

RESTRICTED GIFTS:
Mary Breckinridge Level ($1K or more) since 1/1/17

Midwifery Legacies Project
Royda Ballard

Teresa Marsico Memorial Fund
Georgia Blair
Jenny Foster, *in memory of Alexander Whitman Cecilia Jevitt*
Joani Slager, *in memory of Dorothea M. Lang*

Dorothea M. Lang Pioneer Award Fund, *in memory of Dorothea M. Lang*
Mary V. Widhalm

Midwives of Color Scholarship Fund
Mei-Ka Chin
Pearline Gilpin

UNRESTRICTED GIFTS:
<$1000:
$500-999
Barbara Graves, *in memory of Christine M. Nuger*
Kay D. Sedler

$100-499
ACNM Illinois Affiliate
Cathryn Anderson
Melissa D. Avery
Royda C. Ballard
Mary Banner
Mary Barger
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50th Anniversary Birthday Bash Fundraiser
Many thanks to the 296 individuals who donated one or more tickets for a total of $14,270 in revenue. Your support is very much appreciate!

Bulletin Board

ACME Volunteer Opportunity

The Accreditation Commission for Midwifery Education (ACME) has a vacancy on the Board of Review and the Board of Commissioners (site visit coordinator). ACME seeks a diverse pool of candidates including candidates from the West Coast, Southwest, and Midwest regions. All qualified applicants are encouraged to apply. For more information please visit, www.midwife.org/ACME-Volunteer-Opportunities

2018 ACME Site Visit Schedule

In 2018 ACME will conduct 4 site visits as part of our peer review process. Dates are forthcoming:

Spring 2018

- University of Washington
- Seattle University

Fall 2018

- University of Colorado
- Marquette University

Midwifery Programs Up for Review in 2018

The ACME Board of Review holds its meetings in February and July each year. The following programs are up for review:

- Baystate Medical Center (February 2018 Board of Review Meeting)
- Texas Tech University (February 2018 Board of Review Meeting)
- Stony Brook University (February 2018 Board of Review Meeting)
- University of Washington (July 2018 Board of Review Meeting)
- Seattle University (July 2018 Board of Review Meeting)

Call for 3rd Party Comment

In accordance with ACME Policies and Procedures Manual, and the US Department of Education's requirements, ACME is seeking written third-party comment concerning the qualifications for accreditation of the following listed midwifery programs. These programs will be reviewed for renewal of accreditation at the July 2018 ACME Board of Review meeting. Upon request, comments will be considered confidential.

Your comments will be included with the materials submitted by the program for review by the Board of Review. In all instances, your comments must directly relate to the continuing accreditation of a program and the ACME Criteria for Programmatic Accreditation, (December 2009, Revised June 2013, April 2015). This document may be found at www.midwife.org/Accreditation under ACME Documents. Please cite the particular criterion of concern in your comments.

All written comments should be sent to the attention of Heather L. Maurer, ACME executive director, hmaurer@acnm.org, or mailed to ACME, 8403 Colesville Rd., Suite 1550, Silver Spring, MD 20910.

MIDWIFERY PROGRAM	DEGREE TYPE	TYPE OF ACCREDITION	DEADLINE FOR COMMENTS TO BE RECEIVED FOR JULY 2018 BOARD OF REVIEW MEETING
University of Washington	DNP, Post Graduate Certificate	Accreditation	May 1, 2018
Seattle University	DNP, Post Graduate Certificate	Accreditation	May 1, 2018

Newly Certified Midwives

Congratulations to the following midwives for passing the AMCB Midwifery Certification Exam, July 1 2017–September 30 2017

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Share what's happening in your life. To submit an announcement, please write a short description of the award, appointment, practice update, birth, or obituary and send it to quick@acnm.org.

A FAREWELL

After almost a year serving as ACNM's CEO, I offered and the ACNM Board accepted my resignation at the end of September. As Midwifery Week began early October, the board named a distinguished and highly respected midwife, Kate McHugh, CNM, MSN, FACNM, successor as interim CEO.

It has been a privilege, even as the national policy environment has strained women's health, care, and coverage. Together with a major coalition, we turned back a trillion-dollar reduction to Medicaid, the health plan that covers half of US births. We kept as the law of the land maternity care and other essential health benefits and important protections for people with pre-existing health conditions.

At the board's direction, we strategically restructured our national office staff, consolidating global and domestic grant-funded activities into one unit that helped both important areas of work gain from one another. We also expanded our resources for state affiliate leadership and advocacy development. The national office also took additional steps to operationalize ACNM's commitment to diversity and inclusion. For members, ACNM has modernized its association management system to simplify member transactions. The college also initiated ACNM Connect, a new online network specially for members that places the community of midwifery at members' fingertips easily and conveniently.

Because people need midwives more than ever, midwifery and ACNM have a bright future. I send President Kane Low, Interim CEO McHugh, and so many wonderful ACNM members every best wish as the page turns.

By Frank Purcell

CELEBRATING

Aleida Llanes-Oberstein, CNM, LM, MS, FACNM, CHSE, a member of the Maternal Mortality Review Board of New York State, has been invited to join the executive committee as one of its 8 members. We thank her for her continuing service!

Barbara McFarlin, CNM, PhD, RDMS, FACNM, FAAN, and **Dr. William O'Brien** have been awarded a grant from the National Institutes of Health of $2.85 million for their study, "QUS Technology for Identifying At-Risk Women for Spontaneous Preterm Birth." McFarlin and O'Brien will refine and validate quantitative ultrasound technology for identifying women at risk for preterm birth, a critically important problem. Congratulations, Barbara, Bill, and team!

North Central Bronx Hospital, home of one of the oldest and largest full scope midwifery services in New York City, celebrated its 40th year in October. Hundreds of midwives and student midwives have supported women and their families at NCB over the years and the service remains a strong, vital, and integral part of the community!

Linda Nanni, CNM, MS, FACNM, director of Care New England Medical Group Midwifery Service at Women and Infants' Hospital in Providence, was named Rhode Island's 2017 Certified Nurse-Midwife of the Year (http://bit.ly/2zT12UK).

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