



Mothers and Offspring Mortality and Morbidity Awareness Act (MOMMA Act):

Legislative Issue Brief

POSITION:

The American College of Nurse-Midwives (ACNM) strongly supports the *Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act* (H.R. 1897/S. 916). Introduced on March 27, 2019, in the House and Senate by Congresswoman Robin Kelly (D-IL), Senator Dick Durbin (D-IL) and Senator Tammy Duckworth (D-IL), the *MOMMA Act* would work to prevent America's rising maternal mortality rate and reduce maternal morbidity through implementation of comprehensive set of policies to improve data collection, disseminate information on effective interventions, and expand access to health care and social services for postpartum women. The *MOMMA Act* builds on the *Preventing Maternal Deaths Act*, legislation signed into law in December 2018, which seeks to establish and support existing maternal mortality review committees (MMRCs) in states and tribal nations across the country through federal funding and reporting of standardized data. This was a significant first step, but more needs to be done on an urgent basis to prevent known causes of maternal death. An estimated 60% of pregnancy and childbirth-related deaths are preventable.

BACKGROUND ON LEGISLATION:

If adopted into law, the *MOMMA Act* would:

- Bolster federal efforts to support states in collecting, standardizing, and sharing maternal mortality and morbidity data by using a standard method for data reporting.
- Permit states to expand coverage under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) from a period of one year to two years.
- Issue best practices to state MMRCs on how to best identify, review and prevent maternal deaths.
- Expand Medicaid and the Children's Health Insurance Program for postpartum care for 60 days to one year postpartum.
- Expand oral and dental health coverage for postpartum women beginning one year after last day of pregnancy.
- Support the Alliance for Innovation on Maternal Health (AIM) – a national alliance that works to implement standardized protocols across the country by ensuring that hospitals adopt and implement data-driven maternal safety bundles. Establish Regional Centers of Excellence – a grant program addressing implicit bias and cultural competency in patient-provider interaction education for the purpose of enhancing and improving how health professionals are educated in implicit bias

and delivering culturally competent health care.

ACTION NEEDED:

- ACNM encourages co-sponsorship and passage of H.R. 1897/S. 916 legislation to help improve the health and safety of pregnant and postpartum women and work to end preventable maternal deaths.
- To cosponsor H.R. 1897, please contact Mia Keays in Representative Kelly's office at Mia.Keays@mail.house.gov.
- To cosponsor S. 916, please contact Jessica McNiece in Sen. Durbin's office at Jessica_McNiece@durbin.senate.gov.

ADDITIONAL INFORMATION:

- Maternal and infant health is in a state of crisis in the United States with large disparities beginning in pregnancy and at birth that become magnified over time.
- The United States' maternal mortality, severe maternal morbidity, preterm birth, infant mortality, and low birth weight is the highest among high-income nations.
- The United States now has the highest rate of maternal mortality among developed nations. In 2015, the U.S. ranked 46th among the 181 countries and rates of maternal deaths continues to rise.
- Roughly 700 women die annually from pregnancy and childbirth related complications and more than 50,000 women experience severe maternal morbidity, a life-threatening complication as a result of labor and delivery.
- Major disparities in maternal mortality exist, with black women three to four times more likely than white women to die during pregnancy or shortly after birth.
- For every maternal death that occurs, an estimated 100 other women suffer severe complications of pregnancy or childbirth. An estimated 60% of pregnancy and childbirth-related deaths are preventable.
- The United States is facing a current and increasingly severe shortage of trained maternity care providers, leaving mothers and infants across the country at risk.
- Midwives and their model of care have been demonstrated to significantly improve maternal health outcomes.
- Midwife-attended births help reduce the incidence of cesarean sections which carry well-established risks: higher rates of hemorrhage, transfusions, infections, and blood clots—all primary causes of maternal mortality. Healthy physiologic birth means healthier moms and newborns, fewer complications and side-effects, and much lower health care costs.



Removing Barriers to Midwifery Care: Hospital Privileges

Legislative Issue Brief

POSITION:

The American College of Nurse-Midwives (ACNM) strongly supports legislative efforts that seek to include midwives as full members of hospital medical staffs with voting, admitting and clinical privileges. It is the position of ACNM that safe, quality health care can best be provided to women and individuals when policy makers develop laws and regulations that permit certified nurse midwives (CNMs) and certified midwives (CMs) to provide independent midwifery care within their scopes of practice while fostering consultation, collaborative management, and seamless referral and transfer of care based on the needs of patients. ACNM opposes requirements for signed collaborative agreements between physicians and CNMs and CMs as a condition for hospital admitting and clinical privileges, as this requirement interferes with effective coordination of care and can negatively impact patient safety and quality of care. Hospital medical staffs must be representative of midwives who require clinical privileges to practice.

BACKGROUND:

Hospitals and other health care institutions grant medical professionals the privilege or authority to practice in their facility. Credentialing and privileging are two administrative processes that are intended to ensure that providers have the necessary qualifications to direct the clinical care provided to patients in hospitals. Privileging refers to authorizing the credentialed individual to perform or order specific diagnostic or therapeutic services within a hospital. CNMs and CMs must be eligible for hospital clinical privileges, admitting privileges and hospital medical staff membership. The ability for a CNM and CM to care for a patient who is admitted to an acute care facility is essential, as 95% of CNM and CM attended births occur in the hospital setting.

Lack of access to high quality prenatal and maternity care services is a contributing factor to the high rates of maternal mortality and morbidity in the United States. Women benefit when they receive hospital care from midwives. CNMs and CM patients have lower rates of c-sections, fewer episiotomies and higher rates of breastfeeding. During a normal hospital labor and birth, a CNM and CM can admit a pregnant person to the hospital, write medical orders, including prescribing medications, manage labor and birth, deliver the baby, and provide postpartum care independently within the scope of the CNM and CM's education and training. When CNMs and CMs have hospital privileges, women planning a hospital birth or requiring hospitalization during pregnancy can remain in a midwifery practice.

Better integration of midwives and the midwifery model of care is essential to the provision of quality of care in all settings, including the hospital. Unfortunately, existing federal and state laws and regulations, as well as individual hospital bylaws and policies, create barriers and prevent patients from accessing their provider of choice, if that provider is a CNM or CM. The privileges of hospitals and medical systems may be regulated by the state, but more often institutions make their own rules in terms of what types of providers they allow to admit patients and which services these providers may perform. Several states maintain that hospitals not discriminate against midwives seeking hospital privileges, while several others expressly limit admitting privileges to physicians. In most states there is no regulation concerning who may admit. Medicare regulations allow CNMs medical staff membership if permitted by state law, but do not mandate CNM membership. Amending Medicare statute to include midwives as members of "medical staff" under Medicare's Hospital Conditions of Participation would improve continuity of care, expand consumer choice and access to care and increase cost-effectiveness within the Medicare program. Medicare is viewed as the "gold standard" and it sets precedent that is often followed by other insurers.

It is critical that laws and regulations facilitate effective relationships between health care professionals and create systems in which midwives and physicians can communicate openly, practice collaboratively, and provide quality care that falls within everyone's professional scope of practice. Establishing support mechanisms and process that enable midwives to practice to full extent of their education and training will increase access to quality care and improve maternal health outcomes across the United States.

ACTION NEEDED:

- ACNM encourages support for legislation seeks to amend Medicare's Conditions of Participation to include CNMs and CMs as full members of hospital medical staffs with voting, admitting and clinical privileges.
- For additional information, please contact Amy Kohl, ACNM's Director of Government Affairs at akohl@ACNM.org or Patrick Cooney at patrick@federalgrp.com.

ADDITIONAL INFORMATION:

- CNMs are licensed, independent health care providers with prescriptive authority in all 50 states, Washington, D.C., American Samoa, Guam, the U.S. Virgin Islands and Puerto Rico and are defined as primary care providers under federal law.
- CNMs and CMs practice in hospitals, health clinics, migrant health centers, in the armed forces, in Indian and tribal health centers, in freestanding birth centers, and in the home setting.
- CMs are also licensed, independent health care providers who have completed the same midwifery education as CNMs. CMs are authorized to practice in Delaware, Hawaii, Missouri, New Jersey, New York and Rhode Island. CMs have prescriptive authority in New York and Rhode Island.
- CNMs are recognized as primary care providers under the Medicare program.
- CNMs are paid at 100% of the Physician Fee Schedule under the Medicare program.
- Medicaid reimbursement for CNM care is mandatory in all states. Most Medicaid programs reimburse CNMs/CMs at 100% of physician rates. The majority of states also mandate private insurance reimbursement for midwifery services.



Removing Barriers to Midwifery Care: Increased Funding for Midwifery Education Programs

Legislative Issue Brief

POSITION:

The American College of Nurse-Midwives (ACNM) strongly supports legislative efforts that seek to expand access to the midwifery model of care as practiced by Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) through increased federal funding to midwifery education and training programs. Draft legislation, the *Midwives for Maximizing Optimal Maternity Services Act*, currently under development and pending introduction by Rep. Lucille Roybal-Allard (D-CA), would authorize two federal funding streams under Title VII and Title VIII of the Public Health Service Act to support basic and graduate nursing and midwifery education and training programs, with a specific focus on support for clinical preceptors and designated funding to increase the representation of minority and disadvantaged students within midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME).

BACKGROUND:

Maternal and infant health is in a state of crisis in the United States with large disparities beginning in pregnancy and at birth that become magnified over time. Collective action is needed across the health care continuum to improve outcomes for this population. The United States is facing a current and increasingly severe shortage of trained maternity care providers, leaving mothers and infants across the country at risk. CNMs and CMs are urgently needed to fill the gap. Timely federal action to grow and strengthen the midwifery workforce is a key strategy to address this provider shortage and increase access to quality care, especially in high-need rural and urban areas that too often have no obstetrical providers or maternity care services at all. Direct funding for midwifery education has been identified as the number one priority for growing the workforce to meet the urgent needs of the childbearing population.

Better integration of the midwifery model of care depends on a robust workforce. The shortage of all types of maternity care providers and of maternity services in rural areas presents an opportunity to re-envision the maternity care workforce by increasing access to CNMs and CMs. Expanding funding to accredited midwifery education programs whose graduates provide high-value care and are educated in fewer years at lower cost than physicians; and whose composition better reflects the diversity of childbearing families will increase access to quality care and improve maternal health outcomes across the United States.

The Title VII and Title VIII programs help shape factions of the health care workforce in targeted ways, such as promoting interprofessional, team-based care; encouraging practice in community-based settings as well

as rural and other underserved areas; training providers to respond to emerging and existing public health threats (e.g., maternal mortality and morbidity) and expanding educational funding for nurses and other allied health professionals. As the nation faces widespread maternity care provider shortages, it is crucial to establish a federal funding stream within existing Public Health Service Act programs that will help the next generation of maternity care providers stay ahead of the increasing health care challenges of our country. This draft legislation will authorize federal funding streams under Title VII and Title VIII to help increase the number of midwives available to mothers in the U.S.

ACTION NEEDED:

- ACNM encourages support for legislation that would authorize federal funding streams under Title VII and Title VIII to help increase the number of midwives available to mothers in the U.S.
- For additional information, please contact Amy Kohl, ACNM's Director of Government Affairs at akohl@ACNM.org or Debbie Jessup in Representative Roybal-Allard's office at debbie.jessup@mail.house.gov.

ADDITIONAL INFORMATION:

- The United States now has the highest rate of maternal mortality among developed nations. In 2015, the U.S. ranked 46th among the 181 countries and rates of maternal deaths continues to rise.
- Roughly 700 women die annually from pregnancy and childbirth related complications and more than 50,000 women experience severe maternal morbidity, a life-threatening complication as a result of labor and delivery.
- Major disparities in maternal mortality exist, with black women three to four times more likely than white women to die during pregnancy or shortly after birth.
- For every maternal death that occurs, an estimated 100 other women suffer severe complications of pregnancy or childbirth. A majority of these deaths are preventable.
- The United States is facing a current and increasingly severe shortage of trained maternity care providers, leaving mothers and infants across the country at risk.
- Efforts to improve access and health outcomes across the care continuum, should include enhanced access to midwives and investment in the midwifery model-of-care.
- Midwives and their model of care have been demonstrated to significantly improve maternal health outcomes.
- Midwife-attended births help reduce the incidence of cesarean sections which carry well-established risks: higher rates of hemorrhage, transfusions, infections, and blood clots—all primary causes of maternal mortality. Healthy physiologic birth means healthier moms and newborns, fewer complications and side-effects, and much lower health care costs.
- There are currently 38 ACME-accredited CNM/CM midwifery education programs in the U.S. Two programs prepare CMs. Midwifery education occurs at the post-baccalaureate level and must be incorporated into programs that grant either the master's or doctoral degree.
- Educating CNMs/CMs is cost effective: Educational programs typically require 2 years of postbaccalaureate graduate-level study and cost on average around \$54,000.
- The most significant barrier to educating more midwives is the capacity of educational programs to secure sites for clinical precepting to take place.



TITLE VIII NURSING WORKFORCE DEVELOPMENT PROGRAMS

CONTACT

202-463-6930 ext. 271

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REQUEST: COSPONSOR TITLE VIII NURSING WORKFORCE REAUTHORIZATION ACT (H.R. 728)

ABOUT THE TITLE VIII REAUTHORIZATION ACT (H.R. 728)

RECOGNIZES ALL FOUR APRN ROLES

- The Title VIII statute is amended in two places to include Clinical Nurse Specialists (CNSs), thus creating equity among the Advanced Practice Registered Nurse (APRN) roles. Historically, only three (nurse practitioners, certified registered nurse anesthetists, and certified nurse-midwives) of the four APRN roles have been delineated in the Title VIII statute.

[42 U.S.C. § 296j] – Advanced Education Nursing Grants:
Amended to include a definition of Clinical Nurse Specialist.

[42 U.S.C. § 297t] – National Advisory Council on Nurse Education
and Practice: Amended to include Clinical Nurse Specialists.

INCLUDES CLINICAL NURSE LEADERS

- The Clinical Nurse Leader (CNL) evaluates patient outcomes, assesses cohort risk, and has the decision-making authority to change care plans when necessary. The statute is amended to include CNLs, which allows for parity with the other master's degree programs that can apply for the Title VIII Advanced Education Nursing program.

[42 U.S.C. § 296j] – Advanced Education Nursing Grants: Amended to
include Clinical Nurse Leader in the definition of advanced
education nurses.

DEFINES NURSE-MANAGED HEALTH CLINICS

- Nurse-Managed Health Clinics (NMHCs) are effective in providing individualized care that includes health promotion, disease prevention and early detection, health teaching, management of chronic conditions, treatment of acute illnesses, and counseling. NMHCs, run by nurse practitioners, traditionally focus on populations underserved by the larger healthcare system and are learning environments for healthcare providers. The statute is amended to include a NMHC definition, making them an eligible entity within Title VIII.

[42 U.S.C. § 296] – Title VIII Definitions: Amended to include
"Nurse-Managed Health Clinics."

THE IMPACT OF THE TITLE VIII NURSING WORKFORCE DEVELOPMENT PROGRAMS ON PATIENTS AND COMMUNITIES IN ACADEMIC YEAR 2016-2017*

ADVANCED NURSING EDUCATION PROGRAM

- 5,942 students supported, which includes 1,541 graduates
- Grantees partnered with 2,304 clinical training sites
- 40% of sites were located in medically underserved areas; 59% were in primary care settings

ADVANCED EDUCATION NURSING TRAINEESHIP (AENT) AND NURSE ANESTHETIST TRAINEESHIPS (NAT)

- 2,429 students supported through NAT
- 2,166 students supported through AENT
- 75% of NAT recipients trained in medically underserved areas; 46% were in primary care settings
- 61% of AENT recipients trained in medically-underserved areas; 80% were in primary care settings

NURSING WORKFORCE DIVERSITY

- 4,416 students supported
- Grantees partnered with 571 clinical training sites
- 49% of sites were located in medically-underserved areas; 37% were in primary care settings

NURSE EDUCATION, PRACTICE, QUALITY, AND RETENTION PROGRAM

- 6,430 individuals trained by grantees of the Interprofessional Collaborative Practice Program (IPCP)
- 71% of IPCP clinical training sites and approximately 75% of BSN Practicums in Community-based Settings Program sites were located in medically underserved communities

NURSE FACULTY LOAN REPAYMENT PROGRAM (NFLP)

- 84 schools received new NFLP grant awards
- 1,998 students supported
- 83% of students who received loans were pursuing doctoral-level nursing degrees
- 92% of the 568 graduated trainees intend to teach nursing

NURSE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS

- 1,217 scholarship and loan repayment awards funded
- 55% of Nurse Loan Repayment participants extended their service commitment for an additional year
- 86% of participants retained at critical shortage facility for up to two years beyond their service commitment

TITLE VIII NURSING WORKFORCE DEVELOPMENT PROGRAMS

Administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration, the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.]) address all aspects of nursing workforce demand, including education, practice, recruitment, and retention. Reauthorizing Title VIII ensures that these key initiatives are authorized for funding for five-years.

*Source: Health Resources and Services Administration. Fiscal Year 2019 Budget Justification. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2019.pdf>.

