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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: Reflecting the Contributions of Midwives of Color
14  ACNM Volunteer Structure Realignment

ADVOCACY
16  Affiliate Spotlight: Pennsylvania: Laying the Groundwork for Change
17  Midwives-PAC: Support Key Legislative Goals at the PAC Rally

MIDWIFERY MEETINGS
18  Annual Meeting Preview: Savannah—Something for Everyone!
20  Get “Global” at the Annual Meeting

CLINICAL FOCUS & MIDWIFERY PRACTICE & EDUCATION
21  Midwife to Midwife: Sex Positivity in Clinical Practice
22  Professional Connection: Impacting the Opioid Crisis
24  Quality Initiatives: On Your Marks, Get Set, Benchmark!
25  Professional Connection: Lessons from a Deadly Pandemic
26  Professional Connection: Mental Health and Illness: Building Midwifery Knowledge

FROM MY PERSPECTIVE
28  Giving Back in the US Virgin Islands

PARTNERS & PEOPLE
29  Inside the Journal of Midwifery & Women’s Health
30  Preceptor’s Pointers: How to be a Culturally Sensitive Preceptor
31  Clinical Notes
31  Membership: It’s Time to Connect!
32  Bulletin Board: ACME Accreditation Actions for 2018
33  A.C.N.M. Foundation Update
37  Keeping in Touch
38  AMCB Certification Awardees

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Message from the Interim CEO

Right-Sizing: It goes both ways

As I write this piece for Quickening, we are at the start of the second year of the US Presidential term. Many of our core beliefs as midwives are being challenged by outside forces. Every day we hear of new onslaughts against the women and families we care for. Emboldened by the activities in Washington, many of our state affiliates are being challenged in areas related to scope of practice, full practice authority, and regulation. Each day seems to bring a new worry or assault.

In my role as interim CEO for ACNM, I have focused on “right-sizing” many aspects of the association. What do I mean by this term? To me, right-sizing means constantly evaluating what is within our abilities and resources, what will lead to harmony in our organization, and what will keep us focused on strategic goals. As with many organizations, ACNM is prone to “mission creep,” in which tangential ideas get prioritized to the detriment of core services and progress on strategic goals. An honest examination of good ideas for their feasibility, monetary cost, and cost in terms of staff time is critical to a right-sized organization that can be responsive to the urgent needs of the times.

As we dig in and marshal resources for the political and professional fights of our times, we anticipate the need for increased activity serving membership at the state and federal level. This will take resources. I have made some hard choices about some job descriptions and positions, eliminating some roles, and changing the organizational chart in other areas. We are considering a move to an office suite that is more appropriate for our budget. We are leaner than we were, but with this comes the positive energy of less financial angst.

Although I have focused on the aspect of right-sizing that involves tightening up, I continue to challenge you with helping us right size in the opposite direction: right-sizing through growth. Why can’t we grow to 75% membership? That would be the best right-sizing I can envision! I can help promote growth by making sure the national office provides good service and by assisting our affiliates, but it will take each of you to help assure growth and impact through new membership and donations to the Foundation.

By Kate McHugh, CNM, MSN, FACNM
Interim CEO
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On the Flashpoint of Being an *Independent* Provider

With the AMA opposing full practice authority, now more than ever, we need to push full steam ahead as educated, trained, and licensed independent providers.

I have been pondering many questions in my last few months as your president. Among them are ones I have consistently engaged with throughout the past two years: *How do we generate an improved member experience in ACNM to increase membership and engagement? What is the optimal revenue diversification in a membership organization to meet our growing needs and demands? Why haven’t we gotten the traction needed on some of our critical policy and regulatory issues such as hospital credentialing, residency supervision, and direct insurance reimbursement?* More recently, a new question has entered the mix: *When did “independent” become such a complicated and challenging word?* This word is now a flashpoint in negotiations, legislative initiatives, and even collegial conversations among health care professionals.

In 2011, the official joint statement between ACNM and ACOG ([bit.ly/1gBYnVW](http://bit.ly/1gBYnVW)) included the following sentence: “Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients.” This statement was a clear recognition of our separate and different areas of expertise that could be brought to bear based on the health care scenario before either one of us. Some will read this statement now, seven years later and think “well, of course,” but this sentence with the word independent is complicated. Does “independent” mean the CNM/CM is “going it alone” and not working within a system of health care? No. The ACNM Standards for Practice ([http://bit.ly/1L7x9Ab](http://bit.ly/1L7x9Ab)) require midwives to work within a system of care that provides for consultation, collaboration, and referral.

What “independent” negates is the requirement that anyone supervise this process or have in place a written agreement about how and with whom it should occur. Independent simply means we stand on our own scope of practice to provide the services we educated and trained to do. This is what full practice authority means, in essence, it is doing what we have been educated and trained to do.

Different models of how we work together have been offered, ranging from a captain-of-the-ship approach to full team-based care in which all team members are independent and working to their full education and training to optimize the health care experience and outcomes. This latter model is what both ACNM and ACOG have endorsed, and it is fully articulated in the 2016 publication, “Collaboration in Practice: Implementing Team-Based Care” ([http://bit.ly/2BvWSX0](http://bit.ly/2BvWSX0)]. The model is not one of dependence; it respects expertise and individual contributions of each team member to overall health care delivery, while making the person seeking care the central focus. In essence, it advocates for providing the right care, in the right place, at the right time, by the right provider as in *The Lancet Series* on Midwifery. Numerous studies are demonstrating the value of using this model, which requires full practice authority for CNMs/CMs to be realized.

With data on our side, ACOG in agreement, and a critical workforce shortage looming in the provision of maternity care and aspects of women’s health care, we are pushing forward full steam on assuring full practice authority in all 50 states. Why am I focused on what seems like such an obvious direction and issue? Because the American Medical Association has voted to oppose all legislative efforts in support of full practice authority. Moreover, they did this in November 2017, when the data, momentum, and all directions point to full practice authority as a necessary step in all 50 states in the interest of the health of the country.

As independent individuals who are working to improve the health of our nation, we will be pressing forward. We will be doing so in partnership with colleagues such as ACOG national, who recognize the superiority of working together in a model of team-based care with a focus on the needs and desires of those we serve (instead of in a solo physician-centric silo). I look forward to learning more about what you are doing in individual states on this front. Go California, North Carolina, and Georgia, to name a few! ACNM stands ready to ensure we move forward, together.
Focusing on What Will Serve Members and the Profession

From the launch of plans for a consulting service for fledgling practices to evaluating the current growth of fellowships, the December board agenda was centered on supporting members and midwifery.

The December meeting of the ACNM Board of Directors was focused and productive. Our volunteer leadership is writing position statements that support our field, planning upcoming gatherings, and continuing waves of change in collaborative practice and interdisciplinary environments. Be sure to peruse the open agenda and open minutes posted here (www.midwife.org/Board-Meetings).

A few highlights offers insight into the exciting work our College has happening on behalf of members and the profession.

Developing a Consulting Service

Midwives seeking to start and develop a practice need a centralized source for this information, and ACNM aims to provide this for members. Given that most midwives are employed by hospitals, and nationwide hospital mergers and closures affect midwifery practice, midwives need additional guidance and support in considering independent and private practice development. The national office aims to form a work group with board members to develop a proposal to establish an ACNM consultative service focused on helping members start a successful midwifery practice. The service may include helping members develop a business proposal. This group will present their initial report to the board in May 2018.

Evaluating the Fellowship/Residency Climate

With the growth of post-graduate midwifery employment opportunities, often called “fellowships” or “residencies,” continuing across the country, the Division of Midwifery Education (DOME) submitted an agenda item to discuss their concerns about these programs. The concerns include:

- clinical placement competition for midwifery students,
- exploitation of new graduates, who are paid less than a full salary,
- elitism of midwifery graduates who can afford to accept a partial salary for full-time work,
- employers developing expectations for further training of education for midwifery graduates,
- delays in impacting the midwifery workforce, and
- co-opting a term used by others in the medical community.

The board has approved the development of a multi-stakeholder task force to evaluate the midwifery fellowship/residency climate and look into optimal ways to address these concerns.

Evaluating Care for Transgender and GNC People

The Gender Equity Task Force (GETF) is forging forward with its charge “to consider member education, online and print resources, and language in ACNM documents as it relates to gender equity.” Part of this work has led GETF to develop member surveys and evaluate nationwide scope of practice for midwives caring for transgender and gender non-conforming (TGNC) people. GETF has identified that certain aspects of its charge may take another year and a half to complete, and the board reviewed its scope and approved continued work on these long-term projects.

An Optimal Midwifery Workforce—What Metric?

The refrain “the world needs more midwives” is well-known in our community. What’s missing is a systematic framework to identify the optimal size of the midwifery workforce. (One option is to review number of midwives per applicable clientele total in the nation or per 100,000 clientele of sexual and reproductive age for midwifery scope of practice.) The ability to refer to a metric for the optimal size of the midwifery workforce could be useful not only to ACNM, but also to other stakeholders and health workforce planners. Particularly given the anticipation of the upcoming maternity care shortage in 2020, this model could support efforts toward growing the midwifery workforce. The Workforce Section (WFS) of the Division of Standards and Practice (DOSP) identified this need, and now has a charge to develop a method to create such a model and report its work at the March 2018 meeting.

To participate in a board meeting: 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 (check the board page for details a couple of weeks prior to the meeting); and 3 read the minutes, posted about a month after a meeting. Between meetings, reach out to board members and let us know your thoughts and experiences as a member!

By Stephanie Tillman, CNM, MSN
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Aligning Resources and Expenses for a Positive End-of-Year Report

Careful financial stewardship is paying off at ACNM.

The ACNM Finance and Audit Committee is pleased to report that as of November 30, 2017, our financial picture continues to demonstrate the coordinated efforts of the ACNM Board of Directors and national office staff toward aligning resources and expenses. With deficit spending considerably reduced in 2016, 2017 was anticipated to be a “break-even” year. While final year-end numbers have not yet been released, as of the end of November, ACNM revenue exceeded expenses by $103,733. Investment gains year to date were $191,699 for a total change in net assets (as of November) of +$295,442. We are cautiously optimistic that we will end the year with a positive budget variance, which will support strategic priorities and operations for 2018 as well as contribute to the replenishment of long-term reserves.

"We are cautiously optimistic that we will end the year with a positive budget variance."

Some of the variance realized is a result of the restructuring process and a longer-than-anticipated timeline for filling some positions. The positions were largely filled by the summer months. The board is working with Interim CEO Kate McHugh, CNM, MSN, FACNM and the national office department directors to finish the process of rightsizing the national office staff, aligning our human resources with our strategic priorities. The implementation of the association management system in June required integration of financial information from the old system into the new one, causing a few challenges for the finance team. Their dedication to problem-solving and cooperation has helped to assure continued process improvement.

It is noteworthy that one of our key sources of revenue, membership dues, had a positive budget variance of $104,035 as of November 30. This demonstrates the ongoing commitment of you, the ACNM member. ACNM members individually and collectively assure achievement of ACNM’s mission, by providing financial support to the organization. On behalf of the board of directors, thank you for your continued dedication and support. We look forward with anticipation to 2018 and the continued progress toward financial stability of the ACNM.

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

Making a Difference in Maternal and Newborn Health

Student midwife Maria Luisa Mendoza and Nicolle Gonzales, CNM from New Mexico are 2017 TCS New York City Marathon finishers! Let’s celebrate their great accomplishment and the worthy cause they ran for, Every Mother Counts, which is dedicated to maternal health around the world (#EveryMomCounts, www.everymothercounts.org/). Maria is driven to make a difference because she knows that “Every mother deserves health care that embraces women and treatments that save lives.” Maria, who started running seven years ago, wants to continue to run on behalf of Every Mother Counts for years to come. Nicolle, who is launching the first Native American birth center, just received a grant to help build it from Every Mother Counts.

Worldwide, about 800 pregnant and birthing women die every day, and the US has the highest rate of maternal mortality among high-resourced countries. According to the CDC, black mothers in the US die at three to four times the rate of white mothers. Thank you, Maria and Nicolle, for your dedication and your inspiration.

In response to the maternal health crisis, New York City has followed in the steps of Baltimore and Philadelphia, and formed the New York City Maternal Mortality and Morbidity Review Committee “M3RC.” Congratulations and deep gratitude to midwives Pat Loftman, CNM, LM, MS, FACNM, Helena Grant, CNM, and Mimi Niles, CNM who have been invited to serve as inaugural members of this important committee. Pat Loftman is Midwife of Color Ex Officio Representative to the ACNM Board and chair of the Midwives of Color Committee.

Pat’s recently represented the midwifery community at a discussion in New York City on maternal mortality sponsored by National Public Radio and ProPublica, an investigative journalism organization. ProPublica recently started a maternal mortality series (https://www.propublica.org/series/lost-mothers) after reaching out to women who had experienced life-threatening complications in childbirth and receiving thousands of responses in the first week alone. Pat, thank you for everything you do and for inspiring so many.

By Kathryn Kravetz Carr, CNM, MSN
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Region II Update
DC, DE, MD, NJ, PA, WV, International Addresses

Maternal Morbidity in the US, an Overlooked Story

We have long been concerned that our country has the highest maternal mortality rate among high-resourced countries, but it has been only recently that articles have focused on the fact that we have a rapidly increasing rate of maternal morbidity—that is, an increasing number of women who experience life-threatening complications of pregnancy. Particularly concerning is the fact that an overwhelming proportion—33% of white women; 44% of African American women—of these near-death experiences are preventable. A recurring theme in morbidity accounts involves an attitude women have been encountering for eons: we are not listened to. In nursing school, I remember learning with shock and disbelief that one reason women die of heart attacks is their symptoms are dismissed as psychosomatic.

Now 21 years later, accounts of this dismissive mindset are all too familiar to me. I also recall early in my career as a midwife, first learning the ACNM slogan, “Listen to Women.” I thought it was wonderful, and I acquired buttons of the slogan in two languages that I proudly wore on my lapel. I pictured myself leaning toward my client at a prenatal visit, sincerely listening to her talk about her lower-back pain, the difficulty of finding shoes for swollen feet, or the struggles of integrating a new little one into her family. What I did not picture then is the reality that not being listened to can prove permanently damaging or fatal.

Recently, I read a tragic account of a young mother who, two days postpartum, complained of tightness in her chest and the feeling that it was hard to draw a deep breath. She was told it was a symptom of a panic attack, quite common in new mothers, and was offered a lavender foot bath before being discharged home. She died two days later of a pulmonary embolus. I am proud and grateful to be part of a profession that listens, that does not dismiss, that makes time and space to hear the concerns of our clients. Listening is fundamentally important because it is kind, responsible, respectful, and might make the difference between life and death. In this age of RVUs and DRGs and overcrowded waiting rooms and labor floors, I appreciate being reminded that listening is threaded through all the hallmarks of midwifery, and I thought my midwife, nurse, and physician colleagues might appreciate it too: We all benefit when we listen a little more.

By Mairi Rothman, CNM, MSN
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Region III Update

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

An Important Announcement and Opportunity

I need to inform Region III members of some changes in my personal life that will affect my serving you in Region III on the ACNM Board. In May of 2018, I will retire from my job at Emory University. My husband and I have accepted a two-year service post at the Friends Meeting (Quakers) in Honolulu, Hawaii, effective June 2018. I will never retire from ACNM! I have been a life member since 1982—but I will no longer be living in Region III, so I need to resign from the Region III representative position, effective the day after the close of the Annual Meeting in Savannah.

The board and the national office are well aware of this upcoming change. Our board governance policies state that in the case of resignation of a board member before their term is complete, the position is offered to the runner-up of their election. If that person is unwilling or unable to serve, the president appoints someone to finish out the term of office (in my case for one more year). The appointed person then has the ability to run for election afterwards, for a three-year term. The runner up from the election in 2016 has been contacted by our president, Lisa Kane Low, CNM, PhD, FACNM, FAAN, and he is unable to serve. Thus, Lisa will appoint someone to serve with the intention that the appointee will onboard with the newly elected board members, and then be officially in place at the time of the Annual Meeting.

This is where I ask for your participation. The membership has been crying out for more diversity on the ACNM Board of Directors. If you, or someone you know, would like to serve on the board, please send an email to Lisa Kane Low and me ([kanelow@med.umich.edu, Jennifer.foster@emory.edu)] with your resume. I want to say, even though I have been a life member of ACNM since 1982, it was only when I joined the board in 2016 that I came to learn so much more about ACNM and what it offers every midwife. It is a tremendous opportunity for professional growth with a great group of people. Please don’t hesitate to contact me if you have questions. I will be sad to leave my post early, but very happy to leave it in the good hands of someone great from Region III—who could very well be you!

By Jenny Foster, CNM, MPH, PhD, FACNM
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Region IV Update

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

Cultivating Gratitude for Joys and Challenges

As I write this, the first snow is falling in Novi, Michigan! I am looking out of the window at a winter wonderland. It always feels special to me. I am feeling very blessed, and this is what I want to focus on—gratitude. Recently I have been trying to increase my journaling, and I have a gratitude journal. Research indicates that we can cultivate gratitude through journaling, increasing our well-being and happiness. In fact, studies demonstrate that expressing our gratitude to others is associated with increased energy, optimism and empathy. So here goes ....

As midwives we get to share in small miracles on a daily basis. To the people making them happen within our profession, I truly want to say I appreciate what you are doing and feel grateful to stand with you. We engage in varied ways: clinical full scope midwifery, leading a service or practice, educating the next generation, managing and administrating, advocating for change, developing as students, and a myriad of other ways. At times, we all feel those moments of incredible joy when the world seems to slow down, the noise settles, and we are just mindfully engaged in a particular moment. At other times, we face moments of professional challenge. I am trying to change my mindset and see these challenges as opportunities. Challenges are when we need to pull on our strengths and bridge barriers, and it is during these moments that I am especially grateful for ACNM.

I want to say thank you to our national office and those who help us to do our daily work! I am grateful for my fellow board members. Each brings such unique views and a wealth of knowledge to the table. To the midwives in Region IV, those who are helping our clients focus on optimizing their health, those who are connecting with women and their families as they travel their life paths, and those who are service directors and educators—I am looking forward to what 2018 brings to all of us! And lastly, to the A.C.N.M. Foundation, Inc., which works hard to assist our profession and advance our work, I am truly grateful for your hard work and dedication, and I look forward to giving my donation to support the growth of our profession through scholarships, awards, and grants. Happy 50th Anniversary A.C.N.M. Foundation!

By Katie Moriarty, CNM, PhD, RN, CAFCI, FACNM
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Region V Update
IA, KS, MN, ND, NE, OK, SD, WI

Midwives: We Need You to Step Up for Political Office

Have you ever thought about running for office? In the current shifting political and sociocultural climate, it may not be enough to vote, donate money, or discuss the candidates with your friends. Across the country, nonpartisan political training forums for women are reporting a spike in the numbers of women signing up online for assistance to explore political careers and learn how to run for office. It’s something to consider.

Women are frequently told to start small, for instance, by running for their school board. Men, like my current state senator who retired as county sheriff and immediately ran for our state senate, are much less likely to hear—or follow—this advice. The upshot is women currently hold roughly 19% of US Congressional seats, 24% of elected statewide executive positions, and 25% of state legislative seats. They also comprise about 21% of mayors in cities with a population greater than 30,000, according to the Center for American Women and Politics at Rutgers University. To put this in the context of being a midwife, clearly not all of us are female, however, many of us regardless of gender would like to see changes in what I call our country’s “health care non-system” along with changes in the policies and programs that affect the women and families we care for. As midwives, we strive daily to change systems of care from the challenges of community birth (home and birth center) intersecting with the health care system through systems changes in our hospitals and large hospital systems. Midwives are highly accomplished at facilitating coalitions and continuing to work for improvement when the process is long and difficult. It seems to me, we are experienced in the skills that would make us strong legislators and executives. How great it would be to have some advanced practice providers—including midwives—in positions to affect health care policy!

You know the adage, “If you are not at the table, you’re on the menu”? The American Medical Association (AMA) just passed a resolution to develop a strategy to oppose full practice authority nationwide. We need to get some seats at the table in the legislatures and front offices. Check out some websites that will assist you in exploring political candidacy and learning how to run, such as VoteRunLead.org and sheshouldrun.org. As a friend frequently says, “If not you, who?” “If not now, why?”

By Lynne Himmelreich, CNM, MPH, FACNM
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Region VI Update
AZ, CO, MT, NM, UT, TX, WY, IHS/Tribal

Appreciating Your Work, Dedication, and Innovation

This time of year welcomes a variety of emotions as we wrap up one year and move on to the next. I find that the end of the year provides a protected space for reflection and appreciation. I am appreciative for our profession’s perseverance, passion, expertise, and innovation, which fuels our work every day. I am also appreciative of our leadership and volunteers’ dedication and advocacy that provide our organization support and an avenue for its monumental accomplishments. As the new year unfolds, I am eager to see all of the great work our profession and ACNM will continue to do. I have had the opportunity to attend several affiliate meetings this fall. The work that the affiliate leaders are doing is impressive. I wanted to take a moment to specifically thank our Region VI affiliate leaders for your work, dedication, and innovation. It does not go unnoticed. Here are a few updates from our affiliates. Cheers to a fantastic 2018!

Colorado had a successful National Nurse-Midwifery Week with their annual symposium. They have had several new practices open: Origin Birth owned by Tracey Ryan, CNM, MS, CLC, and To Each Her Own (home birth) by Anne Walters, CNM and Janet Schwab, CNM, MSN (home and hospital birth). Legislatively, they are supporting Colorado joining in the multi-state nursing compact.

New Mexico: Amy Levi, PhD, CNM, WHNP, FACNM, FAAN has accepted the role of vice chancellor for academic affairs at the University of New Mexico Health Sciences Center. Congratulations, Amy! The state’s midwives are working towards development of a maternal mortality review committee. Katrina Nardini, CNM, MSN, Susan Akins, CNM, and Amy Levi are midwives who have been invited to join the committee.

Texas recently had change of leadership in their affiliate. Susan Stone, CNM was recently nominated to affiliate chair.

Arizona’s Willow Midwife Center for Birth and Wellness, LLC just celebrated its first anniversary after a successful year and the addition of home birth to the practice! Arizona also has several educational events (ALSO and Spinning Babies) scheduled in 2018.

Utah’s legislative task force is undergoing a change in leadership. The current chair Maria Lupe Cruz, CNM is contacting local representatives about how to get involved with statewide issues. Utah is also in the process of revising its bylaws, increasing membership, and meeting attendance.

By Jessica Anderson,
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Region VII Update
AK, CA, HI, ID, OR, WA, Uniformed Services, Samoa, Guam

Showcasing Initiatives to Fuel Momentum

Region VII starts the new year by celebrating the past and by showcasing initiatives to fuel midwifery momentum!

Oregon: Oregon leads the country with almost 20% of babies born with a midwife in attendance. Diana Louise-Smith, CNM, has initiated the Fruition Mural Project (bit.ly/fruition_mural) to honor Oregon midwives who have grown the profession over the past 50 years and are beginning to retire. The mural is designed to capture their spirit and stories, celebrate their accomplishments, and envision and invigorate the work of the next generation of midwives. Louise-Smith’s team is now visioning, fundraising, and identifying a site for the mural. Stay tuned for workshops and opportunities to paint and celebrate midwifery in Oregon! Angie Chisholm, CNM, who received the Oregon Affiliate Special Projects grant, has created a short film, The Heart of Touch: Essentials of Skin to Skin Care (www.heartoftouchfilm.com/) with an interdisciplinary team to educate patients on the value of skin-to-skin touch. The project’s overall mission is to cultivate optimal birthing conditions in the United States.

Washington: Home birth is included for Kaiser Permanente (KP) members in Washington! Per KP, “You have several options when choosing a health care provider…. If you want to have your baby at home, a licensed midwife will take care of you during your pregnancy and labor. Licensed midwives … are licensed by the state and have passed both written and oral exams… (and are) specially trained for home births. They provide excellent care and preparation for having your baby at home.”

California: With the support of a grant from California Health Care Foundation, the California Nurse-Midwives Association (CNMA) had a successful annual meeting on October 7 in San Diego. Nearly 70 attendees, including 15 SNMs, enjoyed speakers Donna Emmanuelle, FNP on becoming more politically active; Jean Maunder, CNM on safely rotating the occiput posterior fetus; and Brie Thumm, CNM on the importance of self-care to prevent burn-out/compassion fatigue. Sheri Matteo, CNMA Secretary, shared an update on projects aimed at reducing California’s primary cesarean birth rate. The Maternal Data Center, (part of the California Maternal Quality Collaborative [CMQCC]), now collects both labor and delivering provider data at the 200 enrolled hospitals.

Student Update

The Importance of Taking Time to Reflect

I hope that you had a successful end to the fall semester and got time to enjoy with friends and family over break. And to the December graduates—congratulations and good luck with boards! As I think about my experiences as a student and those of many other students I know, I am reminded of the importance of slowing down and taking time to reflect. We can be so busy with class, clinical, and life responsibilities, it can be hard to process all we are learning. I graduated this past December 2017, and on my final day of clinical, my preceptors gave me a journal so that I could more fully come to understand all that I have learned and experienced as a new midwife. Inside the front cover, they wrote their “pearls” of midwifery for me to take with me into my first job: “Take time to be outside… take care of yourself so that you can care for others… journal through the first year in practice… call a midwife friend when you need to vent or just to ask a question….”

“It is important to have time and space to process the feedback, reflect on clinical experiences, and also to see how far you have come.”

At our ACNM Board meeting several weeks ago, I talked with several midwifery leaders and they offered similar advice: keep a journal and take care of yourself, eat healthfully, exercise, and nurture yourself and your relationships. They stressed that the way we care for ourselves will directly influence the way that we are able to care for the people we serve as a midwives.

Being a student and a new midwife is rewarding in so many ways, but it is also challenging. We are learning and in a state of vulnerability as we receive feedback from preceptors and colleagues. It is important to have time and space to process the feedback, reflect on clinical experiences, and also see how far you have come. I encourage you to take the time and space you need to do this throughout your education and your journey as a new midwife.

By Lillian Medhus, SNM
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Strong work, Region VII. I look forward to connecting with you virtually or in person in 2018.

By Ruth Mielke, CNM, PhD, FACNM, WHNP-BC
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As midwives, we deserve to be knowledgeable about and understand the richness of our history. We must recognize and celebrate the contributions of the midwives of color who paved the way for the development of our profession. Midwifery student education is not isolated to clinical information solely. It also encompasses knowledge that provides the cultural context for midwifery care. Future midwives, if they are to care for women in a culturally appropriate manner, must understand the rich, diverse, multifaceted historical and cultural context for the care that they provide.

A cultural context recognizes diverse identities and histories that are respected, sought, and embraced. Exclusion of this information is damaging to all students. Students of color need to see themselves in the work of midwives who preceded them. White students need to know that midwives of color have always existed and recognize and learn of their contributions to the profession they now seek to enter.

A Motion Consistent with Our Values

For these reasons, at the 2016 Annual Meeting, members passed a motion requesting that the history section of Varney’s Midwifery, our primary midwifery text, be updated to reflect the contributions of midwives of diverse racial and ethnic backgrounds. This motion is consistent with ACNM’s mission, vision, and core values of providing a culture of inclusiveness and one that embraces diverse identities and excellence in midwifery education. It further advances ACNM’s diversification goals as outlined in its 2015–2020 Strategic Plan and the goals of the ACNM Division of Education to establish and update educational resources to facilitate the preparation of midwives.

Through a process that engaged the Varney’s editorial staff and contributors, as well as some members of the Midwives of Color Committee and other ACNM members, Varney’s in its forthcoming edition, will, for the first time, include information on the history of contributions of midwives of color and then transition to the contemporary issue of the importance of workforce diversity.

We eagerly await the upcoming edition of Varney’s Midwifery. The entire midwifery community, midwives, students, educational and service directors, and anyone who believes in health equity will finally be provided with the information they need to understand and care for all of the women and families we serve.

By Patricia O. Loftman, CNM, LM, MS, FACNM
Board of Directors, Midwife of Color, Ex Officio
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63rd ACNM Annual Meeting & Exhibition
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ACNM Volunteer Structure Realignment
Here’s what every member needs to know about our new, improved volunteer structure.
In June 2016, the ACNM Board of Directors established a task force with the charge to “Review the efficiency of the current volunteer structure and how best to meet the needs of the membership and the college as it relates to our strategic priorities.” The charge grew out of conversations with members and the volunteer leadership related to the rollout of ACNM’s strategic plan in 2015. To staff the task force, the board invited members active in the volunteer structure both nationally and locally to participate.

**Identifying Guiding Principles**
As its first step, the task force developed guiding principles to provide a vision for its work based on feedback received during the previous two annual volunteer leadership meetings. Ultimately, the guiding principles the members created specified that any new structure should:

- align with the strategic priorities,
- make it easy for members to become engaged,
- be transparent,
- improve communication between leaders and members,
- be efficient and nimble,
- foster leadership development, and
- provide opportunity for short-term project involvement.

Task force members then undertook a number of activities to inform ourselves as we developed our recommendation. We researched the reasons people volunteer (see sidebar) and the ways other organizations use volunteers. We surveyed our current volunteer leaders and staff about how they see their roles. We reviewed the past two years of board reports to build a picture of how each committee or section relates to the strategic priorities and their current work. We also built a template that identified the role, function, and strategic priority addressed by each committee or section. What became immediately apparent is there were gaps that our current committees and sections were not addressing. The most urgent of these was the need for a State Government Affairs committee, which the board then established early in 2017.

The task force asked the following questions to identify what a new structure might look like:

- How will committees line up under the strategic priorities?
- How will committees interact with one another?
- Will each strategic priority be aligned with a division?

After thoughtful deliberation over many meetings, the task force created a first draft of a new structure and presented it to the volunteer leadership through webinars and again at the annual volunteer leadership meeting in May 2017. After seriously considering feedback from volunteer leadership and the board, the task force made revisions, and presented a final draft to the ACNM board in September 2017. The final draft outlines changes summarized below.

### The Revised Volunteer Structure—Summarized

1. The five strategic priority domains will become the new divisions:
   b. Members Domain -> Division of Membership & Publications.
   c. Global Engagement Domain -> Division of Global Engagement.
   d. Organizational Capacity Domain -> Division of Organizational Capacity.
   e. Advancement of Women’s Health & Midwifery Domain -> Division of Advancement of Midwifery (Divided into two sections Practice and Education).

2. All previous sections and committees will line up under the new divisions and will all be called committees.
3. Changes to existing sections/committees include the following:
   a. Home Birth Committee will become the Home & Birth Center Birth Committee;
   b. D&I Task Force will become the Diversity & Inclusion Committee;
   c. DOE Preceptor Development and Educators sections will join to become the Clinical & Academic Educators Committee;
   d. DOE Education Policy Section will become the Committee for the Advancement of Midwifery Education;
   e. DOE Basic Competency Committee will be retired.

4. Four new committees will be established:
   a. State Governmental Affairs Committee
   b. Affiliate Development & Support Committee
   c. Consumer Engagement Committee
   d. Leadership Development Committee

5. A volunteer leadership group was created to facilitate communication between the divisions. This will include the chairs of each of the divisions and will be chaired by the ACNM vice president.

### Implementation

The goal is to implement the new structure at the Annual Meeting in May 2018. The board has charged Vice President Carol Howe, CNM, DNSc, FACNM, DPNAP, along with key staff members and volunteers, with developing an implementation plan.

By Cathy Collins-Fulea, MSN, CNM, FACNM
Chair, Volunteer Realignment Task Force cfuleal@gmail.com
Pennsylvania: Laying the Groundwork for Robust Engagement and Legislative Change

As an affiliate, Pennsylvania is unique in its revitalization of chapters, development of a new strategic plan, and increased visibility in its state capital.

Pennsylvania, a mostly rural state punctuated by two large cities, Pittsburgh in the west and Philadelphia in the east, is characterized by practices in all settings and three education programs. Some years ago, when the ACNM transitioned to statewide affiliates, the state’s longstanding local chapters disbanded. As our new affiliate found its legs, the board and a Nominating Committee recruited successfully from all parts of the state. The affiliate structure has met the need for organized statewide legislative and lobbying initiatives, efficient fundraising, and linkages with ACNM. This evolution has been an extremely positive development (for example, by providing online CEUs for initial Rx authority renewal, virtual board meetings with membership across the state, and the establishment of both an emergency fund and funds to pay for a lobbyist). However, areas that previously had active chapters lost local engagement.

Rekindling Local Engagement

Several years ago, midwives in the greater Philadelphia area began holding informal meetings about every other month. The gatherings were hosted in the evenings in people’s homes and included potluck refreshments and ample time for socializing. The midwives spent time talking about the needs of the local midwifery community—for more engagement, visibility, support for precepting, and (especially) for more community. Ultimately, attendees decided that re-forming as a local chapter of the state affiliate, in cooperation with the state affiliate, would be the best way to meet the needs of the group.

The Philadelphia chapter based its by-laws on the those of the New York City chapter. (New York is one of several states with a chapter structure.) The chapter collects its dues separately from the affiliate and ACNM national and serves a role that is distinct from and complementary to the state affiliate. Local midwives enjoy gathering to socialize, share information about local events, jobs, and community issues. Liaisons from the chapter participate in affiliate meetings and enable efficient two-way communication.

Initiating Strategic Planning

Simultaneously, the Pennsylvania Affiliate board has been engaged in formal strategic planning to identify a clear mission, vision, and goals that will create an affiliate identity and support engagement and action statewide. Based on two surveys of the membership, board members worked through strategies to dynamically move our affiliate forward. This fall we hosted a two-day board retreat in Chambersburg. Led by members Kate McHugh, CNM, MSN, FACNM and Vicky Ferguson, CNM, MSN, the board delved deep into discussions of achievable priorities to best serve our members. Our member feedback enabled us to identify our strengths and ways we could become more effective. The major goals that grew out of this strategizing include 1) advancing midwifery through advocacy for clear and inclusive state legislation and regulation and 2) demonstrating the great national and local work of ACNM to enhance midwifery and to enrich and engage individual members in professional communities.

“We hope to build member momentum for a full practice authority bill for midwifery.”

In the surveys, our members identified legislative advocacy as an essential affiliate benefit. The Pennsylvania Affiliate has benefited from ACNM’s membership in the US-MERA Task Force, forging relationships with the Pennsylvania NACPM chapter leadership. We have also increased understanding about midwifery with the state organization for nurse practitioners and have had preliminary dialogue with ACOG. Building on these relationships, we drafted language for a modernized midwifery practice act.

Building a Presence

Unfortunately, we found we were stymied by entrenched stereotypes that legislative staffers had about midwives, as well as by their lack of clarity about midwifery as a profession. As a result, we determined the timing wasn’t right and pulled the draft. We are now laying the groundwork by diligently building a midwifery presence in the state capital. Members volunteer with the Legislative Committee from 15 minutes to one hour online and as able. Using a template, members write draft letters about new bills related to women’s health. Committee members review and finalize the letters. Our lobbyist then identifies recipients, adjusts the formatting of the letters, and sends them out on our behalf. Our lobbyist also sends out midwifery-related articles
we find in the press to state legislators. This has resulted in increased visibility, which along with ACNM’s national work with ACOG, has enabled the affiliate to collaborate with the March of Dimes and ACOG on two state bills: the first, establishing a maternal mortality review committee and the second, addressing opioid addiction in pregnancy.

**Momentum for Full Practice Authority**

The Pennsylvania Affiliate’s legislative committee goals for 2017–2018 are to continue a policy presence for midwifery, to establish personal relationships with legislators, and to be recognized as reliable experts. We hope to build member momentum for a full practice authority bill for midwifery as a distinct profession in line with ACNM’s larger strategic vision.

We may be helped by that fact that Pennsylvania nurse practitioners have entered the full practice authority fray, and in January, the Federal Trade Commission (FTC) submitted a letter warning about anticompetitive regulatory practices and the need for attention to the solid track record of independent CNPs. This winter, a house committee, including a key staffer for any future midwifery bill, is holding an information session about written practice agreements in response to the FTC letter. PA ACNM will benefit from the CNPs’ toehold and intends to be next in line to advocate for CNMs and CMs to practice autonomous midwifery as a distinct profession. We hope by participating in formal strategic planning, we have set a solid foundation for our affiliate to support and lead action on the varied professional goals for our membership.

By Dana Perlman, CNM, MSN, FACNM
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**Support Key Legislative Goals by Joining US at the PAC Rally**

As 2018 begins, the Midwives-PAC (Political Action Committee) is busy planning the PAC Rally at the Annual Meeting in Savannah! The PAC Rally is our biggest fundraiser of the year. As always, the Midwives-PAC allocates the money we raise to the campaigns of federal legislators who support midwives, women, and babies. This will be a busy year for the Midwives-PAC as we prepare for the midterm elections in November 2018.

If you are able to attend the Annual Meeting, don’t forget to buy your ticket to the PAC-Rally in Savannah! Tickets are $50 and can be purchased with your ACNM Annual Meeting registration. Celebrate with us and make sure to come home with one of our wonderful silent or live auction items. We will also have a selection of wines available for a donation at our Wine Pull. The rally will be from 4:30 pm-6:30 pm on Wednesday, May 23, just prior to the awards dinner and ceremony.

**Our Success is Your Success**

We need you, the ACNM membership, to help us make the 2018 PAC Rally a success! You can do so by donating items to the Midwives-PAC for our silent and live auctions. We are looking for items of all values, anything from a cute $5 name badge clip to a week at your family’s vacation home. If you have something you would like to donate, please email Amy Kohl at akohl@acnm.org.

**Moving Forward**

This fall, we wrapped up a successful ACNM Affiliate Fundraiser and Student PAC-athon! Thank you to all who participated and donated. We raised more than $10,000! We’ve also been keeping an eye on Washington, D.C. Congress has now extended funding for the Children’s Health Insurance Program (CHIP). We are moving forward on the Maternity Care Shortage Act and working with ACOG on legislation allowing midwives to treat women with opioid addiction. We are also in the process of updating the Midwives-PAC website with an eye toward making our work more transparent to ACNM members.

We are excited to see you at the PAC-Rally in Savannah on May 23! The Midwives-PAC is dedicated to raising your voices as midwives in Washington, DC in 2018.

By Claire Harper, CNM
Secretary, ACNM Midwives-PAC
ecmharper@gmail.com
Join us at the 63rd ACNM Annual Meeting & Exhibition, and you’ll enjoy endless networking, fun events and activities, and cutting edge exhibitions. You’ll also find education sessions and workshops geared to every interest.

PROMOTING MIDWIFERY

- Promoting Physiologic Birth and Midwifery through Social Media
- AIM Bundles are Being Implemented Nationwide & Midwives Must Be Involved!
- Benchmarking 101—Just do it!
- Beyond Benchmarking: Using Benchmarking Data to Drive Practice and Quality Improvement

ENHANCING YOUR SKILLS

- Diagnosis and Management of Sexual Pain in Women: An Innovative Collaboration Between a Midwife and a Physical Therapist
- You, Too, Can Perform Manual Rotation of the OT or OP Fetus in Labor!
- Increasing Access to Immediate Postpartum LARC: Clinical Update, Systems Solutions, and Hands-On IUD Insertion Training
- Elective Newborn Circumcision: Skills for Nurse-Midwives*
- Perineal Repair Update: A Suturing Workshop*
- High and Dry: Pessary Fitting 101*

ENCOURAGING A HEALTHY START

- Effects of Toxic Stress on Early Brain Development
- Providing Informed Individual Choices for Prenatal Screening & Diagnostic Testing: Maintaining a Shared Decision-Making Process
- Let’s Talk about Vaccines!
- Quality Improvement to Promote High-Quality Maternity Care & Physiologic Birth
- Stemming the Tide of Congenital Syphilis: The Role of Nurse, Midwifery in Prevention and Treatment

WORLD CARE

- “I was Satisfied with the Care Because They Didn’t Beat Me”: A Panel Discussion on Respectful Maternity Care and Mistreatment of Women in Childbirth around the Globe
- Being Effective In Global Midwifery: Addressing Power and Cultural Bias to Build Bidirectional and Reciprocal Relationships for Learning
- International Disaster Response for Midwives: The Nuts and Bolts

*Workshops
INNOVATION AND CUTTING-EDGE APPROACHES

- An Optimal Approach: Midwifery Care for Women with Pregnancies Complicated by Life Limiting Anomalies or Fetal Losses
- How Integrated Birthing Centers will Shape the Future of US Maternity Care
- Applying the Triple Risk Model to Stillbirth
- Creating Low Stakes Simulations to Identify Learning Challenges and Optimize Care in High Stakes Settings
- An Update of Shared Decision-Making in Midwifery Care

EQUITY, DIVERSITY, AND INCLUSION

- Tools and Examples for Promoting Equity in Midwifery Education and Training: Towards Meaningful Diversity and Inclusion
- Curriculum Tools for Discussing Race and Racism in Midwifery
- Our Power Within: Contemplative Practices Reduce Racism and Bias
- Beyond Transgender 101: Moving from Provider Shock toward Provider Competence
- Woman-Centered Contraceptive Care for Vulnerable Populations
- Fulfilling the Commitments of ACNM: Changing the Face of Midwifery
- Teaching Students to Care about Cultural Humility and Social Justice: What Does it Take?
- Stillbirth and Perinatal Loss from a Reproductive Justice Paradigm

WORK-LIFE BALANCE

- Who’s Caring for the Midwife? Compassion and Caregiver Fatigue in the Setting of Secondary Traumatic Stress
- Stress and the American Midwife: Causes, Impacts and Solutions
- The Midwife in the Second Half of Life

EQUITY, DIVERSITY, AND INCLUSION

- Tools and Examples for Promoting Equity in Midwifery Education and Training: Towards Meaningful Diversity and Inclusion
- Curriculum Tools for Discussing Race and Racism in Midwifery
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TEACHING AND BEYOND

- Diving for Pearls: ACNM
- Beyond Teaching: The Important Role of PhD-Prepared Midwives in Women’s Health Research and Practice
- Simulation as an Objective Teaching Strategy to Develop Competence in Midwifery Students
- Mentoring Midwives: ACNM-ACOG Maternity Care Education and Practice Redesign: an Interprofessional Education Project
- How to Make Precepting Work for You—Innovative Models for Educating Students

COMPLEMENTARY CARE

- Acupressure in Labor
- Scents and Sensibility: Clinical Aromatherapy in Midwifery Practice*
- Bugs Not Drugs: Selecting Probiotic Bacteria to Meet Client Needs

SHIFTING THE PARADIGM

- Pregnant at Work: Time for Prenatal Care Providers to Act
- Integrative Midwifery for the Underserved
- What’s New in Bacterial Vaginosis Diagnosis and Treatment?
- Amniotic Fluid Lactate Monitoring: A Novel Approach to Labor Dystocia Diagnosis and Management
- Clinical Strategies for Addressing Maternal Obesity
- A Meta-Analysis of the Neonatal Outcomes of Waterbirth
- Neonate Fecal Microbiota Following Home or Hospital Delivery
- There is No Such Thing as Cord Blood: Shifting the Paradigm
- Reducing Recurrent Preterm Birth: Predictive & Preventative Strategies for Midwifery
- Induction of Labor: Are you Choosing the Best Techniques and Medications for Success? A Review of New Evidence
- Preeclampsia Primer: What’s Old, What’s New, and “Must-Knows”

HOT TOPICS

- The Heroin and Opioid Crisis: Lessons for Nurse-Midwives
- Pregnancy-Associated Stroke: Incidence, Outcomes, and Treatment
- Cultural & Historical Complexities of Breastfeeding in the African American Community
- Peripartum Cardiomyopathy: A Women’s Healthcare Provider’s Guide to Identifying Risk and Distinguishing Symptoms
- Opioid Use in Pregnancy: Structuring Care to Improve Outcomes for Mothers
- Refugee Women’s Health Care
- Beyond The Pink Pill: A Step-wise Approach to Female Sexual Interest/Arousal Disorders

BEYOND THE HOSPITAL

- AABC Strong Start: Freestanding Birth Centers Serving Vulnerable Populations
- Interprofessional Communication and Collaboration during Emergent Birth Center Transfers: A Quality Improvement Pilot Project
- A Tale of Two Births: Newborn Resuscitation and the Use of CPAP in the Out-of-Hospital Setting

ADDRESSING PROFESSIONAL CHALLENGES

- Nuts and Bolts of Legislation: Updates and Action
- Collaboration across the Continuum: Safe and Collegial Transfer of Women from Community Setting to Hospital
- We’re All In This Together: A Unique Approach to Interprofessional Education on Labor and Delivery
- Conflicts of Conscience: The Midwife’s Professional Role and Personal Responsibility
- Lessons Learned by the Organizers of the Massachusetts Midwives Summit; the Who, What, Where, When, Why, and How to Convene a Successful Summit
- What Happens After You Are Named in A Lawsuit?
5 Easy Ways to “Get Global” at the ACNM Annual Meeting

Curious about midwifery in global and refugee health settings? Take time at this year’s Annual Meeting to discover what it means to work globally or with diverse communities at home.

The ACNM Division of Global Health (DGH) offers five ways that midwives and midwifery students can meet experts, learn about other midwives’ global or refugee work, and hear innovative ideas about this area at the 2018 ACNM Annual Meeting in Savannah, Georgia.

1. **Education Sessions:** Learn about the competencies that midwives need to work effectively in the global arena, the latest on global health clinical hot topics, midwifery response to disasters, and other global health topics. These presentations, panels, and workshops will be identified as “Global Health” tracks on the website, app, and printed program.

2. **Posters:** By visiting the poster sessions, you can hear from and talk to midwives about their specific projects, including several in regions in Central America and Africa. Discussing the details about their work with midwives and communities in Guatemala and Ethiopia, among others, may inspire your own plans.

3. **Reception:** Join us at the DGH Reception on the evening of Monday, May 21, 2018. (Be sure to purchase your ticket to this event when you register for the Annual Meeting!) This is your chance to rub elbows with globally experienced midwives. You can also talk with representatives of several global health organizations that are seeking midwives.

4. **Silent Auction & Raffle:** Go home with a treasure from the DGH Silent Auction & Raffle. Each year, midwives donate beautiful items, including clothing, jewelry, and art from around the world. Items are priced to accommodate everyone’s budget and the fund supports the travel of the ACNM Pederson Award Winner, a midwife from a developing country or a midwifery student in an ACME-accredited program who has demonstrated leadership and vision.

5. **Join DGH:** Become part of the Division of Global Health and one of the DGH Sections (Communication, Education and Networking). Talk with DGH leaders to learn more about joining.

Come join ACNM’s Division of Global Health at the 2018 Annual Meeting to learn about this exciting division and area of midwifery work.

By the Division of Global Health
Sex positivity is a framework that affirms safe, consensual, and pleasurable sexual experiences as healthy behavior and holistically beneficial. Through this framework, all sexualities, relationships, and experiences are acknowledged and supported. Within the three essential components of safety, consent, and pleasure, sex is not shameful, and people who engage in it are not themselves to be shamed. The lens of sex positivity supports comprehensive, evidence-based, and non-judgmental sexual health education; values people’s agency in determining their own sex lives; and affirms all genders, expressions, orientations, and partner statuses. Finally, sex positivity fully acknowledges that sex can be hurtful or traumatic.

Shifting from a Risk-based Model
Traditionally, sexual health providers engage clinically with clients through a risk-based model focused on infections or pregnancy. The sex-positive framework includes risk (in the pillars of safety and consent), but also addresses the positive side of sexual health. If a client desires to discuss their sex lives, clinicians support discussion related to sexual health and wellness that is self-defined. They are also open to topics such as sexual goals, personal exploration, orgasms, desire, and partner communication.

To be able to best apply a sex-positive framework in a society where sex is shamed, secret, or devalued (or all three!). Value clarification exercises (bit.ly/2sg2S3e) can aid clinicians in addressing known and unknown personal biases that may impact the care they provide. Such exercises encourage people to fully acknowledge their own belief systems so they can avoid having their personal biases impact appropriate clinical care. Sex positive clinicians acknowledge and work intentionally to break down the assumptions we make about our clients: Our clients are not all heterosexual, they and their partners are not necessarily cis-gendered, monogamous, not all have (at all, or solely) penile-vaginal insertive sex, not everyone has a relationship where sex is negotiable or consensual, and clients of all ages and stages of life have sex that can be safe, consensual, and pleasurable.

Providing a “Safe Space”
Clinicians often discuss the desire to provide a “safe space” for people, and finding ways to become a sex-positive clinician is one way to do so. When it comes to discussing people’s sex lives, and how this facet of their lives impacts their holistic, physical, and mental health and well-being, creating a safe space means providing nonjudgmental and inclusive clinical care. Additionally, sexual health support must always and absolutely be trauma-informed. Knowing that most women have experienced sexual trauma in their lives, and that assault occurs more often in queer and LGBT communities, means the majority of people in our care likely have trauma in their past. Bringing up conversations about sex may trigger anxiety or traumatic feelings for individuals, despite any attempt to make the conversation positive or safe. Take their lead as in any other circumstance.

A Gateway to Conversation
There are many ways to begin a conversation with patients using a sex positive statement. Examples include, “Many of my patients ask about topics such as orgasms, anal sex, consent, and multiple partners. If you have any questions about topics like these, I’m here for you,” or, “This is a safe space to talk about all things related to sex and sexual health. I’ll take your lead if you’d ever like to discuss those topics.” If a patient asks follow-up questions, next statements could be, “What kinds of sex are you having?” “Tell me about your sexual partners” or, “How are your orgasms?” Open-ended questions can be a gateway to gratifying discussions that address all aspects of a person’s sexual health.

If you are already taking opportunities to be a sex-positive clinician, spread the good news about what works in your practice. Not every clinician is ready to discuss what patients may bring up. Different kinds of sex toys and lubes, review of safe anal sex practices, or considerations of multiple relationship or sexual encounter scenarios may lead clinicians to recommend referrals or additional resources. Making the space to discuss the topics clients bring up and not shaming them is what makes a safe space and a sex-positive provider. The key is to start the conversation and create the space where talking about sex becomes a routine part of gynecologic and obstetric care.

By Stephanie Tillman, CNM, MSN
ACNM Secretary
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Impacting the Opioid Crisis: Midwives on the Frontlines

As our survey shows, CMs and CNMs are facing new responsibilities as opioid use among pregnant women continues to climb. The bottom line? Increasing access to care.

Late last October, President Trump declared the opioid epidemic that has swept the United States to be a national public health emergency. It is also a maternal and infant health crisis, as many state maternal mortality review boards have identified substance use as a major risk factor for pregnancy-associated deaths. Chronic, untreated heroin use during pregnancy is associated with fetal growth restriction, placental abruption, pre-term labor, and fetal death. Untreated addiction is also associated with many high-risk social behaviors, including prostitution, trading sex for drugs, and criminal activity—behaviors that expose expectant mothers to STIs and violence, and that often result in legal consequences including incarceration and loss of child custody. The National Institute on Drug Abuse states that a multidisciplinary approach to treatment combining medication-assisted therapy (MAT) with counseling services can mitigate negative health consequences and reduce high-risk behavior. Yet, only 20% of people with opioid use disorder receive treatment for their addiction, according to researchers at the Johns Hopkins School of Public Health, despite the known benefits.

Limited Access to Treatment

According to ACOG, opioid use disorder is a “chronic, treatable disease” best managed through a combination of medications—such as methadone or buprenorphine—with behavioral therapy and recovery support. Unfortunately, women in many communities, especially in rural areas, do not have access to an adequate treatment program. Opioid replacement therapy, also known as medication-assisted treatment (MAT), is only available at special methadone clinics certified by the Substance Abuse and Mental Health Services Association (SAMHSA), or by prescription from specially trained providers.

Methadone is an opioid agonist, and treatment requires the patient to make daily trips to a clinic to obtain a dose of medication that will control their craving and withdrawal symptoms for 24 hours. Buprenorphine is a partial agonist used in MAT under the brand name Subutex or combined with naltrexone and sold as Suboxone or Zubsolv. The addition of naltrexone limits the high that can be experienced...
with the drug, reducing abuse potential. Buprenorphine does not always require daily dosing, but is tightly controlled by SAMHSA. Until recently, only physicians were eligible to obtain a waiver to prescribe buprenorphine and were limited in the number of patients they could treat at one time. Last year, through the Comprehensive Addiction and Recovery Act (CARA), this number was expanded from 100 to 275. CARA also grants waiver privileges to nurse practitioners and physician assistants for a preliminary period of five years. CMs and CNMs were not named specifically in this legislation. Therefore, at this time, they are eligible to obtain a buprenorphine waiver only in states where they are licensed as nurse practitioners.

**Supporting a Healthy Transition**

Pregnancy is often a motivation for behavior change, and pregnant women struggling with addiction should be connected to evidence-based treatment programs that will support a healthy transition away from non-prescription opioid and heroin use. This process begins at the first prenatal visit with universal screening for opioid abuse using a validated instrument. ACOG and SAMHSA recommend the SBIRT approach—Screening, Brief Intervention, and, importantly, a Referral to Treatment. Abrupt or medically supervised withdrawal is not recommended during pregnancy due to the high rate of relapse associated with this approach. Additionally, the postpartum period is a highly vulnerable time period where relapse is more likely to occur.

“Fifty-eight percent of ACNM midwives surveyed report caring for women suffering from opioid addiction.”

CMs and CNMs are uniquely positioned to increase the number of women who access treatment services. Midwives attend 8% of births in the United States, and in a recent survey of the ACNM membership, 58% of respondents reported caring for women suffering from opioid addiction, with 26% providing care for these mothers at least monthly. The survey, which was administered via e-mail over three phases throughout 2017 as a joint project between the ACNM leadership and Public Health Caucus, was a pilot study about the relationship between CMs and CNMs and the opioid crisis. Fifty-seven percent of more than 500 respondents reported an interest in caring for women with opioid addiction, citing continuity of care, ensuring access to services, and minimizing the stigma of seeking treatment through midwifery care instead of drug treatment centers as motivating factors. The most frequently cited reasons for not caring for women with opioid addiction included time constraints, the perception of burdensome complex care, and not obtaining or maintaining a Drug Enforcement Administration (DEA) number. Those respondents with a current DEA number noted they were more likely to incorporate MAT into their practice in the future. The results also indicated that if provided with the training and appropriate resources, 45% of all CMs and CNMs would probably or definitely be likely to incorporate buprenorphine training into their practice, if given the opportunity.

**Increasing Education Opportunities**

In terms of opioid prescribing patterns, 68% of CMs and CNMs reported currently prescribing opioid medication for acute pain control. The most frequent reason for prescribing was intrapartum or post cesarean pain management. Forty percent of respondents received training specific to opioid prescribing during their midwifery program, with 32% receiving post-licensure training at a conference or via a self-study module. Despite this variation in training, more than half of the respondents reported feeling average confidence to being very confident in prescribing opioids. Determining confidence level is important because it positively correlates with frequency of prescribing opioids for acute pain relief. The findings of this preliminary pilot study suggest that increased education and training opportunities specific to opioid prescribing and MAT may increase the confidence level of CMs and CNMs in both prescribing opioids and treating women suffering from addiction, thereby increasing access to care.

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**Update on Buprenorphine Prescribing Legislation**

Interested CNMs hoping to gain buprenorphine prescribing privileges may soon be able to. On September 7, 2017, Ben Ray Lujan (D-NM) and Paul Tonko (D-NY) introduced the Addiction Treatment Access Improvement Act (H.R. 3692), into the House of Representatives and bipartisan companion legislation, S. 2317, was introduced in the Senate in January by Senators Markey (D-MA), Hassan (D-NH), Paul (R-KY) and Baldwin (D-WI). The act expands the recent CARA legislation by permitting CNMs to prescribe buprenorphine medication-assisted treatment in states where they have the authority to prescribe Schedule II drugs. The legislation would also allow non-physician providers to gain waiver privileges permanently, eliminating the five-year preliminary period outlined in CARA, and strengthen the regulation allowing qualified providers to treat as many as 275 patients. The bill is currently in committee and seeking co-sponsors. It is scheduled to be “fast tracked” to address the opioid crisis.
On Your Marks, Get Set, Benchmark!

Now is the time to submit your 2017 data—for even six basic items. Your participation helps yourself, all midwifery practices, and our profession by tracking our contributions to quality care.

It’s that time of year again: time to submit your practice data to the ACNM Benchmarking Project. The online survey opened February 1, 2018, and the deadline for midwives to submit their 2017 practice data is March 15, 2018. The ACNM Benchmarking Project is a unique benefit that provides ACNM members with the ability to track their practice data in an appealing visual display. The ability to monitor practice data is an essential step to improving quality in midwifery care. In addition to providing the opportunity to track practice level data, ACNM Benchmarking offers the ability to compare your practice data to practices of similar size and characteristics. The metrics included in the ACNM Benchmarking Project provide participating practices with a national snapshot of quality metrics sensitive to perinatal outcomes.

How to Get Started

If you are new to benchmarking, or intended to participate but are now short on time, all you need to do to participate in this cycle is to submit 2017 data for six mandatory survey items. To get started, you simply need the answers to these questions:

1. Total number of vaginal births,
2. Number of primary cesarean births,
3. Number of repeat cesarean births,
4. Number of CNM/CM full-time equivalents (FTEs),
5. Your practice name and mailing address,
6. Your contact name, phone number, and email address.

Chances are that your practice has even more data to share, so download the ACNM Benchmarking Project Information Packet (bit.ly/benchmark17), answer the required six survey items and any others you have complete data for. Downloading the packet also helps you set up your data collection for 2018.

Although participation is voluntary, your robust participation benefits all practices and provides important data on the contribution of midwifery care to perinatal quality measures. Practices with excellent outcomes or those that meet or exceed accepted national perinatal quality benchmarks, are listed on the ACNM Benchmarking website. They also receive an honorary certificate of their practice achievements. These commendations are great for media releases. What’s more, the ability to share your practice’s quality outcomes can be a power tool in a health care environment that increasingly demands that providers document the quality of care they deliver. The ACNM Benchmarking Project is ready to help you showcase your practice and provide a platform for quality improvement.

Questions?
We’re here to help. Contact Karen Perdion kperdion@ucsd.edu or Molly MacMorris-Adix mmacadix@gmail.com.

By Cathy Emeis, CNM
Chair, Quality Section
emeisc@ohsu.edu

Karen Perdion, CNM
Chair, Benchmarking Committee
kperdion@ucsd.edu

Highlights from ACNM’s Latest Benchmarking Survey

Here are averages for all benchmarking participants for 2016—a total of 276 practices. See all of the results at www.midwife.org/Benchmarking-Project-Results, along with information about best practices.

15.6% NTSV Birth
(Nulliparous, Term, Singleton, Vertex)

9.3% Primary Cesarean

80.5% VBAC Success

3.6% Preterm Birth
(37 Weeks)

85.3% Breastfeeding Initiation
(Exclusively Breastfed for first 48 hours of Life)
This year marks the 100th anniversary of the 1918 influenza pandemic, one of the deadliest in recorded history. Nicknamed the “mother” of all pandemics, it caused the deaths of between 20 million and 50 million people worldwide, largely killing young adults from secondary bacterial pneumonia.

A pandemic is a worldwide outbreak of influenza that typically develops when a new strain of the flu virus reaches populations with limited previous exposure and limited immunity. The most recent pandemic, in 2009, was caused by the H1N1 virus, and left more than 12,000 people dead. In the 20th century, pandemics have occurred in 1918, 1957, and 1968. Each involved a different specific strain of influenza type A (H1N1, H2N2 and H3N2, respectively), and each involved a different population. (The influenza virus is classified into families of viruses including type A, type B and C. Types A and B are the ones that usually cause flu outbreaks, and each one is broken down into sub categories of different strains of the virus.)

Unprotected by Exposure
In 1996, researchers determined that the H1N1 strain caused the pandemic of 1918 by conducting forensic RNA PCR research on formalin samples collected from US servicemen who had died in the outbreak. A descendent of the 1918 H1N1 virus has circulated since then and has caused disease for decades, but scientists have not been able to determine why the virus that year was so deadly. They theorize, however, that the predominate strain of the flu that circulated from 1880 to 1900, during the formative years of young adults in 1918, was H3N8. This left the cohort without antibodies to H1N1.

The lesson here is that our immunity is based on our collective antibody response. The more often we are exposed to a wide variety of antigens, the more broadly we are protected. Making sure we get vaccinated every year increases this spectrum of antibodies.

Predicting Next Year’s Strains
The influenza season typically runs from autumn until spring, with peak activity in December, January, and February. When preparing the composition of the vaccine for each influenza season, the Centers for Disease Control and Prevention, along with the World Health Organization, attempt to predict the strains of influenza that will be circulating. Based on these predictions, manufacturers change the composition of the vaccine slightly annually. The vaccine is more or less effective each year based on the accuracy of the CDC and WHO predictions, as well as the ever-changing mutations, known as antigenic drift, of the circulating strains of flu virus. For example, this year’s vaccine is proving to be less effective than in recent previous years.

The CDC Advisory Committee on Immunization Practice recommends everyone over the age of 6 months receive the flu vaccine annually. The morbidity and mortality of influenza varies each year, as does the number of cases, but it is more dangerous in the very young and the very elderly. Even with a less-than-perfect match between the vaccine and the circulating strains of the flu, having been vaccinated reduces the chance of developing complications such as pneumonia. The CDC recommends pregnant women are vaccinated anytime during pregnancy with any licensed available inactivated flu vaccine. Although the effectiveness varies from year to year, and may not always be a good match, it is still recommended that everyone get vaccinated every year.

By Carol E Hayes, CNM, MN, MPH
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Mental Health and Illness: Building Midwifery Knowledge

Women face heightened risk of mental illness, especially during pregnancy and the postpartum period. Midwives are uniquely positioned to help.

Some years ago, I cared for a confident, married woman in her twenties. Her first pregnancy brought her a healthy baby girl via a midwifery-attended birth. Within weeks of delivery, she became overwhelmed with guilt about perceived parenting inadequacies. Her sleep grew fragmented and she worried ceaselessly. Panic, anxiety, and depression darkened the backdrop of her transition to motherhood.

During this period, I cared for another woman who had transferred into our practice mid-pregnancy, reporting a history of anxiety and depression along with a distant bipolar diagnosis. She had no psychiatric symptoms when I met her. However, toward the end of her pregnancy, she became hyper during prenatal visits, speaking rapidly and fidgeting. Within days of delivery, she stopped sleeping altogether and called after hours with generalized paranoia and bizarre interpretations of her infant’s behavior.

Facing a Knowledge Gap

In recalling these scenarios from 10 years of full-scope practice, I revisit the bewilderment I felt as a new midwife, eager yet underprepared to assist women with common and complex psychiatric symptoms. My tools for screening and diagnosis were minimal, and my resources for helping—education, treatment, or referral—felt inadequate.

Through experience, research, and additional education, I learned that more than 20% of reproductive-age women suffer from mental illness at some point between adolescence and menopause. In fact, with the onset of puberty, the percentage of women with major depression jumps from between 5% and 7% up to 10%. This heightened risk persists through menopause. What’s more, the percentage itself increases dramatically during pregnancy and postpartum with 15% to 20% of women becoming clinically depressed.

“Additional training can increase our feelings of confidence and competence when caring for distressed women.”

Obsessive-compulsive disorder (OCD) also spikes in frequency and severity during pregnancy and the postpartum period. Anxiety-spectrum disorders, including generalized anxiety and panic, impact women more than men at a ratio of 2:1. Complicated psychiatric conditions including bipolar and psychotic disorders, while less common, confer perhaps, the greatest risks on women and families—especially during the years of pregnancy and lactation when women face ensuing challenges related to sleep deprivation and parenting. In fact, the highest lifetime risks of suicide and psychiatric hospitalization for women occur during the postpartum year. These increases in morbidity and mortality are often due to bipolar or other psychotic disorders, including psychotic depression, all of which present as emergencies and require immediate recognition by health care providers.

Impacting Children and Vulnerable Populations

Not surprisingly, psychiatric illness in pregnant and parenting women may impact their offspring. For example, women with gestational depression are more likely to deliver preterm and have infants with poor health that stretches across childhood and into adolescence. What’s more, the worst outcomes related to maternal mental illness disproportionately impact those women and children who are most vulnerable in our society—immigrants, people of color, teens, and those living in under-resourced areas. The more I learned about mental illness in women and mothers, the more concerned I became.

Fortunately, detection of symptoms, along with treatment to remission, mitigates many of the harms associated with psychiatric illness during the reproductive years. Since women prefer to receive much of their health care from their midwife while shortages of psychiatric clinicians exist in every community, we are uniquely positioned to utilize our full-scope practice to screen, assess, diagnose, and treat women with common psychiatric presentations. With training, we can also learn to recognize and refer those women with bipolar, psychotic, and other complex disorders requiring management by specialists. Additional training can increase our feelings of confidence and competence when caring for distressed women, reducing our job-related stress, and improving our resilience as midwives.

Challenging Midwives to Lead

Both within our profession and beyond it, there is a growing appreciation of the role of midwives in addressing the suffering and health consequences that accompany mental illness. In 2014, one of the most frequently read articles in the Journal of Midwifery & Women’s Health was an editorial by midwifery leader and journal Editor-in-Chief Frances E. Likis, DrPh, NP, FACNM, FAAN. In this piece, entitled “Mental Illness: My Personal Experience, Our Professional Responsibility,” Frances challenges midwives to lead by taking decisive action in their practice of midwifery to reduce stigma and improve outcomes for women who suffer from psychiatric illness.

Having earned a post-master’s certificate in 2011 to become a psychiatric mental health nurse practitioner (PMHNP), I had been working as a women’s mental health specialist offering psychotherapy and psychotropic medication management to reproductive-age women with psychiatric illness when I read the article. I felt called to merge my midwifery and psychiatric experience to support midwives in their most holistic care of women. Dr. Likis’ decision to reveal her own
challenges in the service of women everywhere moved clinicians from many fields to respond to her editorial with support, and it propelled me further toward my goal of addressing the mental health knowledge gap within midwifery.

Beginning the spring after her editorial was published, I filled my nights and weekends with home-stretch research, eventually designing a course to provide what I had wished for when I was practicing midwifery. This effort has now culminated in live and web-based continuing education trainings created specifically for midwives. My goal is to shore up the knowledge gap regarding evaluation and management skills for psychiatric illness, within our midwifery scope of practice. (To learn more, see sidebar.) My hope is my effort contributes in a small way toward my ultimate wish for our profession: that we provide the most holistic care of women—*for body and mind*—within our scope of practice, to be “with women” to the greatest extent possible, across the many cycles of life.

By Adria Goodness, MN, CNM, PMHNP-BC
Founder, Life Cycle Health and Education
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Stepping Up after Hurricane Marie

After experiencing life in the wake of Superstorm Sandy, one nurse-midwife felt called to provide relief on St. Thomas.

Fall 2012 was a very emotional time in my life because my mother had just died after being in hospice for nine months. Then Superstorm Sandy hit the Jersey Shore. It flooded the first floor of my home, and there was devastation everywhere. People were living in their flooded homes without electricity and water. The basic resource for drinking, washing, flushing toilets (!) was not at your fingertips. I was lucky enough to supported by my group of collaborative physicians, friends who were not hit by Sandy who lived further inland, and volunteers from so many organizations. On an island, where do you find that help!? Where can you drive to?! Everywhere you go there is no electricity, no open stores, and total darkness at night except for your generator, which has limited capability.

The Urge to Help
After going through Sandy, when hurricanes Harvey and Marie hit, I wanted to help. Plus, I’d always felt an urge to do relief work in my capacity as a midwife. Then our affiliate sent out a request from New Jersey Medical Emergency Medical Services and the New Jersey Hospital Association for volunteers for a medical relief mission to the US Virgin Islands. The staff at the only hospital serving St. John and St. Thomas—Schneider Regional Medical Center—had been working nonstop. They wanted to spend the Christmas holidays with their families. Helping felt more important than being home, and once again, my employer was very supportive.

I went to St. Thomas with three emergency room nurses. We shared rooms on a small “cruise” ship that FEMA had commandeered to provide housing for relief workers. We had clean sheets, food. I never felt unsafe; that definitely wasn’t a concern. I give a lot of credit to groups like Doctors without Borders that take care of people in dangerous places. We worked 12-hour shifts over 14 days (with days off). I was on the third-floor maternity unit. There was leaking into the maternity unit because the windows on the fourth floor were all blown out from the winds of Irma and the rain of Marie. The operating room attached to Labor and Delivery was totally shut down because of flooding from the fourth floor.

Positive Attitudes
Basically, I acted as laborist, as I triaged both private and service moms-to-be. The staffing was surprising because it was a midwife and an RN who staffed the unit, and, occasionally, an obstetrical tech. Typically, the hospital, a federally funded facility, has midwives who travel to three clinical sites that are serviced by midwives. Unfortunately, that isn’t happening now, because the housing has been damaged throughout the island. On a busy day, you could have the five labor rooms that are still functional occupied with labor, birth, antenatal high risk, and post-

The healthy birth of her second child is a joy, even when flooding has left this mom and her family displaced.

"On an island, where do you find that help!? Where can you drive to?"
partum complications. That is quite an overwhelming responsibility for the staff. The nursing staff and midwives do such an amazing job with such positive attitudes.

"Most of the staff were at 100, 101, or 102 days without electricity."

There were many stories of property damage from winds, loss of homes from flooding, damage to boats (which are many people’s livelihood) that caused post-traumatic stress disorder. When I arrived for my first shift on December 15, the staff was comparing days without electricity. Most of the staff physicians, nurses, tech, secretaries were at 100, 101, or 102 days without electricity. Many residents had generators, but imagining more than three months without being able to turn on a light with the flip of a switch.

Putting Life in Perspective

I was glad I was able to go, but you feel sad nonetheless about what the people there are going through. The majority of people in the mainland don’t realize the devastation that happened in the US Virgin Islands. Most of the media coverage was about Houston and Puerto Rico. Our government, through the Federal Emergency Management Agency (FEMA), is working hard to help the islanders secure housing. FEMA workers go to these areas, help people navigate the system, and give them shelter and food. It can get very complicated for these workers to make the appropriate allocation of funds. There also was a large group of young volunteers from AmeriCorps and Helping Hands, but the people need their tourism back. The suffering that happens when someone goes through a 150-mph hurricane and is off the grid for over three months puts in perspective our little daily frustrations. It’s a reminder to remember the important things in life.

By Barbara B. Lutz, CNM
Private clinician
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Share with Women Patient Education Handouts: New Topics and Redesigned Website

The Journal of Midwifery & Women’s Health (JMWH) and ACNM have recently launched redesigned access to the Share with Women patient education handouts found at www.ShareWithWomen.org. The handouts are now hosted on the Our Moment of Truth website for increased patient access. We have updated and expanded the handout categories as well as created a separate page for each category where anyone can download the relevant handouts. On the category pages, the handouts that are available in Spanish are marked with an asterisk. There is a separate page that has all of the Spanish-language handouts together. We hope this redesign will make it easier to find the specific handouts midwives and women want to use.

A full list of the Share with Women categories can be found in the box (right). We recently added a mental health category. Additionally, the November/December 2017 JWMH theme issue: Mental Health: Illness and Wellness includes four new handouts related to mental health. The titles of these handouts are “Posttraumatic Stress Disorder and Its Effects on Pregnancy and Mothering,” “Depression During Pregnancy,” “Intimate Partner Abuse,” and “Therapy: Counseling for Mental Health and Illness.” Additionally, the July/August 2017 issue contained the handout “Resilience: Bouncing Back from Hard Times,” which is relevant to mental health promotion.

There are now more than 100 Share with Women handouts available covering a wide variety of topics. As always, the Share with Women handouts may be copied and shared with your patients. They are publicly available for download via www.ShareWithWomen.org if you want to share that URL with patients. This offers consumers a robust collection of midwife-authored health information. We hope you’ll find the Share with Women collection and website valuable and use the handouts often. Please send any feedback about the handouts or website to jmwh@acnm.org.

By Brittany Swett
Managing Editor, JMW
JMWH@acnm.org
Welcome to our column by and for preceptors (and for midwives considering precepting). Please think of it as your forum for sharing expertise, ideas, questions, and concerns.

This edition’s question elicited a great response. Thank you to everyone who contributed!

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?

A: I would meet with her prior to beginning the preceptorship and ask her if she has any concerns and what cultural influences she has identified that might impact her learning or practice. Beginning the precepting relationship on a foundation of open, honest communication and respect will go a long way toward minimizing conflicts or misunderstandings. You could also suggest a plan for how your student can handle an issue if it arises and discuss appropriate times to bring up any concerns.

A: Rule 1: Make No Assumptions. Don’t assume a level of comfort, familiarity, or knowledge. When the preceptor and student meet, it should be in a safe place and there should be an open level of conversation about expectations on both sides.

Rule 2: Think before you speak or act (unless there is an obvious danger). Remember there are often many adequate ways to accomplish the goals before you. I sit in front of a birthing woman. My students often stand. One preceptor might be all about hand maneuvers and another is about letting the mom do whatever. Is one way more right than another?

Rule 3: The person is the expert on his or her own culture. Communicate. Suppose that you have a belief that all members of X group behave in Y way, and in front of you is a member of X group who doesn’t behave in Y way. Who is in error here? I have been a preceptor for years and have had dozens of students and each was a universe into his or her self.

A: Do it the same way we deal with our patients every single day, with respect, understanding, and acceptance, enhanced by open and straightforward communication and questions. Our students should be coming to us with those qualities too (since they are going to be midwives). Asking questions and seeking information in a sensitive manner are critical elements to interview skills and showing a caring attitude in everything we do.

A: What does it mean to be culturally competent? This is an important question that providers need to be asking themselves in order to not only provide culturally competent care, but also to be able to have an effective professional relationship with health care professionals from different cultures.... We can best support our students in cultural competence by leaning on the principles of bioethics. We can discuss our own professional challenges about how certain patients or situations have challenged our own moral agency. Serving as a preceptor holds ethical weight just as does caring for a patient. Regardless of who our students are, the focus must remain on the patient, on the learning, and on the professional growth.

A: Precepting for years has shown me no two students are alike. Just as siblings are related, but different, similarly, students and preceptors are related by their desire to help women, but different in many respects. Start on common ground with common goals and interests. Then, be respectful and curious: “Tell me about...,” “What are your thoughts about...,” “How do you think women might react or respond to...” Capitalize on and encourage honest responses. Try to remain open and nonjudgmental as a modeling strategy for your student to model for her patients. Differences are not negatives; they are opportunity for growth on both parts. Relax.

Question for Spring 2018 Quickening
When is a new midwife ready to be a good preceptor? How much experience should she or he have?

Responses should be no more than 250 words (they may be edited) and can be submitted to quick@acnm.org. Thank you!
Join the Conversation—it’s Time to Connect!

Hedy Ross, director of membership and publications, discusses ACNM Connect, our new online community.

One of the benefits ACNM members have been asking for is an improved online community to replace our eMidwife Discussion Groups (listservs). This past fall, ACNM delivered that benefit in the form of ACNM Connect, a dynamic new members-only online community platform. ACNM is conveniently accessed via your smartphone, tablet, or computer.

With ACNM Connect, you can easily access midwifery content, groups, members, and discussions that interest you most. Here are a few of the enhanced features provided by ACNM Connect:

- An improved Membership Directory with more search options and faster search results.
- Enhanced email capabilities. Receive emails in an improved and easier-to-read format. Choose the frequency of email notifications (daily, real time, or no email).
- Sign up for all your member alerts in one area. Previously, you had to go to every single group in which you were a member to get alert notifications.
- Mobile friendly—access to your online community on the go, in the palm of your hand, on any mobile device.

To get started, access Connect at connect.midwife.org. Click the SIGN IN button and log in with the same email and password you use for your ACNM membership. An ACNM Connect Getting Started Guide is available at connect.midwife.org/about/guide.

There are 129 communities to choose from. All members are automatically enrolled in the Town Hall Community. This is where all ACNM members come together for discussions of general interest. All members are also enrolled in the Quickening community—to easily view and discuss articles in each issue. Each state affiliate has its own community, to address issues specific to their state. Students, special interest groups, and committees have their own communities as well. We also have a community set up to discuss matters related to the ACNM Annual Meeting—including ride and hotel room shares.

The more members who join the conversations in ACNM Connect, the richer the experience becomes. In fact, members have already started or participated in 22,619 conversations. So, don’t miss out. I encourage you to Connect with your colleagues today. I also welcome your feedback about our new platform.

By Hedy J. Ross, MS, MBA
ACNM Director of Membership and Publications
hross@acnm.org
As an essential component of its mission to advance excellence in midwifery education, the Accreditation Commission for Midwifery Education (ACME) undertakes period reviews of midwifery education programs. The reviews are designed to ensure that each program possesses the organizational characteristics, professional orientation, and resources necessary to provide an educational experience of high quality for its students to become competent, safe midwives. The review framework encompasses a self-evaluation that each program conducts in which it analyzes its activities both in relation to its stated philosophy, purpose, and outcomes and objectives and in relation to ACME standards and criteria. Additionally the framework encompasses an ACME site visit and a review by the ACME Board of Review. These activities are key to determining the granting of pre/accreditation status. The education program then uses the results to maintain or improve the performance of its program. The entire process is a voluntary quality assurance activity that combines self-assessment and peer evaluation.

2018 ACME Site Visit Schedule
In 2018 ACME will conduct five site visits as part of our peer review process:

- **Spring 2018**
  - University of Washington
    - February 14–16, 2018
  - Seattle University
    - April 9–11, 2018
  - Southwest College of Naturopathic Medicine & Health Sciences
    - May 2018

- **Fall 2018**
  - University of Colorado, date to be determined
  - Marquette University, date to be determined

2018 Midwifery Programs up for Review:
- The ACME Board of Review holds its meetings in February and July each year and reviews select programs at each meeting.

Board of Review February 16, 2018 Meeting:
- Baystate Medical Center
- Texas Tech University
- Stony Brook University
- University of Colorado

Board of Review July 2018, date to be announced:
- University of Washington
- Seattle University
- Southwest College of Naturopathic Medicine & Health Sciences

Call for 3rd Party Comments
ACME, in accordance with its policies and US Department of Education requirements, is seeking written third-party comments concerning the qualifications for accreditation of the following midwifery programs (see below). These programs will be reviewed for renewal of accreditation at the July 2018 ACME Board of Review (BOR) meeting. Upon request, comments will be considered confidential. Your comments will be included along with other 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. 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.

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<th>TYPE OF ACCREDITATION</th>
<th>DEADLINE FOR COMMENTS TO BE RECEIVED FOR JULY 2018 BOARD OF REVIEW MEETING</th>
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Midwifery Works Fundraiser & Sing-off Great Results!
Sisters in Song, a Portland, Oregon-based a capella quartet that includes Sally Hersh, CNM, of OHSU, provided pitch-perfect entertainment for a memorable Foundation fundraiser at MidwiferyWorks! 2017. Sisters sang about community and empowerment and engaged the audience in a celebration of the Foundation’s 50th birthday. Not only was attendance at an all-time high, fundraising was as well. Sisters in Song donated half of their honorarium back to the Foundation and the Oregon Affiliate of ACNM presented a $1001 sponsorship check to President Elaine Moore, CNM, MSN, FACNM immediately thereafter. The Foundation Board is deeply grateful to the sponsors and donors who helped make this annual event so successful!

MidwiferyWorks! 2017 also included a sing-off that broke donation records, largely due to friendly rivalry among four teams. Each team represented a popular Foundation-endowed fund. First-place winners, the MOC-ettes, added $1100 to the Midwives of Color Scholarship Fund. Second-place winners, the ToneDefs, more than doubled their team’s competition donations with the help of midwife auctioneer extraordinaire, Jane Houston, CNM, DMP adding $1275 to the Pedersen Fund. Bringing in the rear while adding another $1200 combined to the Marsico and Thacher Funds were: the Marsicko’s, comprised of multi-talented ACNM Board and staff members, and the MBNs (Mary Breckinridge Nerds) anchored by Floridian midwives Mary Kaye Collins, CNM, MN, JD, FACNM and Denise Henning, CNM, MSN.

Five Thacher-MBN Fellowship Awards Announced In Portland, Oregon
The Portland fundraiser was also the setting for presentation of certificates to five CNMs who received $1000 fellowship awards to attend the MidwiferyWorks! 2017 meeting. Each was supported by a Thacher-MBN Leadership Fellowship, designed to build leadership skills in business management and marketing midwifery practices. (Awards are funded by the Frances T. Thacher Midwifery Leadership Endowment and matched by support from the Midwifery Business Network.)

Midwives of Color Doctoral Scholarship Goes to Mimi Niles!
Paulomi “Mimi” Niles, CNM, MSN, MPH, who is pursuing a PhD in nursing at New York University, is the 2017 recipient of the Carrington-Hsia-Nieves Doctoral Scholarship for Midwives of Color, named in honor of three distinguished midwives of color. Ms. Niles will use her $5000 scholarship to support her research entitled, Relationship-Centered Midwifery Care in an Urban Public Health Care Setting: “An Ethnographic Case Study.” This is the third doctoral scholarship awarded from the Midwives of Color Scholarship Fund, which continues to grow as a result of the remarkable fundraising collaboration the Foundation has with the ACNM Midwives of Color Committee.
Thacher Community Grants Support Exciting Projects!
Four $500 Thacher Community Grants were awarded in late 2017 for small, yet innovative community-level projects that promote excellence in health care for women, infants, and families in their communities. The awards are made with preference for projects that address leadership development at the community level, care for women with physical or mental illness or disability, or care of underserved populations, especially those in low-resource settings. Angie Chisolm, CNM, plans to use her grant to develop the Midwives & Mamas Podcast. Elizabeth Curtis, CNM, will train teachers for a School Health Program: ARSH Life-Skill Building in Rural Uttar Pradesh (India). Two other grantees will use their funds for work with Native American women. Indian Health Service midwives R. Kate Mitchell, CNM and Allison Conti-Taranto, CNM will embark on the project entitled: Supporting Mothers: Increasing Screening for SUD during Pregnancy on the Blackfeet Indian Reservation. Alli Starling, CNM, MPH and Lisa Jim, RN, for their project on the Navajo Nation’s Chinele Comprehensive Healthcare Facility entitled: Prenatal Education and Empowerment Project.

Raisler Award Winner will Expand Work with Indigenous Guatemalan Midwives
The 2017 recipient of the Jeanne Raisler International Midwifery Award is Mallory Betz, CNM, MSN, BASW, who is receiving a MSN in Advanced Practice Nursing Immersion, Nurse Midwifery. This award honors the memory of Jeanne Raisler, CNM, DrPH, FACNM and supports midwives to become more involved and experienced in global midwifery. Since June 2017, Mallory has been in residence at the Asociacion de Comadronas del Area Mam (ACAM), an association of traditional indigenous Mam-speaking midwives who own and operate a clinic and birth center in an indigenous area of Guatemala. This $3000 Raisler Award will enable Mallory to extend her stay at ACAM for another six months to: 1) collaborate to develop a midwifery home-visit system and agenda for postpartum patients who received care at ACAM; 2) develop midwifery education standards in the Quetzaltenango region, in collaboration with the local government health center; to be presented at the local, state, and, ultimately, national level; and, 3) implement a cervical cancer-screening program using visual inspection of the cervix with acetic acid.

Three More Texas Midwifery Scholarships Awarded
The productive fundraising of the Texas Affiliate of ACNM—the Consortium for Texas Certified Nurse-Midwives (CTCNM)—made possible the award of three $1000 scholarships that aim to increase the number of practicing CNMs/CMs in Texas. The 2017 recipients of the Texas Midwifery Creation Scholarships, awarded to student midwives with Texas roots who intend to practice midwifery in Texas after graduation, are: Lesslie Bull, SNM, RNC-OB; Erica Eggebrecht, SNM, MBA; and Olivia Delavega, SNM, RNC-MNN—all studying at Texas Tech University Health Sciences Center. Their scholarships were given in honor of two Texas midwifery legends, Mary Brucker, CNM, PhD, FACNM, FAAN and Nancy Jo Reedy, CNM, MPH, FACNM, who are shown above with Jo-Anna Rorie, CNM, PhD, FACNM at the Foundation Founder’s Hall of Fame in May, 2017.

In a thank you letter to the Foundation, Texas student midwife Lesslie Bull wrote: “By awarding this scholarship, you have allowed me to focus promptly on my studies while allowing my husband and I to continue working on our debt-free goal. I hope that one day we will be able to pour into our community and to bless others with irrational generosity as you have helped me with this $1000.”
In Memory of Friend, Supporter, and Benefactor, Thomas D. “Toby” Thacher, II (1946–2017)

The Foundation Board is deeply saddened to announce the sudden death on October 30, 2017 of dear friend, long-time supporter, and generous benefactor, Thomas D. “Toby” Thacher II. In 2008, Toby and his wife, Frances T. Thacher, CNM, MS, FACNM (2017 winner of the Hattie Hemschemeyer Award and long-time member of the A.C.N.M. Foundation Board) established what has become one of the Foundation’s most significant and influential endowed funds: The Frances T. Thacher Midwifery Leadership Endowment.

Toby’s professional life was characterized by his roles as public prosecutor; independent monitor, and private investigator who was instrumental in curbing corruption, fraud, and waste in the construction industry. His personal life was full of love, support, and advocacy for his family and friends, which include the midwifery community. Foundation CEO, Lisa Paine, CNM, DrPH, FACNM said: “We have been enormously privileged to be considered among Toby’s closest friends. His influential work on our behalf, including the intimate way in which he stayed directly involved in fundraising for the Thacher Endowment will be a lasting legacy for midwives. We will sorely miss this remarkable ‘larger than life’ man with a huge heart.” Donations in Toby’s memory may be directed to the A.C.N.M. Foundation’s Thacher Endowment at: www.midwife.org/Charitable-Contributions. Notes of condolence may be sent to the family at the following address: Frances T. Thacher, CNM, 370 Pine Brook Road, Bedford, NY 10506.
## Gifts to The A.C.N.M. Foundation, Inc. September 1, 2017 to December 31, 2017

### UNRESTRICTED GIFTS

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<th>Individual(s)</th>
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#### Founders Pledge ($10,000 by 2022)

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<td>Laraine Guyette</td>
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<td>Timothy B. Johnson</td>
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<td>Suzanne M. Wertman</td>
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<td>Barbara Wax</td>
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<td>B. Wonnell, CNM</td>
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<td>Moira Tannenbaum</td>
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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.

Transitions
Tina Johnson, CNM, MS, FACNM, formerly ACNM director, midwifery practice, education and global outreach, has accepted a position as co-director for midwifery services at George Washington University Medical Faculty Associates. Congratulations Tina! Below is an excerpt from an open letter Tina wrote to her midwifery friends and colleagues. You can read the letter in full here http://bit.ly/2G36Qht.

“I will dearly miss working directly with so many amazing, dedicated colleagues, but I know our paths will continue to cross. I carry many fond memories of my years at ACNM and an ongoing commitment to the organization with me into the next chapter of my journey as a midwife.... Most importantly, I value the friendships we have formed and the strides we have made to lead our essential professional association into the coming years. Regardless of extraordinary recent challenges, our future is ripe with opportunities. The moment is now for further expansion in collaboration, education, high value care, research, and an enhanced practice environment for a growing number of midwives. I am inspired by your fortitude, wisdom and grace, and I will continue to work alongside you to ensure that very soon there will be a midwife for every woman in the United States.” Sincerely, Tina Johnson

Welcoming
Donna Harvel Balo, CNM and proud first-time parents Seth and Danielle Balo announce the birth of Landon Levi, 7 pounds 8 ounces, born in a gentle unmedicated birth on November 4, 2017. Landon is the fourth grandchild delivered by this proud grandma!

Honors & Occasions
Amy Levi, PhD, CNM, WHNP, will assume the role of vice chancellor for academic affairs at the University of New Mexico Health Sciences Center. Levi, the Leah L. Albers Endowed Professor of Midwifery in the UNM College of Nursing, will oversee career development, faculty promotions, interprofessional education, Native American recruitment into health professions, and other education-related matters. Congratulations, Amy.

Máirí Breen Rothman, CNM, MSN, ACNM Region II representative, and Erin Fulham, CNM, co-founders of M.A.M.A.S., Inc., were awarded the ACNM “With Women for a Lifetime” Commendation for their longstanding practice, which recently celebrated its tenth year.

Barbara B. Lutz, a CNM in private practice in New Jersey, was featured recently on the TLC network program, Married at First Sight. The reality program follows a couple from Lutz’s practice, Jamie and Doug Hehner, and she is featured in an episode delivering their second child. Check TLC for episode access.

The following midwives have been named as new members of the board of directors of the American Midwifery Certification Board, effective January 1, 2018:

- **President-Elect:** Linda Hunter, EdD, CNM, FACNM has served as a member of the AMCB Board of Directors from 2013 through 2017. She is currently a clinical assistant professor in obstetrics and gynecology at the Warren Alpert Medical School of Brown University and in clinical practice on the nurse-midwifery faculty at Women & Infants Hospital in Providence, Rhode Island.
- **Treasurer:** CDR Amy Wootten, CNM, WHNP, CNS is a commander in the United States Navy and the vice chair of the Examination Committee.
- **Secretary:** Erin McMahon, EdD, CNM, RN, MSN is a member of the Continuing Maintenance Program (CMP) Committee, and acted as the interim secretary in 2017.
- **CMP Committee Chair:** Jan Kriebs, CNM, MSN, FACNM has been a member of the CMP Committee for the past two years.
- **Credentials, Administration & Reporting (CAR) Committee Chair:** Elizabeth Pickett, CM, LM, MS is continuing her chairmanship. She is also a member of the Research Committee.
Congratulations! New Midwives

Stacie Diette CNM
Sarah Debs CNM
Caitlin Connelly CNM
Andrea Cole CNM
Tia B Cole CNM
Jin Han Cody CNM
Ione Chan CNM
Jacarra Kenisia Carey CNM
Rebecca Lynn Butler CNM
Tracy Lee Burns CNM
Ashley Nicole Burden CNM
Ishimabet Makini Valdene Bryce CNM
Amanda Mary Brown CNM
Nicole Lynn Brooks CNM
Katya Monet Brickman CNM
Paula Brandt CNM
Talia Borgo CNM
Jennifer Nicole Bonner CNM
Christina Bennett CNM
Rachel Annalee Beck CNM
Camra Janell Bearnson CNM
Madison Jay Beal CNM
Halima Barqadle CNM
Lisa Marie Bagwell CNM
Jenny Marie Bagg CNM
Bridgette Aumand CNM
Dinah Augustin CNM
Abeer Almohammad CNM
Melanie Ann Delaney Abner CNM
Whitney Anne Abernathy CNM
Melanie Ann Delaney Abner CNM
Abeer Almohammad CNM
Danielle Nana Ekuu Abisio-Gilmore CNM
Dinah Augustin CNM
Brigitte Aumand CNM
Jenny Marie Bag CNM
Lisa Marie Bagwell CNM
Halima Barqadle CNM
Madison Jay Beal CNM
Camra Janell Bearnson CNM
Rachel Anneale Beck CNM
Christina Bennett CNM
Jennifer Nicole Bonner CNM
Talia Borge CNM
Paula Brandt CNM
Katya Monet Brickman CNM
Nicole Lynn Brooks CNM
Amanda Mary Brown CNM
Tracie Alicia Brown CNM
Ishihabat Mark Valdene Bryce CNM
Ashley Nicole Burden CNM
Rebecca Lynn Butler CNM
Kathyrin Eck Campbell CNM
Jacarra Kenneth Carey CNM
Ione Chan CNM
Jin Han Cody CNM
Tia B Cole CNM
Andrea Cole CNM
Caillen Connelly CNM
Sarah Deh CNM
Stacie Diette CNM
Kristin Linh Dovao CNM
Georgia Margarita Eldridge CNM
Rachel Ely CNM
Julia Ray Faidley CNM
Monica Sarah Fields CNM
Estefany Jamileth Flores-Godaire CNM
Isabelle Floyd CNM
Carole Diane Ford CNM
Asmara Gehr CNM
Sarah Jean Gill CNM
Melissa Goodrich CNM
Michelle Greg CNM
Emily Green CNM
Maisy Grief CNM
Catherine Hagan CNM
Emily C. Hardy CNM
Nicole Hardy CNM
Kelby Renee Harris CNM
Michelle Harris CNM
Jennifer Michelle Hayes CNM
Shalisa Anne Henson CNM
Crystal Marie Hicks CNM
Caroline Tufts Hutton CNM
Aissanat Idrissiou CNM
Tatyana Jack Ruddock CNM
Kelley Johns CNM
Alicia Danielle Jowers CNM
Shannon Kelley CNM
Angella Knobbe CNM
Erica Koltemk CNM
Caillen M Kraft CNM
Michelle R Lacy CNM
Jenkins Michelle Lawhorn CNM

NEWLY CERTIFIED MIDWIVES

Congratulations to the following midwives for passing the AMCB Midwifery Certification Exam,

October 1, 2017–December 31, 2017

Audrey Lawler CNM
Debra Ann Ledingham CNM
Patricia M. Lewis CNM
Paige Marie Lymeuau CNM
Laura Margaret MacCarl CNM
Christina Marie MacDowell CNM
Chelsea Helen Masler CNM
Carla McGuinness CNM
Alexandra Cristina Medina CNM
Jessica Ann Meyers CNM
Billary Barfield Miller CNM
Emily Sara Miller CNM
Page Miller CNM
Debbie Jo Miller CNM
Dawn Moore CNM
Alexandra Moser CNM
Leah Moses CNM
Veronica Sue Muller CNM
Hayden Paige Murrell CNM
Nicole Maria Myers CNM
Sophie Ness CNM
Jennifer Ochse CNM
Victoria L Orem CNM
Genise LaShelle Owens CNM
Katherine L Park CNM
Kerry Beth Parker CNM
Lilya Mahen Passman CNM
Sandra Pauline Perry CNM
Mervide Parri CNM
Justina Polvere CNM
Barbara M Purnell CNM
Kayla Marie Quinn CNM
Nicole Quinones CNM
Melissa Rags CNM
Chantel Redding CNM
Shannon Marie Reed CNM
Holly Riley CNM
Devon Riley CNM
Jocelyn Westport Rinse CNM
Joie Rodriguez CNM
Devon Root CNM
Ximena Rossato-Bennett CNM
Kelly Frick Ruse CNM
Erica Schatter CNM
Sara Paige Shanahan CNM
Heather Anne Sheriff CNM
Katya Simon CNM
Katrina Aubriane Skinner CNM
Kristin Savannan Smith CNM
Melanie Staeberlin CNM
Justina Staroska CNM
Lara Lynn Stelbou CNM
Karie Stewart CNM
Katherine Tan CNM
Amie Marie Thompson CNM
Darcie R Tough CNM
Sage Ungefelder CNM
Crystal Iyle Upton CNM
Bianca Graciela Weaver CNM
Katherine An Welter CNM
May Wheelwright CNM
Brittany E White CNM
Amy L White CNM
Mary Elizabeth Winters CNM
Kelli Wol CNM
Rachel Yanda CNM

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