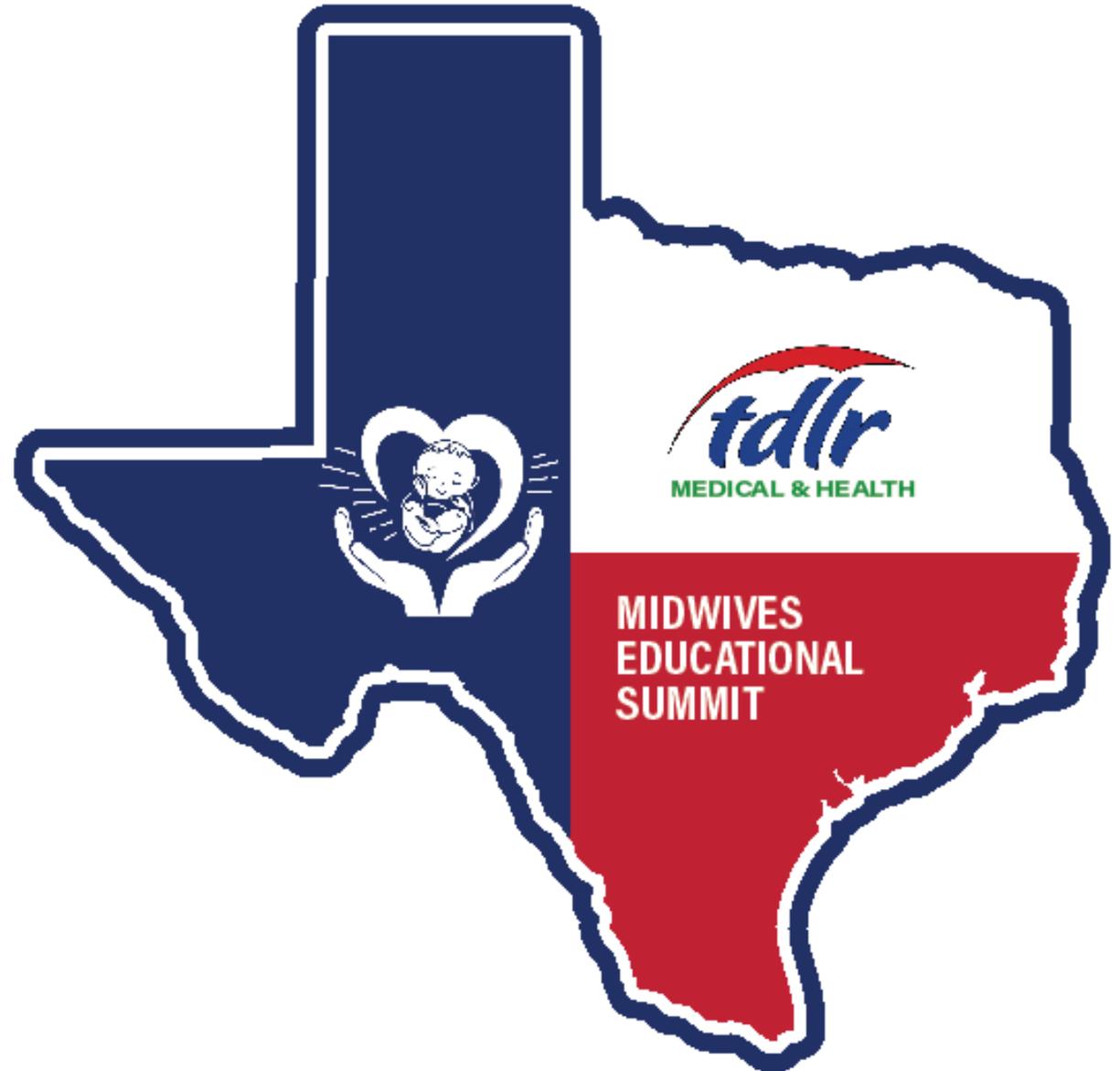


TEXAS DEPARTMENT OF
LICENSING AND REGULATION
welcomes you to the
**MIDWIVES EDUCATIONAL
SUMMIT**

Hurst, Texas
July 26, 2019





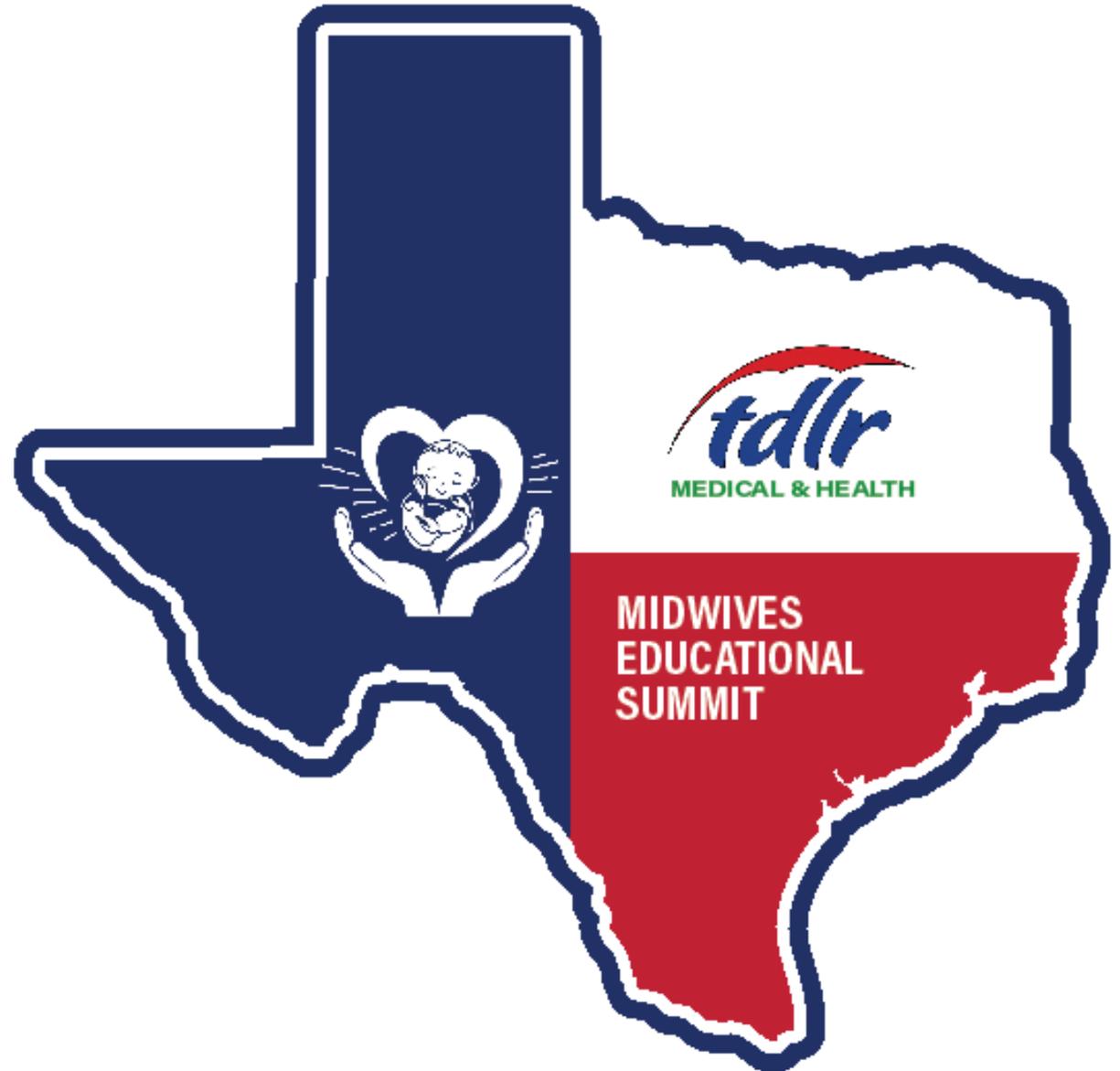
First Up:
Opening Remarks

Followed By:

Acknowledgement of Commissioners
Roll Call and Acknowledgement of Quorum
Statement on Continuing Education
Procedures

TDLR Enforcement

Presented by
Karen Cox, Senior Prosecutor
LaChasity Cloud, Investigator



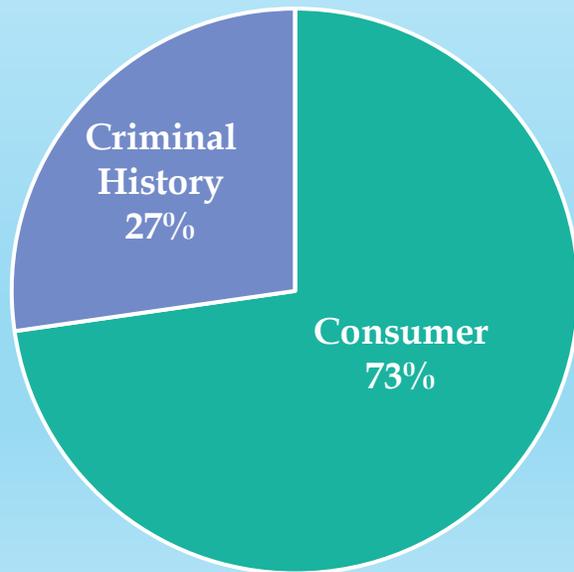
TDLR Midwives Educational Summit: Enforcement Division

Karen Cox, Senior Prosecutor
LaChasity Cloud, Investigator

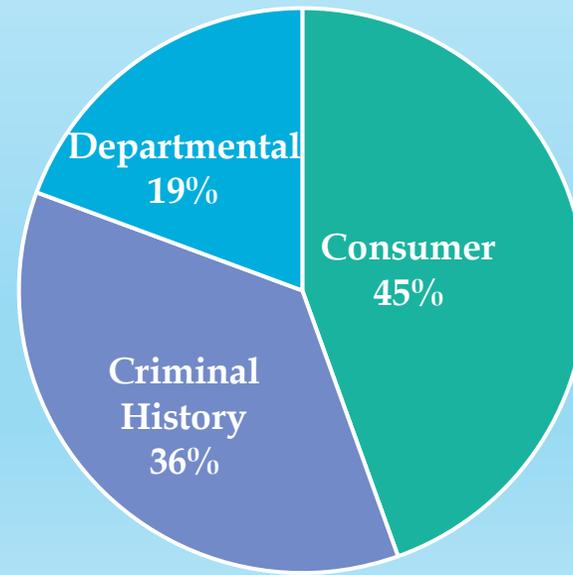
Introduction to the Enforcement Process

- The Enforcement process is “complaint driven.” Complaints can come from outside the agency (Consumer), from an applicants criminal history (Criminal History) and from within the Department (Departmental).

**Midwife Source of Cases Opened
Fiscal Year 2018**



**TDLR Source of Cases Opened
Fiscal Year 2018**



Enforcement Statistics

Shown below are key statistics for the Midwives program and for all TDLR programs combined through June of Fiscal Year 2019.

	<u>MID</u>	<u>TDLR</u>
▪ Number of cases opened:	23	9,189
▪ Number of cases resolved:	26	8,459
▪ Number of Final Orders:	4	1,480
▪ Total amount of penalties assessed:	\$5,800	\$2,554,530
▪ Total amount of penalties collected:	\$1,800	\$1,317,787

Enforcement Statistics

Shown below are case statistics for alleged violations at opening for the Midwives program through Fiscal Year 2018.

Alleged Violation at Opening	2017	Alleged Violation at Opening	2018
Unlicensed Activity	5	Criminal History	3
Transfer Violation	5	Professional Character	3
Professional Character	4	Failed to follow Emergency Protocol	2
Deceptive Practice	3	Unlicensed Activity	2
Failed to follow Emergency Protocol	3		
Unsafe Environment	2		
Expired License	1		
Criminal History	1		
Referral Violation	1		
Failed to Comply with Investigation	1		

Enforcement Statistics

Shown below are case statistics for violations resulting in disciplinary action for the Midwives program through Fiscal Year 2018.

Violation Resulting in Disciplinary Action	2017	Violation Resulting in Disciplinary Action	2018
Failed to follow Emergency Protocol	1	Unlicensed Activity	1
		Records Violation	1

The Enforcement Division

- Enforcement's employees are organized into three sections that reflect the major functions in the life cycle of an enforcement case:
 - Intake
 - Investigations
 - Prosecution

INTAKE

The Intake Section substantiates the agency's jurisdiction and performs initial research on each complaint filed, ultimately making the decision whether an investigation should be opened.

Summary: Is this a person TDLR regulates? Is this an activity TDLR regulates? If the answer is yes, they open a case. Intake does not make a determination about the quality of the evidence or the legal sufficiency of a case.

INVESTIGATIONS

Investigators are neutral fact-collectors who gather facts about the case. They contact and interview the **complainant, respondent,** and possible witnesses and collect documents that contain information about the case.

This is the point in the case where we use expert witnesses. If the case involves an issue where an expert evaluation would be useful, the investigator contacts one of our experts and asks for an opinion.

PROSECUTION

The Prosecution section ensures the proper disposition of each case. Once the investigation is completed, the prosecutors review the facts collected and the applicable law, and determine whether a case should be closed or proceed further.

- Prosecutors can:
 - Close a case with no further action
 - Issue a warning letter
 - Issue a Notice of Alleged Violation.

IMPORTANT DEFINITIONS

- **“Complainant”** is the person who filed the complaint with the agency. This person usually, but not always, is the person who received the alleged injury from the licensee. We do accept complaints from other people on behalf of injured parties.
- **“Respondent”** means the licensee who caused the alleged injury, and who will be the person the agency pursues if the matter becomes a contested case. This is similar to the familiar word “defendant,” but is used in administrative proceedings.

Contested Cases

If the Respondent receives the Notice of Alleged Violation and requests a hearing, we set a hearing at the State Office of Administrative Hearings (SOAH). SOAH assigns an Administrative Law Judge (ALJ) to the case, who holds a hearing and issues a Proposal for Decision (PFD) that finds facts, and recommends a decision based on those facts.

The Commission on Licensing and Regulation then hears arguments about the merits of the PFD and then issues a final order. Only 1% of our cases get this far.

Who is an expert witness?

- Rule 702 of the Texas Rules of Evidence states that “an expert witness who is qualified as an expert by **knowledge, skill, experience, training or education** may testify in the form of an opinion or otherwise if the expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.”
- The Department uses experts from our advisory boards and contracts with others as necessary.

What does the expert witness do?

The expert is a specialized witness, who provides information during the investigation stage of the case.

The prosecutor uses this information later in determining whether to proceed further or close the case.

The expert's role in the investigation

- The expert reviews the documents and statements the investigators collect, and then writes a report stating her opinion as to whether the Respondent violated a rule or law in the provision of care to a client.
- The prosecutor will narrow the issues and ask the expert to answer specific questions about the case.
- If the Respondent requests a hearing, the expert will testify as a witness for the Department in that hearing.
- HB 2847 this bill added Texas Occupations Code § 51.252(e), which provides immunity from lawsuits for 'qualified individuals' who 'assist the department with reviewing or investigating complaints filed with the Department.'

When do we use experts?

- In some instances, our Intake section asks for a very brief opinion about whether a complaint should be opened. For example, they might need to know if a complaint actually raises a standard of care question or for a definition of a term of art.
- In most instances, we consult experts during the investigation, when we know the basic facts of the case and need to know whether the facts constitute a violation of the standard of care or not.

How do we choose expert witnesses?

- We use advisory board members and contract with others if that is required.

Contract Experts

- We contact industry organizations and ask for recommendations. In your industry, we asked the Association of Texas Midwives; we have asked organizations in all programs where we use experts.
- We ask each potential expert to complete a questionnaire and return it.
- We screen each potential expert who returns a questionnaire to see if they have any history of enforcement actions, and exclude anyone who has such a history.
- After Enforcement screens the experts, our Finance division does further screening for state of Texas contracting requirements. Only after the potential expert has passed all these screens do we issue a contract.

1.) Please list all undergraduate and graduate degrees you hold. For each degree, please provide the name of institution that awarded it, the date you received it, and your major and minor field of study, if applicable.

[Enter text]

2.) Please list all professional licenses you currently hold or have held in the past. For each license, please also provide:

- the name of the agency or authority that granted it;
- the date you first received it;
- any officially-recognized specializations or endorsements associated with the license;
- how much continuing education, if any, is required to renew the license; and
- an explanation of any time periods in which your license was not active.

More on Experts.

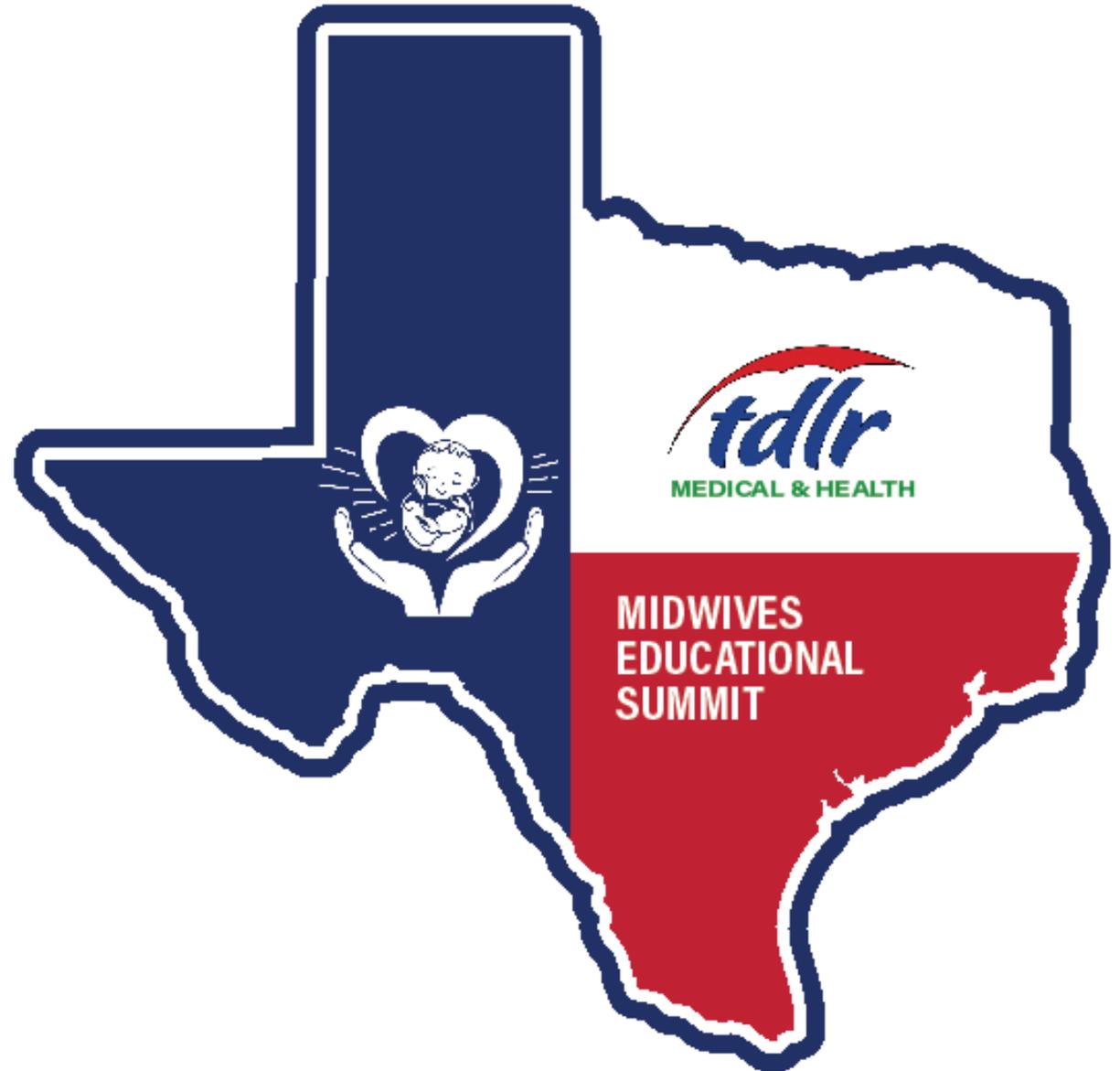
- After the screening has been completed and the expert has been contracted, we give them a short training about the Enforcement process and their role in the specific case.
- Before they are assigned any specific case, we screen again to see if the expert has any conflicts of interest with any participants in the case.
- After all the preceding has been completed and documented, we send the expert the information the investigator collected by secure methods and then the expert produces a report based on that information.

THANK YOU!

- Our mission is to protect the citizens of Texas and the law-abiding and hard-working members of your profession. We cannot do that without your specialized knowledge of the complexities of your profession.

Caring for Babies in the First Six Weeks of Life

Presented by
Dr. Charleta Guillory, M.D., M.P.H.,
F.A.A.P.





Charleta Guillory, M.D., M.P.H., F.A.A.P.

Dr. Guillory is an Associate Professor of Pediatrics in the Section of Neonatology at Baylor College of Medicine and Director of the Texas Children's Hospital Neonatal-Perinatal Public Health Program. She earned her doctor of medicine degree from Louisiana State University Medical School and completed her pediatric residency at Louisiana State Medical Center and the University of Colorado. She received her post-doctoral fellowship training in neonatal-perinatal medicine at Baylor College of Medicine and is board certified in both pediatrics and neonatal-perinatal medicine. She received her Master's in Public Health

from the University of Texas Health Science Center in Houston. Dr. Guillory has championed landmark legislation on Newborn Screening and the Children's Health Insurance Program (CHIP) which has placed Texas in the forefront of infant care. Dr. Guillory presently serves as Chair of the Texas Department of State Health Services, Newborn Screening Advisory Committee and as Co-Chair of the Texas Collaborative for Healthy Mother and Babies (TCHMB)-Neonatology Section. In addition, she serves on the Texas Health and Human Services Perinatal Advisory Council designating levels of neonatal and maternal care. Dr. Guillory is a member of the Midwives Advisory Board.

WARNING:

The following presentation
contains some graphic imagery.

CARING FOR BABIES

During the First Six Weeks of Life

Charleta Guillory, M.D., M.P.H. F.A.A.P.

Associate Professor of Pediatrics

Baylor College of Medicine

Director, Neonatal-Perinatal Public Health Program

Texas Children's Hospital

Robert Wood Johnson Health Policy and Congressional Fellow

Objectives

- ❑ Screen for diseases in the newborn through interpretation of prenatal labs and prenatal screening tests.
- ❑ Identify risk factors for sepsis in the newborn.
- ❑ Identify babies at risk for common newborn problems such as, hypoglycemia, hyperbilirubinemia, etc. and know how to screen these babies.
- ❑ Be prepared for newborn emergencies

Definitions

- Infant mortality rate (IMR) is the number of deaths per 1,000 live births under one year of age.
- Neonatal mortality is newborn death occurring within 28 days postpartum.
 - Neonatal death is often attributed to inadequate access to basic medical care, during pregnancy and after delivery. This accounts for 40–60% of infant mortality in developing countries.
- Postneonatal mortality is the death of children aged 29 days to one year.
 - The major contributors to postneonatal death are malnutrition, infectious disease, troubled pregnancy, Sudden Infant Death Syndrome and problems with the home environment



“INFANT MORTALITY
is
the most sensitive index
we possess of social welfare...”

(A)nnual (R)eport of the (M)edical (O)fficer of (H)ealth, of the (L)ocal (G)overnment (B)oard, Thirty-ninth Report, PP.1910, Cd5263 (XXXIX), supplement on Infant and Child Mortality, Report of Dr Arthur Newsholme.

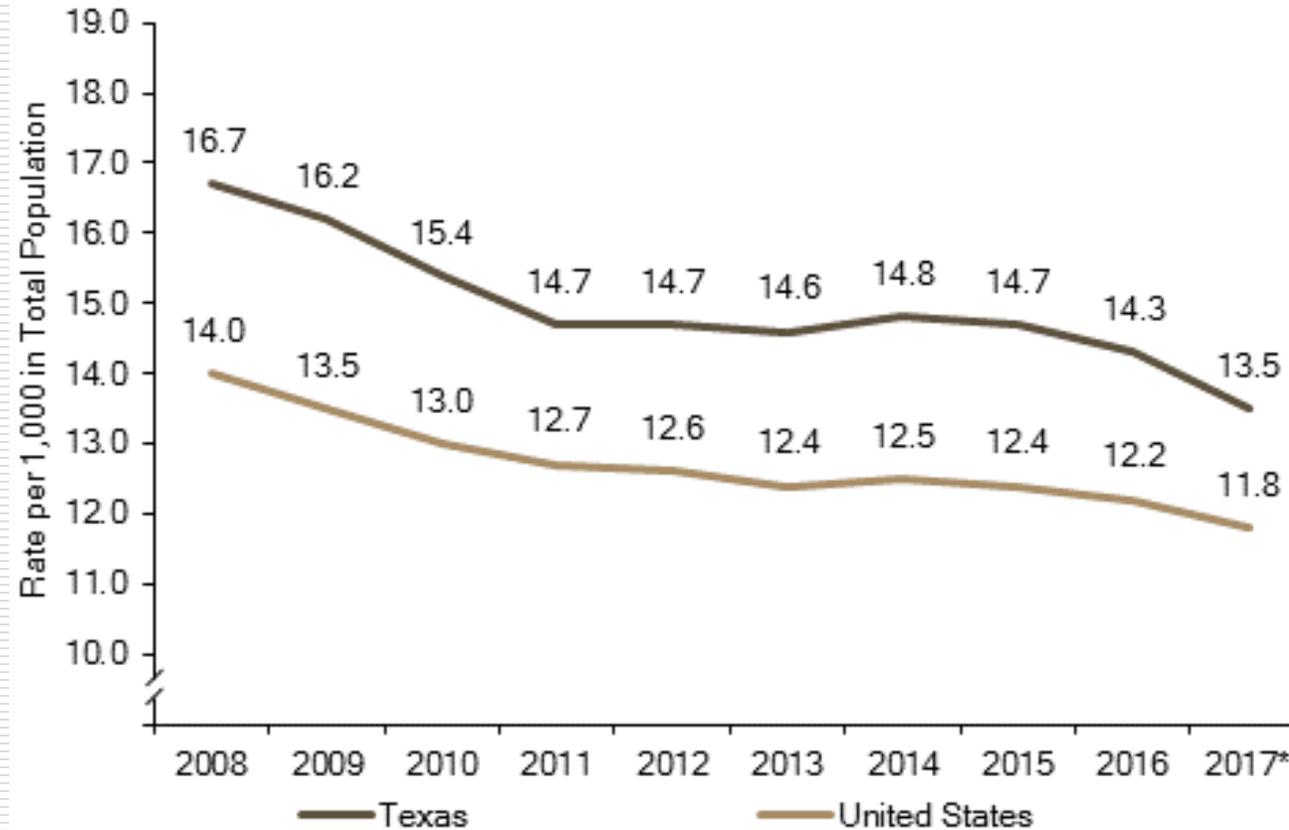


**Despite spending the most on
health care, the U.S. ranks behind**

26

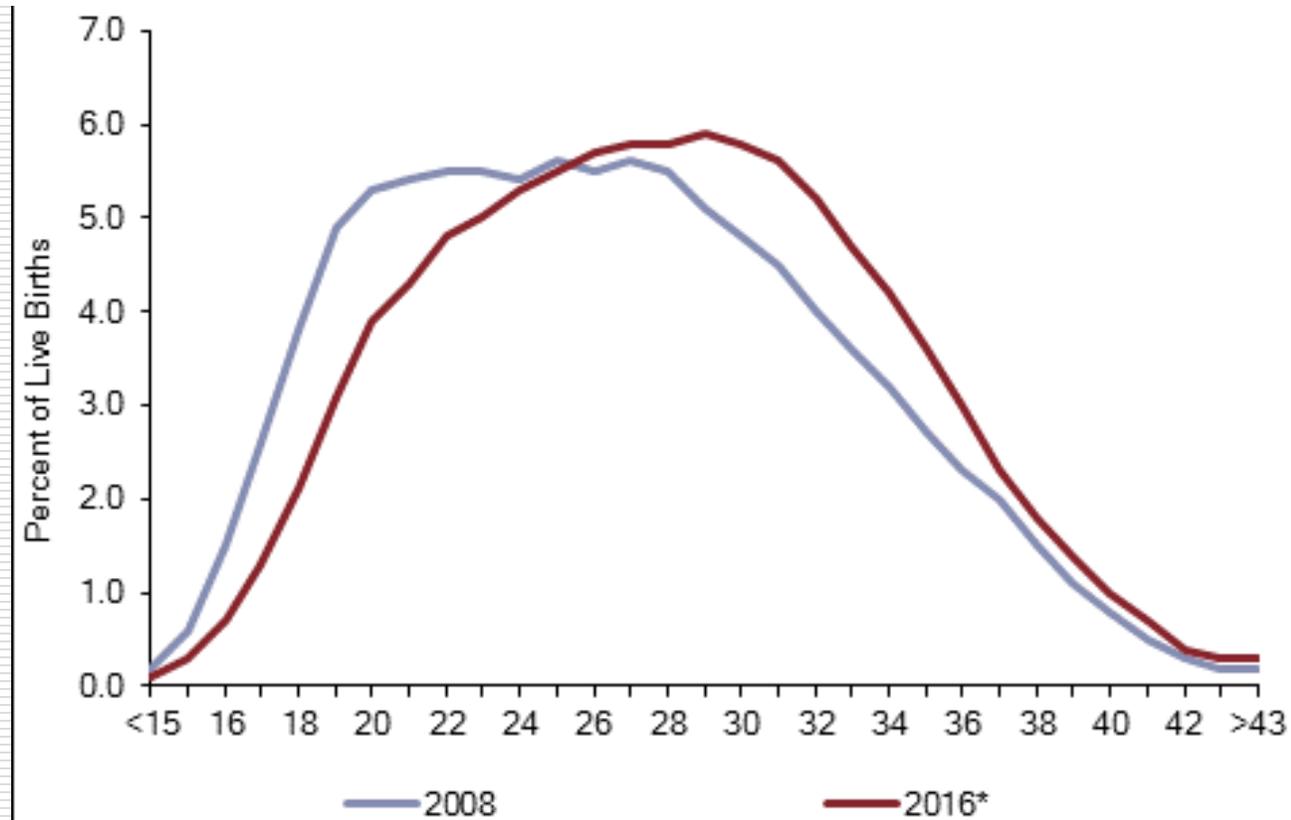
**other industrialized countries
in infant mortality**

Birth Rate in Texas & US, 2008-2017



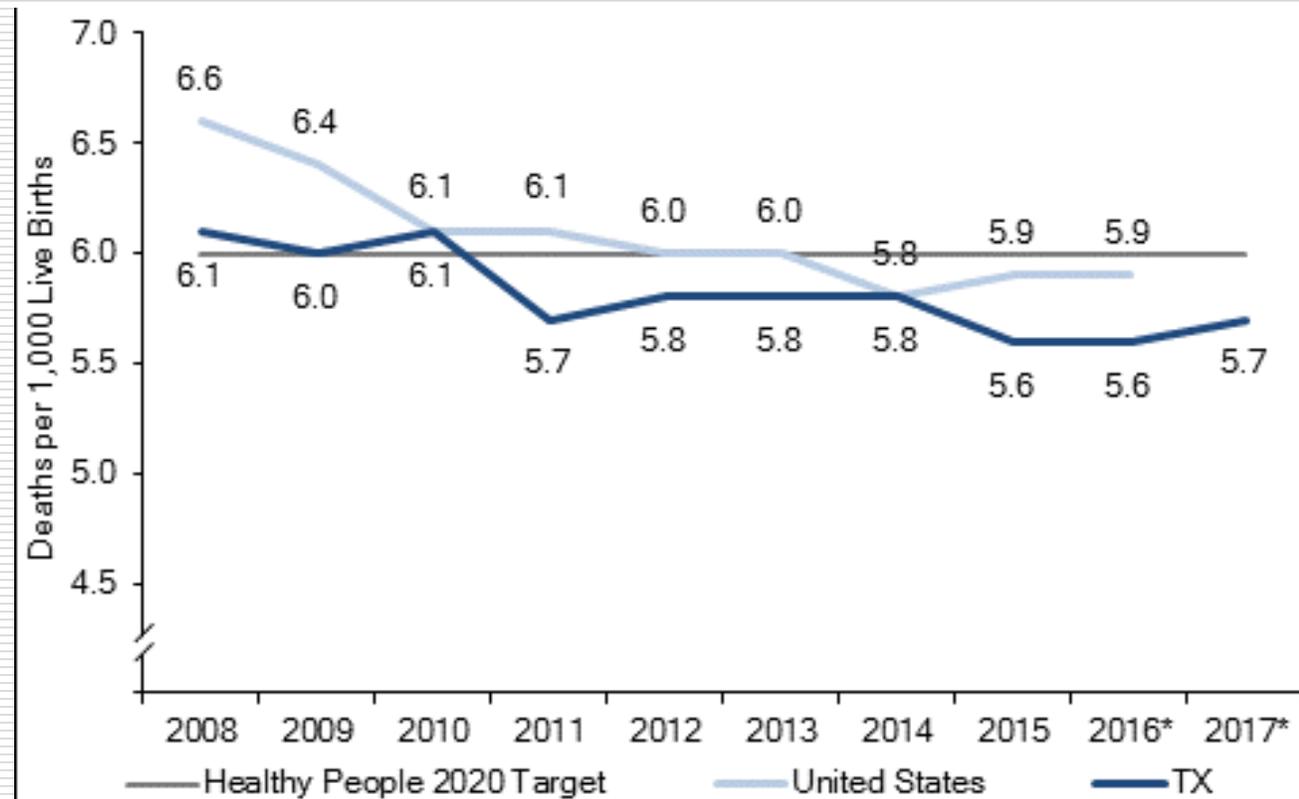
*2017 Texas and United States data are provisional
Source: National Center for Health Statistics
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2018

Maternal Age, Texas 2008-2016



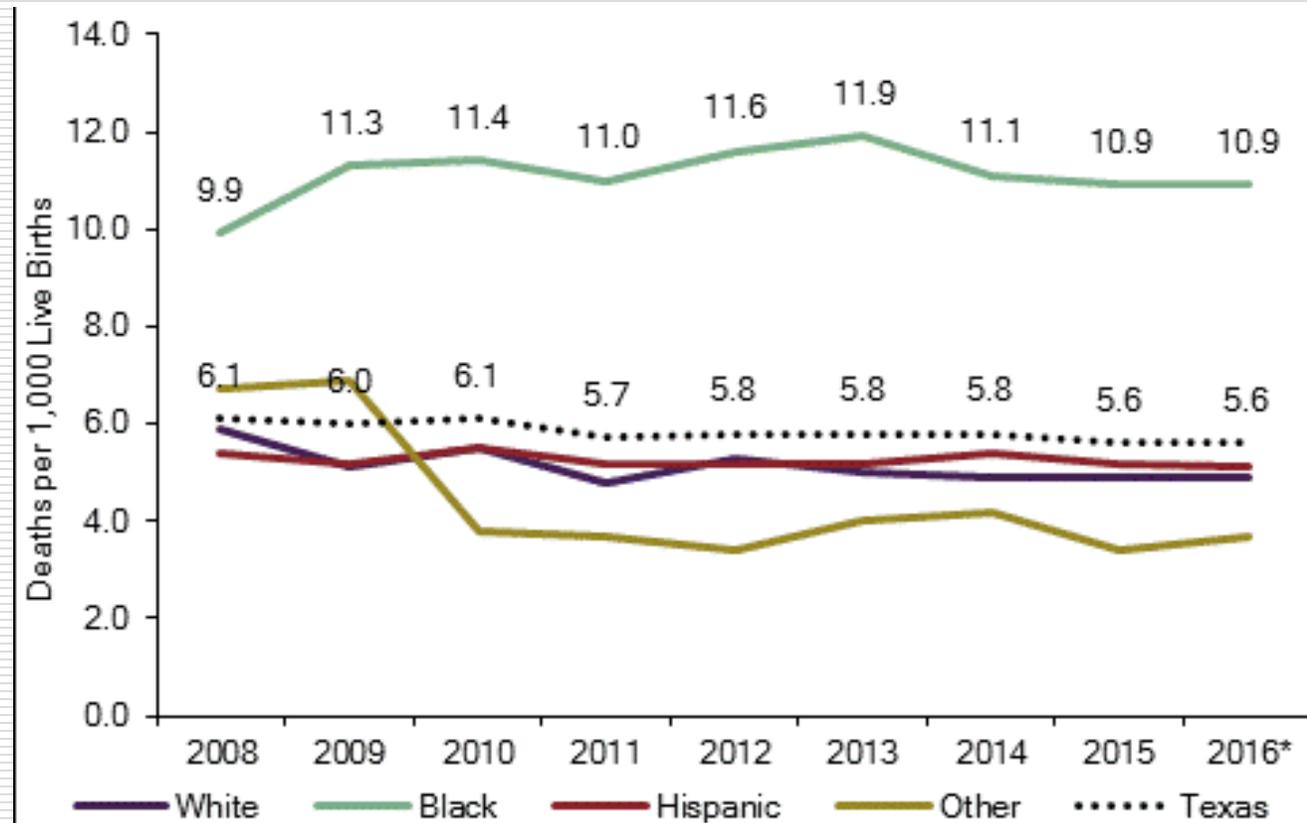
*2016 Texas data are provisional
Source: 2008 & 2016 Birth Files
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2018

Infant Mortality Rates, Texas & US, 2008-2017



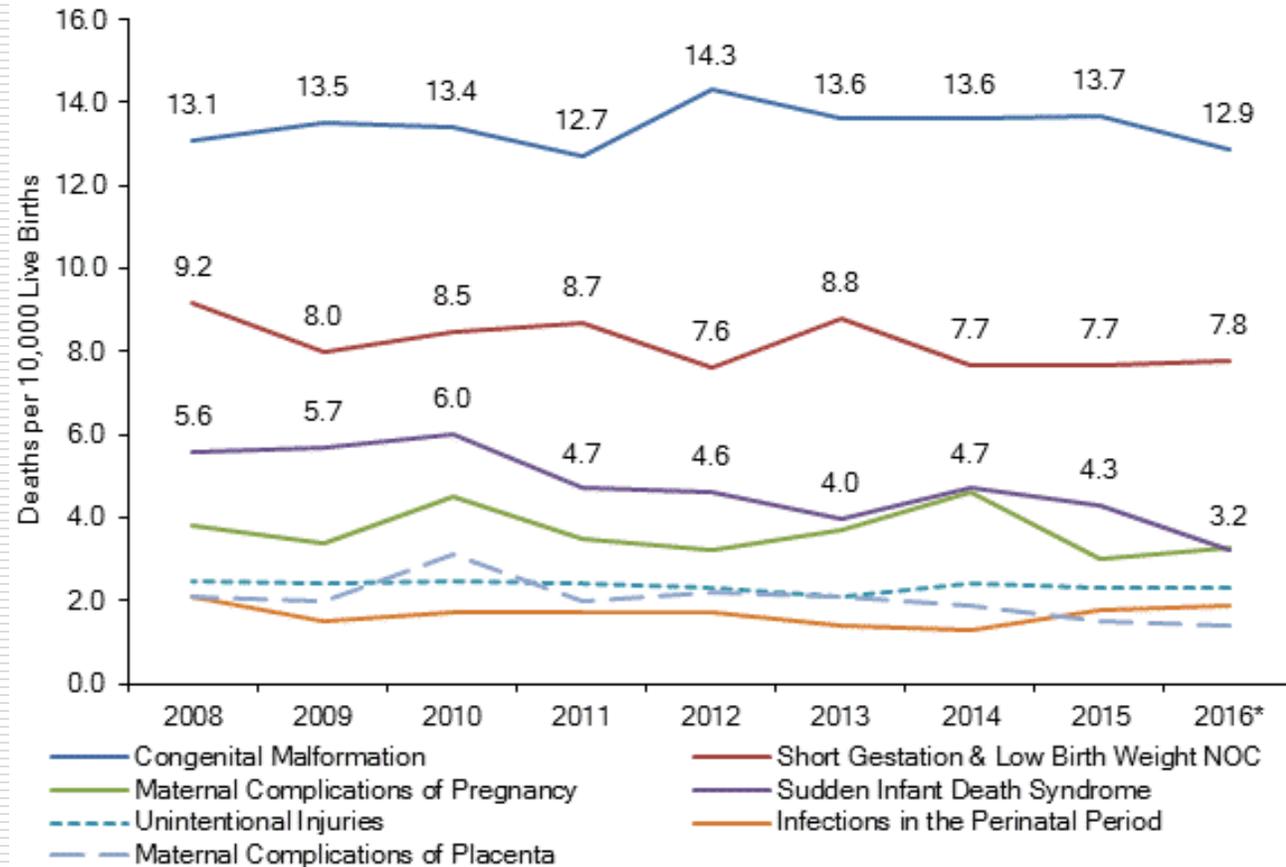
*2016 and 2017 Texas data are provisional
Source: 2008-2017 Texas Birth and Death Files,
National Center for Health Statistics
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2018

Infant Mortality Rate By Race/Ethnicity, Texas, 2007-2015



*2016 Texas data are provisional
Source: 2008-2016 Texas Birth and Death Files
Prepared by: Maternal & Child Health Epidemiology Unit
Oct 2018

Leading Causes of Infant Death, Texas, 2008-2016



*2016 data are provisional
 NOC: Not otherwise classified
 Source: 2008-2016 Death & Birth Files
 Prepared by: Maternal & Child Health Epidemiology Unit
 Oct 2018

Why is the First Six Weeks of Important?

Infant Mortality

2/3 of deaths – occur during the neonatal period

Screening for Disease

- Prenatal Labs should be available at delivery:**
 - Maternal blood type, Rh factor, antibody screen**
 - Rubella titers/evidence of immunity (or non-immunity)**
 - Maternal GBS status**
 - RPR, HIV, HepBsAg**
 - STD screens**

- Review results of prenatal screening:**
 - CVS, amniocentesis**
 - US evaluation for structural defects, fetal weight, amniotic fluid index (AFI)**
 - Multiple marker screening**
 - Glucose tolerance test**
 - Toxicology screen**







Screening for Disease

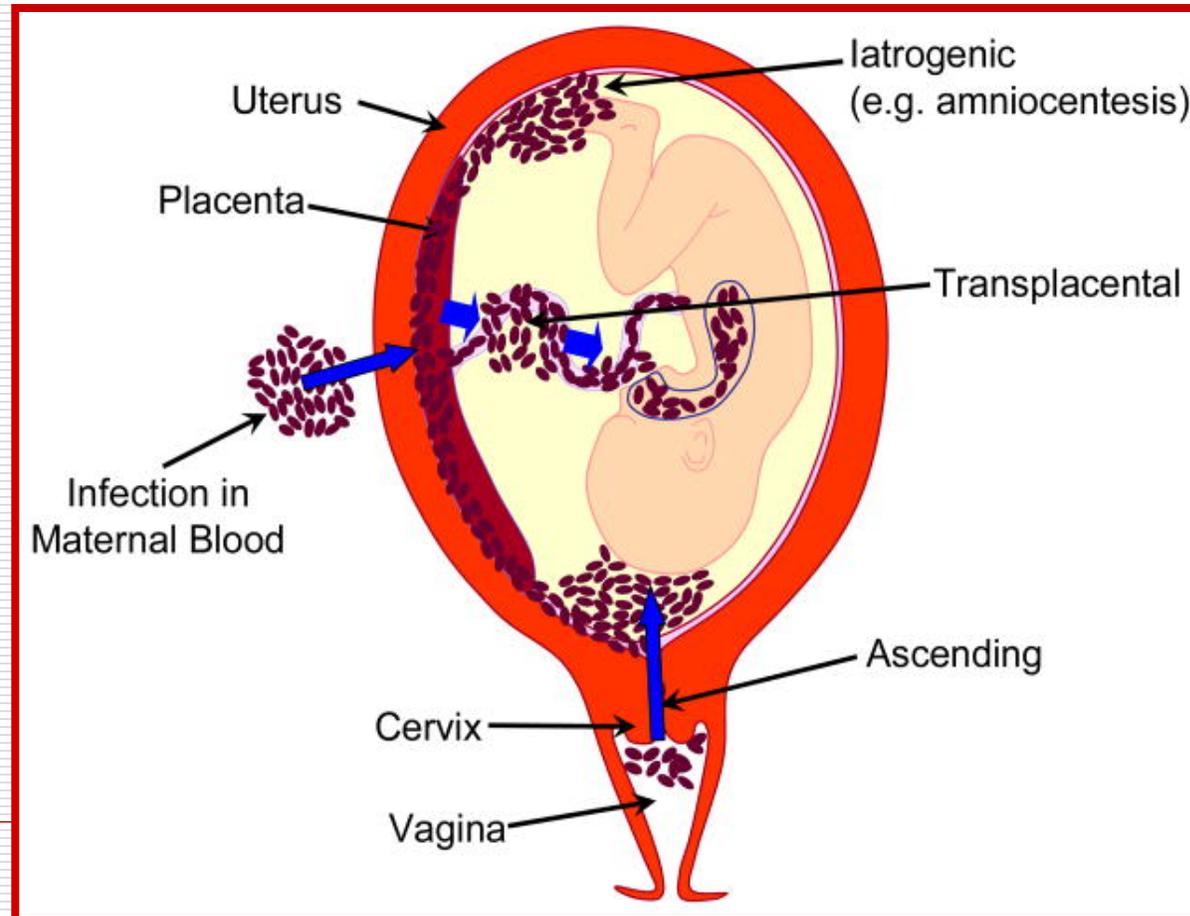
□ Sepsis Risk Factors

- Maternal intrapartum temperature of > 100.4
- Rupture of membranes > 18 hours
- Delivery < 37 weeks gestation
- Maternal chorioamnionitis
- Sustained fetal tachycardia
- Maternal GBS colonization

Maternal Chorioamnionitis

- Maternal fever
 - $> 100.4^{\circ}$ persisting more than an hour
 - $> 101^{\circ}$
- Uterine fundal tenderness
- Maternal tachycardia ($>100/\text{min}$)
- Fetal tachycardia ($>160/\text{min}$)
- Purulent or foul amniotic fluid
- Meconium stained fluid is common

- Usually ascending: repeat vaginal exams, prolonged rupture, internal monitor
- Hematogenous spread: Listeria
- Intact membranes: Ureaplasma species, Mycoplasma hominis



Symptoms of Infection

- Respiratory distress:
 - Tachypnea (RR > 60/min)
 - Grunting, retracting
 - Cyanosis
- Lethargy
- Irritability
- Poor feeding
- Hypoglycemia
- Temperature instability
 - (NOT initial “fever” in newly born babe)





Suspected infection: Management of Neonate

- IV Ampicillin and Gentamicin
 - Amp 100 mg/kg every 12 hours
 - Gent 4 mg/kg every 24 hours
- Antibiotics can be discontinued if blood culture remains negative after 48 hours of incubation
- Why Amp and Gent?

Top 3 neonatal bacterial pathogens:

- 1) GBS
- 2) E. coli
- 3) Listeria

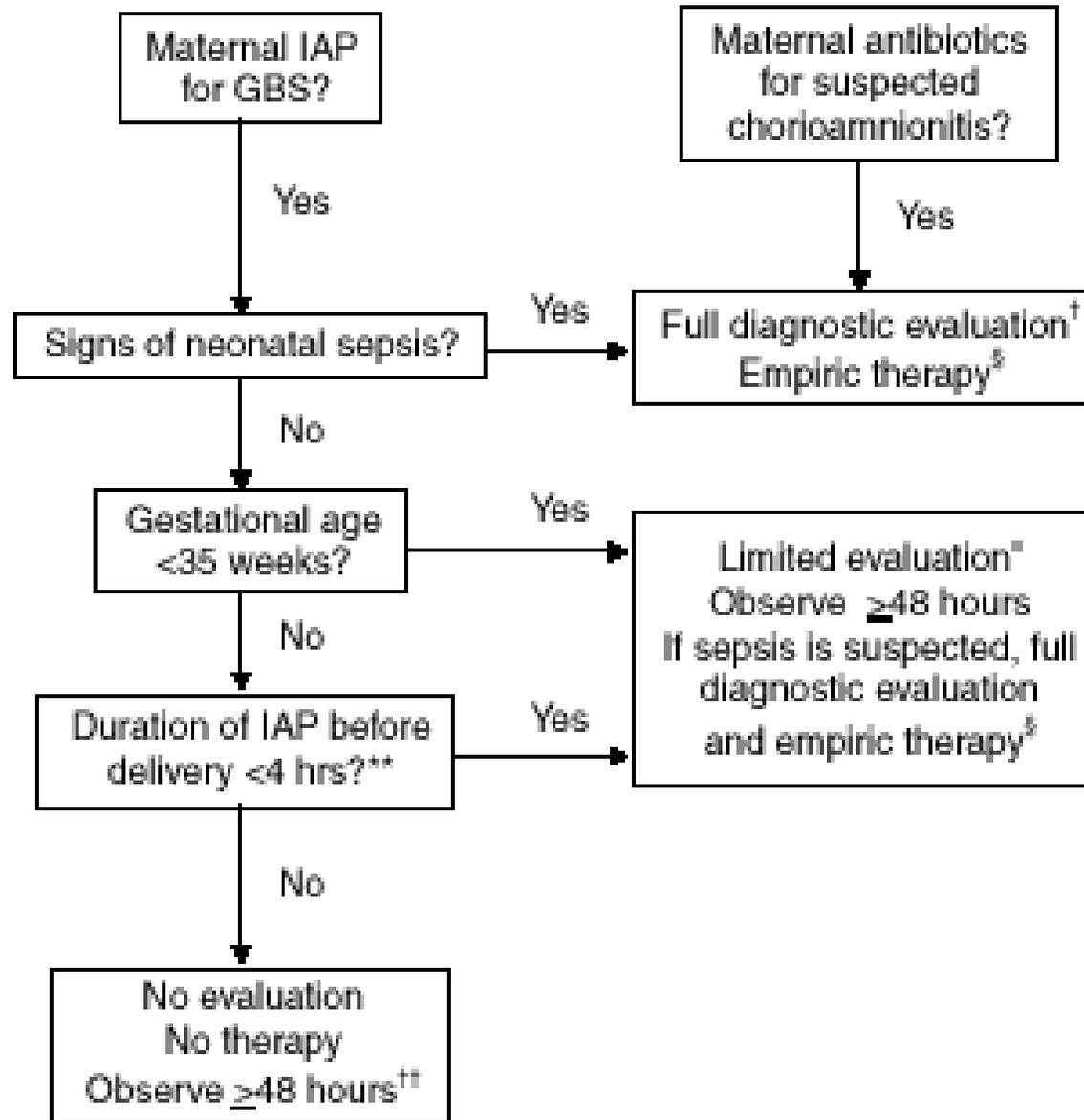
GBS Prophylaxis

- *Appropriate* intrapartum prophylaxis:
 - IV penicillin given 4 hours or more prior to delivery.
- Penicillin *sensitive* = cefazolin (Ancef)
- Penicillin *allergic (anaphylaxis)* = Vancomycin*

*Unless there is documented sensitivity to a different antibiotic, i.e. clindamycin

GBS Disease

- ❑ Before 1996: 7600 cases of sepsis and 210 deaths per year.
- ❑ Early onset GBS: ~ 80% of cases.
- ❑ Transmitted from mother to baby during labor and delivery.
- ❑ Baby usually symptomatic in first 24 hours of life.
- ❑ Antibiotic therapy given *during* pregnancy does not eradicate GBS from the GI and GU tract.
- ❑ Initiation of GBS screening/prophylaxis has resulted in a decline in the incidence of the disease to 0.34 cases/1,000 live births. (down from 1.7 - 3/1,000).
- ❑ IAP does *not* prevent late onset GBS disease, which is often manifested as meningitis.



Management of Asymptomatic Neonate

- Mothers who received *inadequate* IAP:
 - Observe neonate in the hospital for a minimum of 48 hours (no early discharge).
 - Screening for infection with a CBC/diff and Blood culture is recommended IF:
 - 1) Prolonged rupture (18 hours)
 - 2) and/or Preterm (< 37 0/7 weeks GA)

ROUTINE MEDICATIONS

Eye Prophylaxis



What:

- ❑ 0.5% erythromycin ophthalmic ointment placed in baby's eyes within 2 hours of delivery

Why:

- ❑ Prevention of Ophthalmia Neonatorum (ON) and blindness



IM Vitamin K

What:

- ❑ AAP recommended IM vitamin K at birth in 1961
- ❑ All newborns receive vitamin K1 as a 0.5 – 1 mg IM dose within the first 6 hours of life.

Why:

- ❑ Prevent vitamin K deficiency bleeding
- ❑ Classic VKDB : 1/250 (1-7 days).
- ❑ Late VKDB: 1/14,000 to 1/25,000
 - ❑ (2-12 wks, up to 6 months)
- ❑ Mortality for VKDB is 1 out of 5

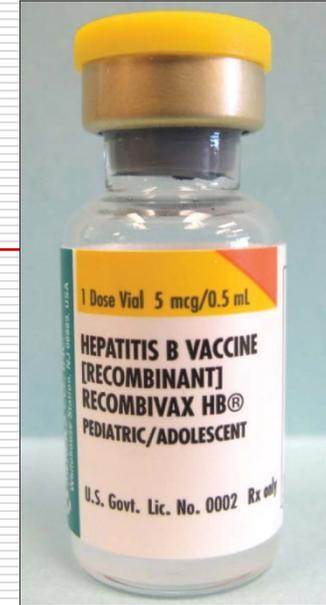
Hepatitis B

What:

- Hepatitis B Vaccine
+/- Hepatitis B Immunoglobulin
- AAP Policy statement August 2017:
Give HBV within 24 hours of birth.

Why:

- Protect against hepatitis B and chronic liver disease/cancer



NEWBORN SCREENING TESTS



Newborn Metabolic Screen

What:

- Blood spot test at 24-48 hours of life
- Done in every state in the US (although diseases screened for can differ between states)

Why:

- Screen for rare genetic disorders for which early diagnosis and treatment saves or improves an infants life (in Texas 53 are screened)
 - Amino acid disorders (ex PKU)
 - Fatty acid disorders (ex MCAD)
 - Endocrine disorders (ex CAH, hypothyroidism)
 - Organic acid disorders (ex methylmalonic acidemia)
 - Hemoglobinopathies (ex sickle cell)
 - Other disorders (ex CF, galactosemia, biotinedase deficiency, SCID)

Metabolic Screening







Hearing Screening



What:

- A Hearing Screen should be performed on all newborns before discharge.

Why:

- Prevalence of newborn hearing loss is about 1 to 2 per 1000 live births in the normal newborn population.
- Incidence is 20 to 40 per 1000 in the NICU population.
- Early intervention improves outcomes

NICU:

- 34 weeks CGA
- Open crib
- Not intubated, trach okay.
- By 3 months of age

Universal Hearing Screening



Universal Hearing Screening

- ❑ A Hearing Screen should be performed on all newborns before discharge.
- ❑ Prevalence of newborn hearing loss is approximately 1 to 2 per 1000 live births in the *normal* newborn population.
- ❑ Incidence is 20 to 40 per 1000 live births in the NICU population.
- ❑ 50% of newborns with significant congenital hearing loss can be detected by high risk factors.
- ❑ The rate of abnormal hearing screens should be less than 4%.
- ❑ After screening, confirmation of hearing loss should occur by 3 months of age, with appropriate intervention initiated no later than 6 months of age.
- ❑ Early intervention has been shown to improve developmental outcomes

Critical Congenital Heart Disease Screening

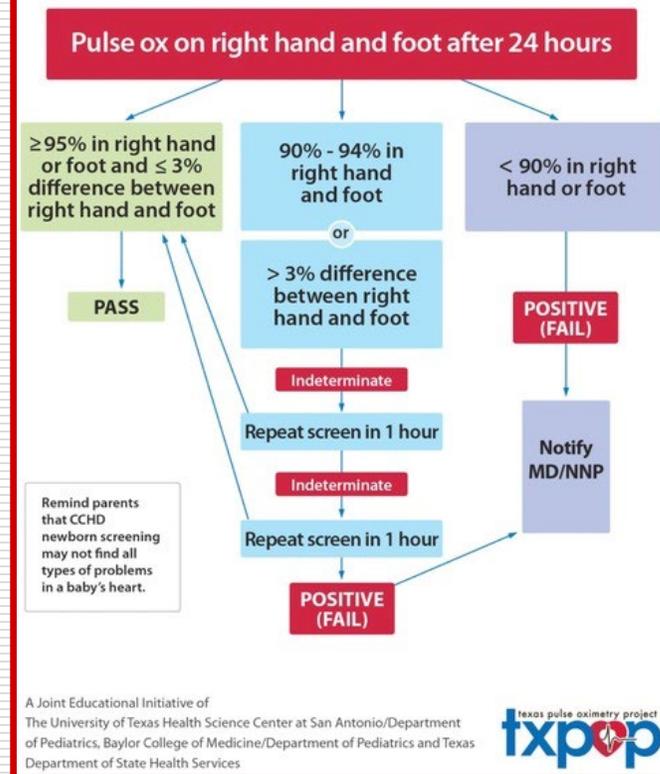
What:

- Pre and post ductal oxygen saturations are compared after 24 hours of life

Why:

- Failing to detect CCHD while in the newborn nursery may lead to critical events such as cardiogenic shock or death at home
- Outcomes are better if babies diagnosed before becoming symptomatic

Critical Congenital Heart Disease Newborn Screening Algorithm



CCHD Screening



- ❑ Critical Congenital Heart Disease Screening
- ❑ Potentially lethal, or “critical”, heart defects.
- ❑ Incidence 2/1,000 live births
- ❑ Requires expert cardiac care and intervention in the immediate newborn period or early infancy
- ❑ Leading cause of death in infants <1 yr old

CCHD Screening

The **seven** defects classified as CCHDs are:

- Hypoplastic left heart syndrome
- Pulmonary atresia (with intact septum)
- Tetralogy of Fallot
- Total anomalous pulmonary venous return
- Transposition of the great arteries
- Tricuspid atresia
- Truncus arteriosus.

Five secondary conditions include:

- Coarctation of the aorta
- Double outlet right ventricle
- Ebstein anomaly
- Interrupted aortic arch
- Single ventricle.



Asymptomatic Hypoglycemia Screening

What:

- Intermittent POC glucose for at risk infants
- Hypoglycemia is treated if necessary

Why:

- Untreated hypoglycemia can be dangerous
- Some data shows early transient newborn hypoglycemia associated with lower achievement test scores at age 10 years

Asymptomatic Hypoglycemia Screening

Glucose screening

At Risk Babies include:

- *Large for Gestational age (LGA)
- *Small for Gestational age (SGA)
- Infant of Diabetic Mother (IDM)
- Premature (< 37 0/7 weeks GA)
- Symptomatic (jittery, tachypneic, lethargic, poor feeder)

*classification per Olsen table



Cord Blood Screening

Type and coombs:

- Screening of neonates for potential significant hemolysis
- Infants born to type O mothers and/or Rh *negative* mothers:
 - Cord blood is obtained for a direct coombs test.
 - An Rh is also done when mother is Rh negative to assess need for maternal Rhogam administration at discharge.
 - Results needed by 6 hours of age to assess need for early bili level.



Bilirubin Screening



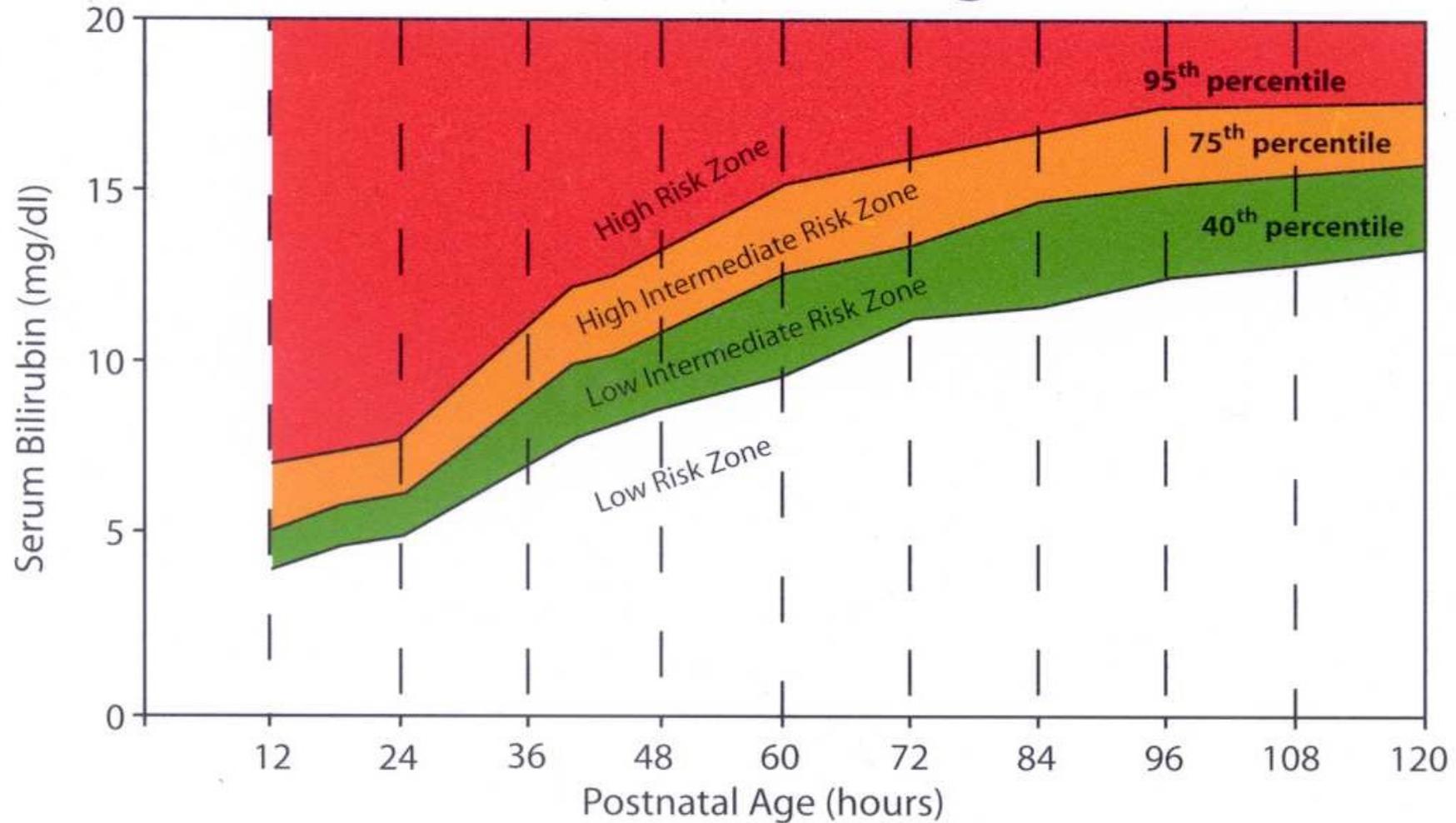
What:

- ❑ Screen all infants for elevated total bilirubin levels.
- ❑ AAP recommendation since 2004.
- ❑ Many centers now also do a direct or conjugated bilirubin with the total or unconjugated bilirubin.

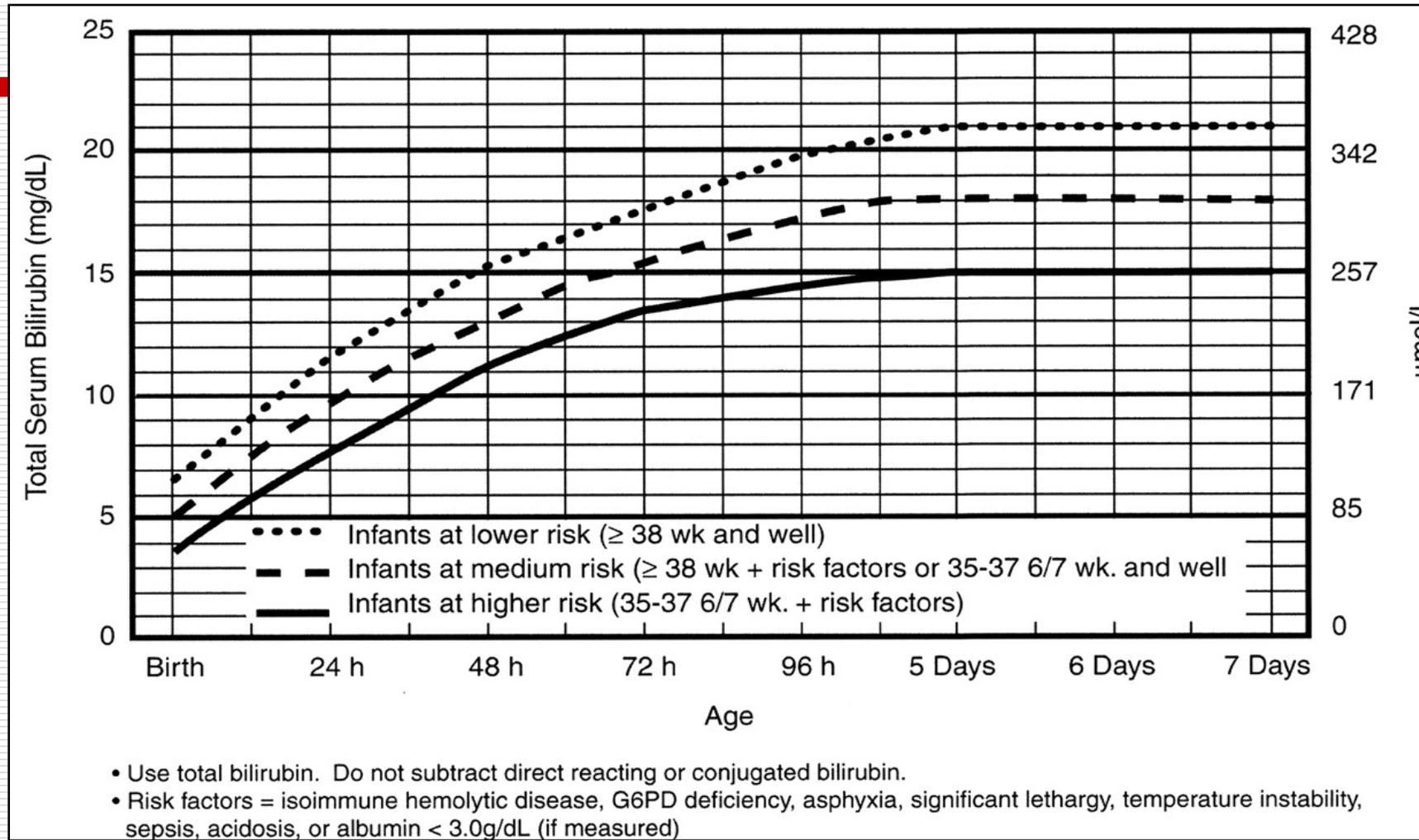
Why:

- ❑ Identify infants with elevated bilirubin levels
- ❑ Treat with phototherapy if needed to prevent bilirubin encephalopathy and kernicterus
- ❑ Early screening for possible biliary atresia (elevated direct or conjugated bilirubin)

Hour Specific Bilirubin Nomogram



Guidelines for phototherapy in hospitalized infants of 35 or more weeks' gestation



Risk Factors







Risk Factors for Development of Severe Hyperbilirubinemia in Infants of 35 or More Weeks Gestation

- TSB level in the high-risk zone
- Jaundice observed in the first 24 hours
- Blood group incompatibility with + Coombs' test, other known hemolytic disease (i.e. G6PD).
- Gestational age 35 – 36 weeks
- Previous sibling received phototherapy
- Cephalohematoma or significant bruising
- Exclusive breastfeeding, particularly if nursing is not going well and weight loss is excessive
- East Asian race

COMMON NEWBORN EMERGENCIES

Morbidity

- Identify danger signs
 - Lethargy
 - Poor feeding/not feeding
 - Temperature instability
 - Respiratory difficulty
 - Convulsions
 - Persistent vomiting
 - Irritability
 - Doesn't "look" right

Neonatal Morbidity

Has a direct correlation to:

- Gestational age
- Chronologic age
- Birth weight
- Intrinsic health problems
- Type of care given at birth

Neonatal Morbidity

Serious illness

- Clinical signs/findings:
 - 90% Respiratory and neurological

Transitional Care

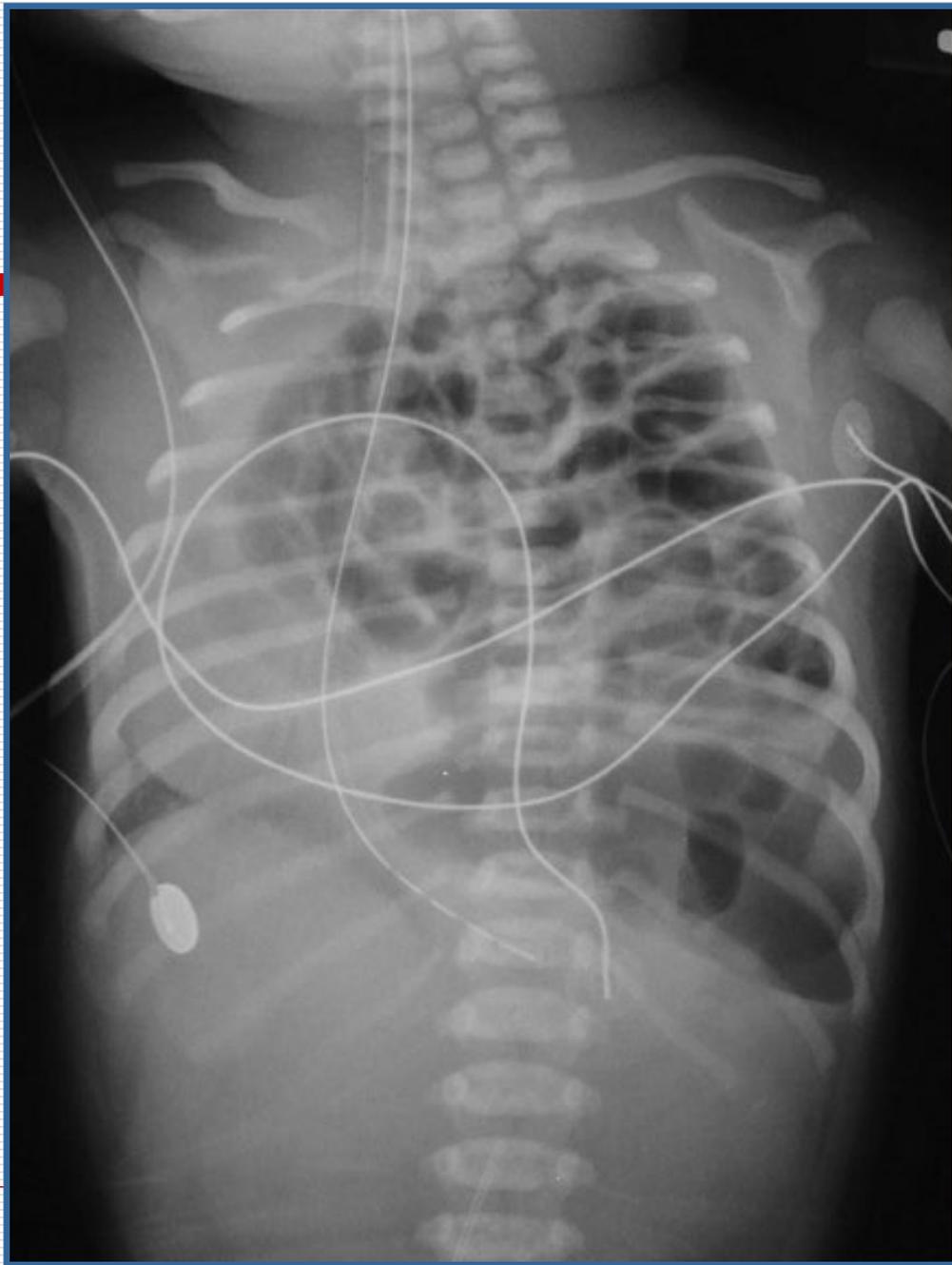
- The baby with respiratory distress:
 - **Tachypnea** (resp rate > 60 at rest, count for at least one full minute)
 - Grunting
 - Nasal flaring
 - Cyanosis
 - Retractions: subcostal, substernal, intercostal, subxiphoid
 - Decreased breath sounds
 - Stridor

Pulmonary Morbidity

- ❑ *Delayed/disorganized transition
- ❑ Transient Tachypnea of the Newborn (TTN)
- ❑ Surfactant deficiency (hyaline membrane disease)
- ❑ Meconium aspiration
- ❑ Congenital pneumonia
- ❑ Air Leak
(pneumothorax/pneumomediastinum)







Newborn Transition

Delayed (Disorganized) Transition

- ❑ Diagnosed *retrospectively* when symptoms resolve within the first few hours of life instead of *progressing*
- ❑ The etiology is most likely a combination of retained fetal lung fluid and incompletely expanded alveoli.
- ❑ **Treatment is supportive until the distress resolves in a few hours as the transition completes (by 6 hours).**

Delayed Newborn Transition

Risk Factors

- Late Preterm/Early Term gestation
- C-section (no labor, ROM at delivery)
- Difficult delivery
- Perinatal Depression
- Short labor
- Rapid vaginal delivery





Transient Tachypnea of the Newborn (TTN)

- ❑ Delayed absorption of pulmonary fluid
- ❑ Oxygen need usually highest initially, then decreases progressively
- ❑ O₂ need rarely exceeds 30%.
- ❑ Generally self-limiting, lasting 48 - 72 hours
- ❑ Increased morbidities due to:
 - ❑ IV fluid administration
 - ❑ Lengthened hospital stay
 - ❑ NICU , Level II admission
 - ❑ ?Medication administration, i.e. Amp/Gent



Risk Factors for TTN

- Premature delivery (\leq 36 6/7 weeks)
- Early term delivery (37 – 38 weeks)
- C-section delivery without labor
- Maternal diabetes
- Maternal sedation
- Perinatal depression
- Delayed cord clamping

Meconium Aspiration

- ❑ Meconium stained fluid occurs in 9%- 20% of all deliveries.
- ❑ Rare before 37 weeks gestation
- ❑ Common after 42 weeks gestation
- ❑ Antenatal course frequently complicated by fetal distress

Meconium Aspiration

- ❑ Aspiration may occur in utero as the compromised fetus passes meconium and begins to gasp
- ❑ More often, aspiration occurs with the initial breaths after delivery
- ❑ Large airway obstruction initially (trachea)
- ❑ Chemical pneumonitis and interstitial edema may obstruct smaller airways later

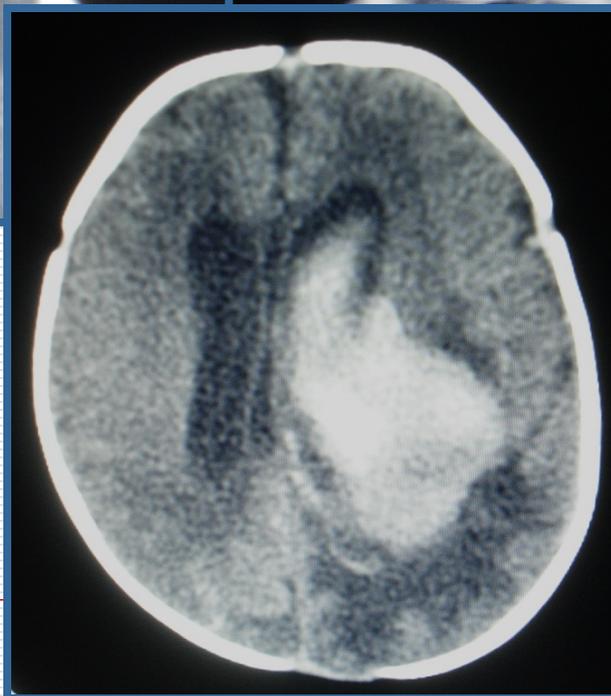
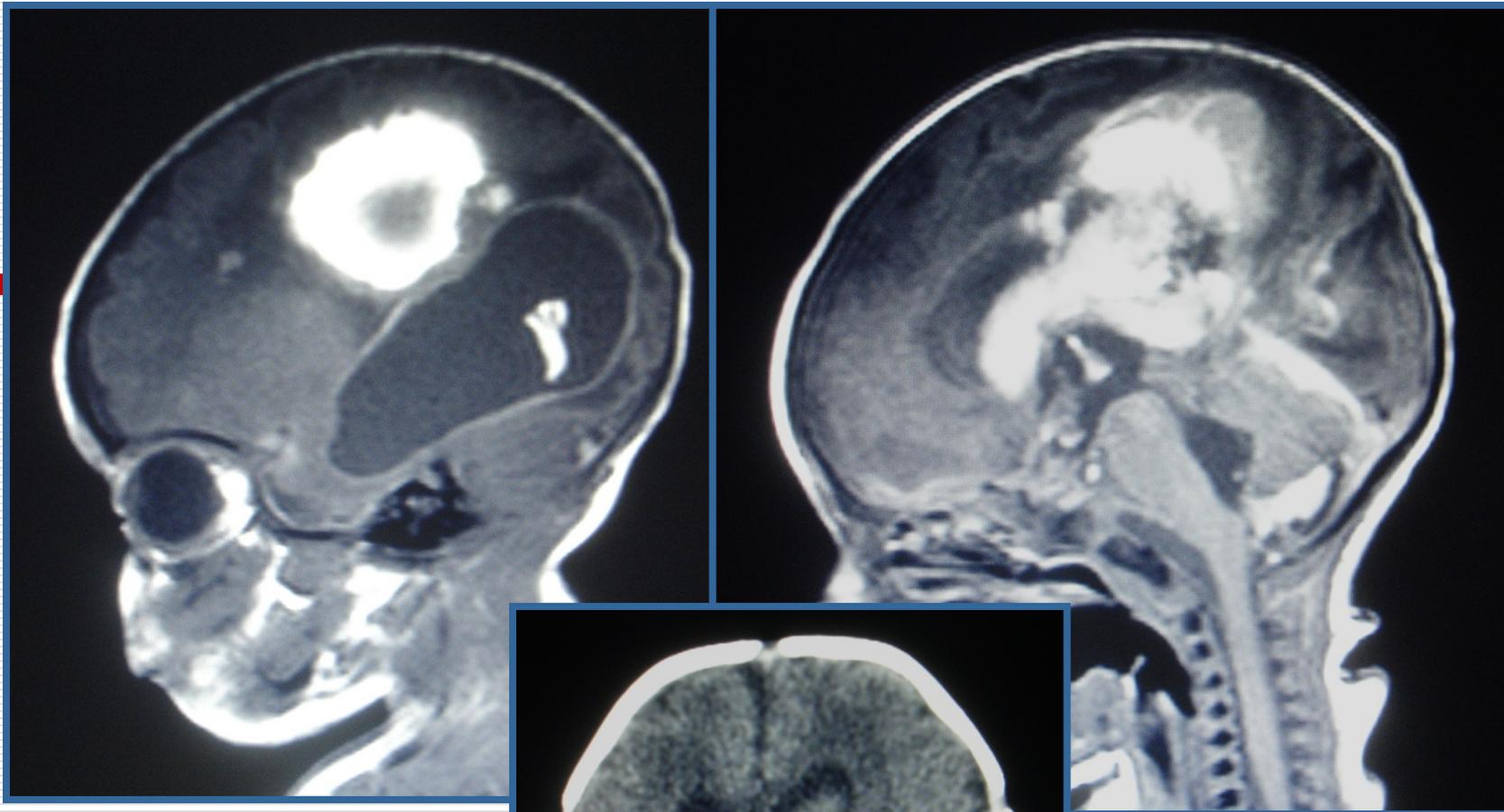


Circulatory Morbidity

- Shock
 - Multiple causes; hemorrhage, sepsis, cardiac
- Anemia
 - Hydrops – immune and non-immune
 - Maternal hemorrhage, fetal, neonatal
 - Transfusion, fetal-placental
 - Hemorrhagic illness (dependent on Vitamin K) by RN
 - Hemolysis
 - Iatrogenic

Neurologic Morbidity

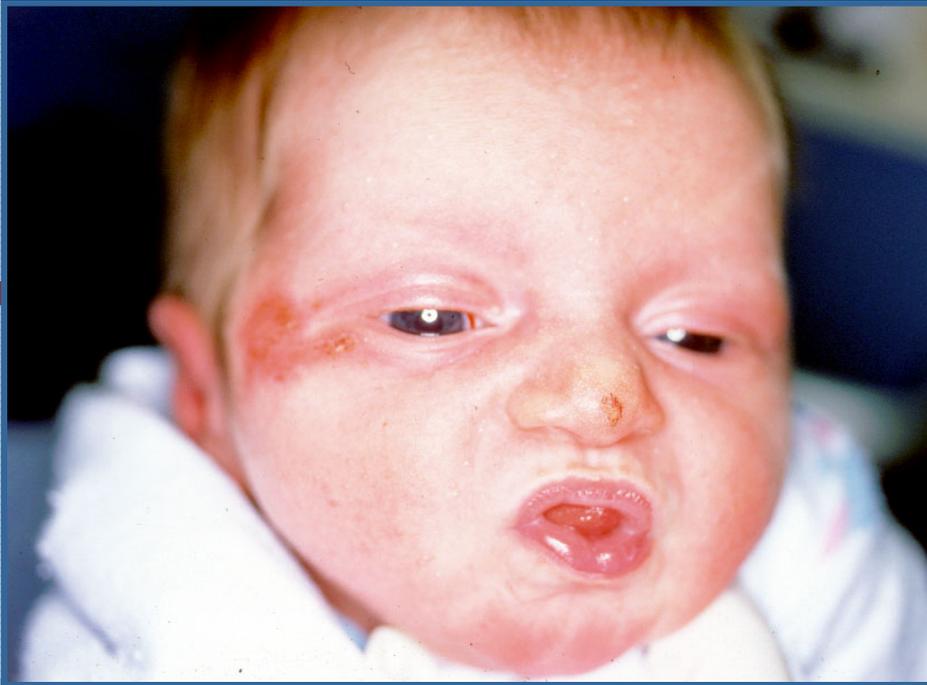
- Asphyxia/Birth trauma
- Convulsions
- Tone disorders
- Hemorrhages
- Congenital anomalies











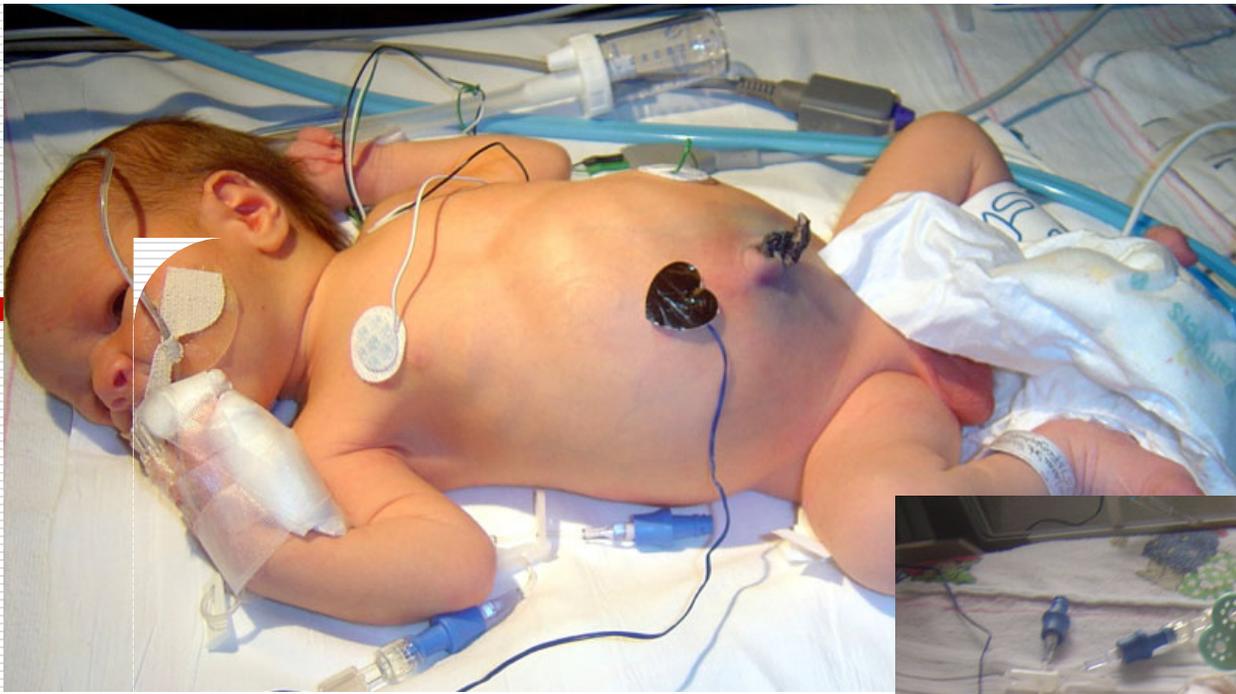


Gastrointestinal Morbidity

- Congenital anomalies
- Vomiting – different etiologies, residual gastric
- Evacuation of meconium – when?
 - Meconium plug
- Diarrhea
- Melena, hemorrhage, acolia
- Distension abdominal – many causes





































Hematologic Morbidity

- Anemia
- Polycythemia
- Icteric
- Hemorrhage
- Thrombocytopenia/Leukopenia
- Tumors









Genito-Urinary Morbidity

- Infection
- Congenital anomalies
- Trauma





Morbidity Observed Via Skin

- ❑ Neurocutaneous syndromes
- ❑ Infection
- ❑ Color – “neonatal rainbow”
- ❑ Trauma
- ❑ Gestational age & vitality





Recommendations

- Perform a thorough medical history and physical exam
- Focus on risk and use a system of triage
- Anticipate
- Put into use, practices based on evidence (preconception, pregnancy, labor & delivery and post delivery)
- Patient safety
- Continuing education and collaborative learning
- Team work
- Evaluate, monitor and measure results

Indications for Early Transfer

- Significant distress
- Inability to p.o. feed
 - (Particularly if glucose is low)
- Concern for sepsis/infection
- Supplemental oxygen need
- Suspicion of congenital heart disease
- Suspicion of anatomic anomaly
 - i.e. CDH, choanal atresia, etc.
- Worsening clinical status

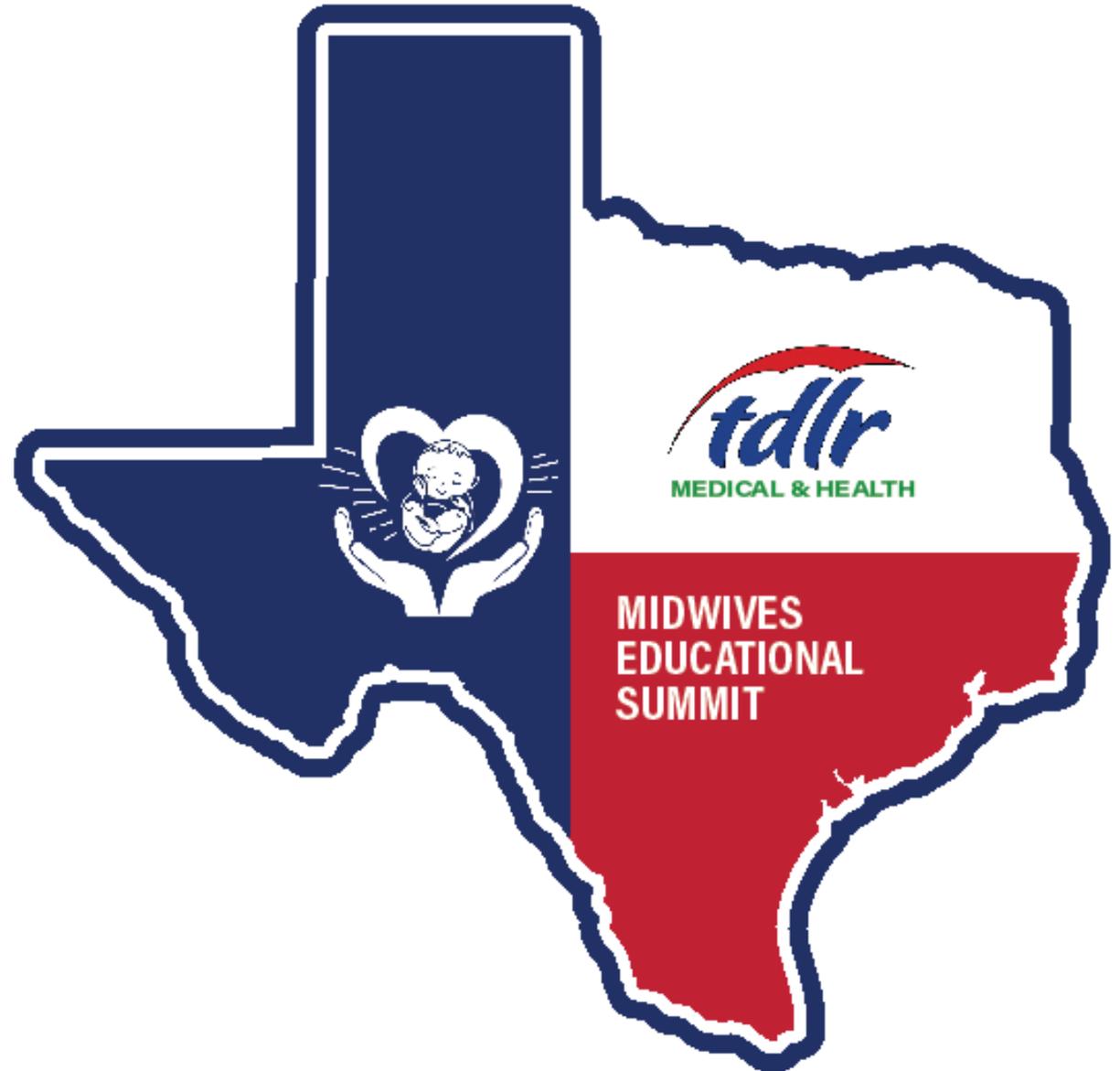
Questions ???



THANK
YOU

PANIC! Yours, Hers, and Medical Considerations

Presented by
Leena Pacak, M.A. and
Jennifer Stout





Leena Pacak, M.A.

Leena Pacak, M.A. is a student midwife who will graduate from the Association of Texas Midwives Training Program in 2020. Before beginning her studies in midwifery, Leena earned a Master's Degree in Clinical Psychology in 2008 and a Bachelor's degree in Special Education. She worked as a teacher for many years in both Chicago and in Colombia, South America. Her background and professional experience in psychology inform her understanding of an individual's growth in the transformative process of pregnancy, birth, the postpartum and motherhood.



Jennifer Stout

Jennifer Stout currently serves as the Education & Community Programs Faculty for MedStar Mobile Healthcare. She has been involved in EMS for 10 years and has been instructing for 5 years.

Jennifer has served in urban and frontier EMS services and EMS education. Jennifer also serves on the Texas Association of EMS Educators as Secretary, and the GETAC EMS Education Committee and as Affiliate Faculty for NAEMT in various educational programs.



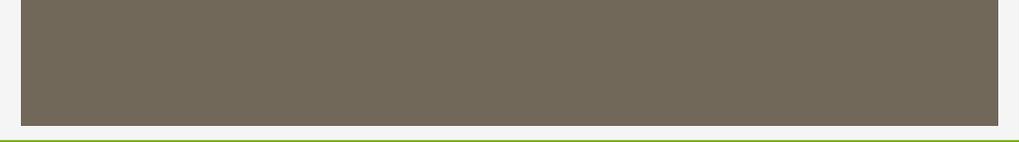
PANIC! Yours, Hers, and Medical Considerations

Leena Pacak &
Jennifer Stout



Let's talk about.....

- Panic Attack Diagnostic Criteria
- Differential Diagnoses
- The EMS View
- What we bring into a clinical situation that impacts our judgment
- How do we make the most accurate assessment possible?



We feel each other's anxiety

- We pick up on each other's emotions.
- Empaths are easily overwhelmed.
- Clients respond to our emotions.
- Bring calm energy to every birth!

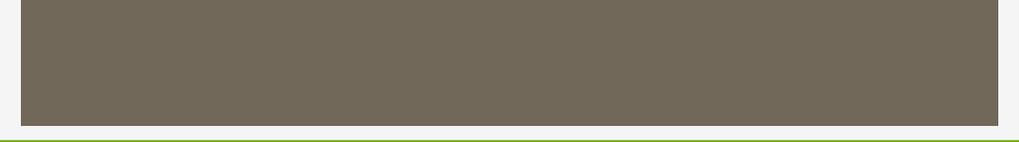
Categories of Panic Attacks

- Expected: associated with a certain fear
- Unexpected: no known trigger or cue

Panic Attack: DSM-V Diagnostic Criteria

- Sweating
- Palpitations
- Trembling, shaking
- Shortness of breath
- A feeling of choking
- Chest pain, discomfort
- Nausea, abdominal distress
- Dizzy, lightheaded, faint

- Derealization or depersonalization
- Fear of losing control or “going crazy”
- Fear of dying
- Numbness or tingling (paresthesias)
- Chills or heat sensations



What conditions might arise at a birth that mimic some of these symptoms?

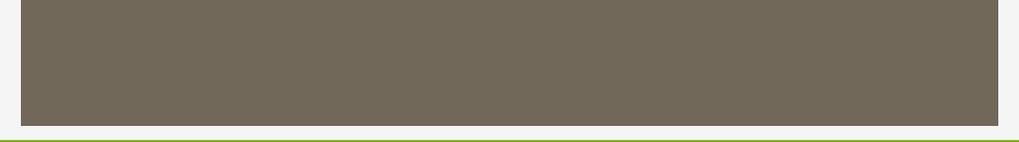
- Uterine Rupture
- Amniotic Fluid Embolism
- Pulmonary Embolism
- Placental Abruptio
- Hemorrhage (Concealed)

When EMS needs to be called!

- Uncertain times!
- What we are looking for!
- Educate us on what you do!
- How you can help us!
- We are all there for the patient!

Panic attacks deserve our FULL attention

- Client is experiencing frightening physical sensations
- It's NOT "in her head"
- She deserves respect and compassion
- Coping strategies (i.e. deep breathing) may be applicable
- NO HARM in transporting someone for "just" a panic attack!



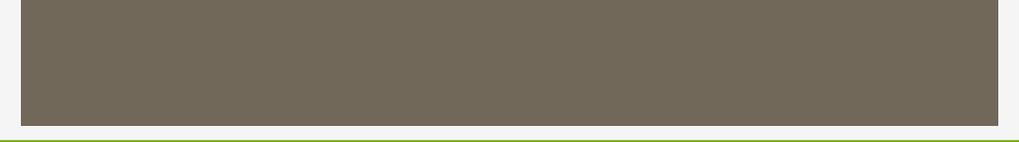
What gets in the way of
seeing with clarity??

- Resistance to our mortality
- We are dealing with LIFE-THREATENING CONDITIONS
- Attachment to our clients
- Our own fear

Let's take a look at OUR panic:

- Our work is heavy and we ALL have fears and baggage that we bring in
- The less awareness we have about our fear, the more likely it is to be in the driver's seat

- Fear of a certain outcome or situation can either make us:
 - ◆ Likely to see it all the time, even when it isn't there
 - ◆ Deny it's existence, even when it is right in front of us

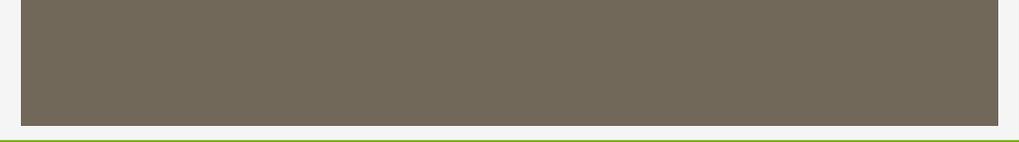


What is the solution??

Bring AWARENESS to
ourselves and our fears

Reflection Exercise:

- 1) Name a fear



2) Think of a time when you misperceived a clinical situation or were wrong in your assessment.

In small groups:

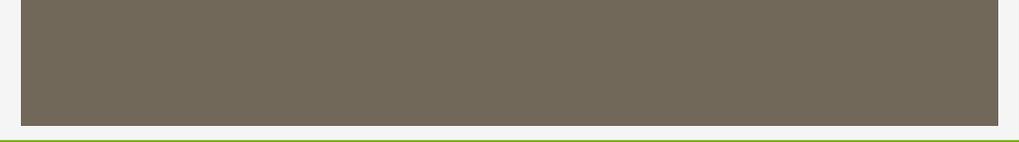
- Share your fear
- Share the incident in which your judgment was off
- Can you think of a fear or feeling that may have been underlying your misperception?

What can we do to better assess our clients' panic with clarity and objectivity?

- TALK ABOUT OUR FEARS/ANXIETIES WITH EACH OTHER
- Process challenging births with a trusted colleague
- Seek professional help when necessary

Ask ourselves and each other:

- What did I feel during this challenging situation?
- Did these feelings impact my judgment?

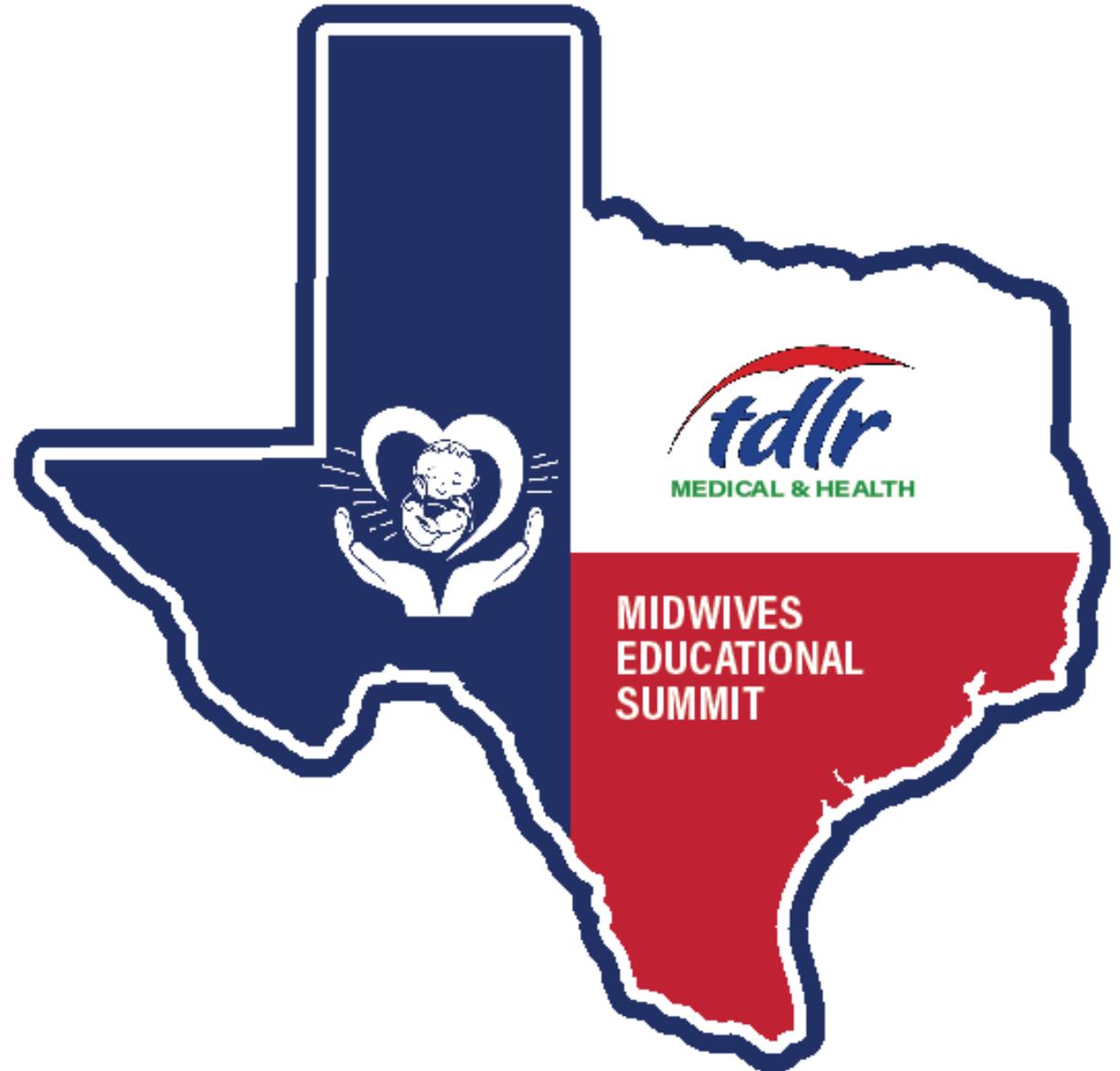


PANIC! Yours, Hers, and Medical Considerations

- Medical conditions exist!
- Advocate
- Be aware

Postterm Pregnancy:
*Research on risks,
monitoring, and
management*

Presented by
Brielle Epstein, CPM, LM





Brielle Epstein, CPM, LM

Brielle Epstein is the mother of two beautiful children born in 2002 and 2006. After the birth of Brielle's first child, she knew birth was her calling. Brielle worked as a doula for over 7 years before becoming a Certified Professional Midwife and Texas Licensed Midwife.

In addition to training with some of Austin's most experienced midwives, Brielle has received additional training in birth support and midwifery from ALACE, the Farm Midwifery Center in Summertown, TN, and Casa de Nacimiento in El Paso, TX.

Brielle is the legislative chair and a Region 1 co-director for the Association of Texas Midwives.

POSTTERM PREGNANCY

Research on risks, monitoring, and management

TDLR Midwifery Summit 07/26/2019

Terminology

- Postterm pregnancy = ≥ 42.0 weeks of gestation
- Late term = $41+0$ to $41+6$ weeks of gestation
- Postdates = ≥ 40.0 weeks of gestation

Dates are based on EDD determined by early ultrasound
+ 14 days

or

294 days from the first day of the LMP

Incidence and "Risk Factors"

- In the US, **5.5%** of pregnancies go beyond 42.0 weeks gestation
- In Denmark and Sweden, where births are primarily managed by midwives, rates are **8.1% and 7.5 %**

Factors that increase likelihood of postterm include:

- Previous postterm birth (most significant factor)
- Nulliparity
- Male fetus
- Obesity
- Advanced maternal age
- Family history of postterm birth
- Maternal race/ethnicity - non-Hispanic white women most likely to go postterm

Dating

- Most accurate method of dating is ultrasound between 11-14 weeks. Up to 22.0 weeks is acceptable but less accurate.
- Inaccurate dates are most common cause for postterm intervention.
- Consider early ultrasound when client is unsure of LMP or conception. If client declines ultrasound, take a thorough menstrual and conception history.
- Use ultrasound date if ultrasound performed at <22 weeks differs from LMP date by more than 5-7 days.

Risks

- Perinatal mortality rate at ≥ 42 weeks of gestation is twice the rate at term
 - Increases fourfold at 43 weeks, and five- to sevenfold at 44 weeks
- Though these increases are significant, *the relative risk is still very low*
- Stillbirth risk:
 - 39 weeks = 3.5 per 10,000
 - 40 weeks = 4.2 per 10,000
 - 41 weeks = 6.1 per 10,000
 - 42 weeks = 10.8 per 10,000
- While there is less data on >43 weeks, the numbers are significant, ranging from 15.8 per 10,000 to 63 per 10,000
- There is also a small increase in early neonatal death among postterm infants

Risks cont'd.

Increased risks of:

- *Postmaturity syndrome (10-20% of postterm pregnancies)*
- *Neonatal convulsions*
- *Meconium aspiration syndrome*
- *5 minute Apgar scores of <4*
- *NICU admissions*
- *2x risk of macrosomia (and associated risks of shoulder dystocia and cesarean birth)*

What do the MANA Stats tell us?

Perspectives on risk: Assessment of risk profiles and outcomes among women planning community birth in the United States

- Looked only at community birth, and was conducted by midwives. Study looked at 47,394 low-risk pregnancies with planned community birth
- **“Those giving birth at or beyond a full 42 weeks of pregnancy...had a moderate risk (2-3 times the very low-risk group) of serious complications.”**
- “Results confirm elevated risks associated with postterm pregnancies; indeed, postterm was riskier in our sample than either advanced maternal age or obesity”

The conclusion is that additional monitoring is warranted and thorough informed choice must be applied

Factors to Consider

- IVF – Pregnancies conceived with AFT are more likely to have placental insufficiency and SGA
- GDM – more likely to have macrosomia and potential for hormonal imbalance. Risk increased if combined with obesity and/or PCOS
- PIH – women with elevated blood pressure face additional risks
- Poor diet or smoking – increases risk of placental insufficiency
- Thyroid or autoimmune disorders – could delay labor even when baby is “ready”
- Trauma and/or fear - counseling needed to uncover concerns
- Adhesions – can often be assessed by digital exam, explore if history of biopsy, cervical trauma, or cesarean
- VBAC – ACOG agrees that TOLAC is reasonable even with postterm
- SGA – higher risk of mortality and morbidity postdates, may require additional monitoring

ACOG Practice Bulletin

Note: Using medical model practice guidelines has significant limits in the community birth setting. These guidelines do not consider the risk assessment done throughout the pregnancy to determine suitability for community birth or the level of personal care given by most community midwives

- Accurate determination of gestational age in early pregnancy (rates of postterm reduced from 9.5% to 1.5%)
- Membrane sweeping – proven effective in late-term or postterm pregnancies. Important to do proper informed consent. Note: Study is needed to understand role of GBS and trauma history should be considered
- No randomized controlled trials of monitoring beyond 42.0 weeks due to ethics of placing pregnant people into the expectant management group since there is a known risk of stillbirth
- ACOG says monitoring at or beyond 41.0 “may be indicated”
- BPP versus NST plus amniotic fluid measurement are both considered viable options for fetal monitoring

ACOG Practice Bulletin (cont'd)

- BPP versus NST plus amniotic fluid measurement are both considered viable options for fetal monitoring
- Small number of studies found twice-weekly fetal surveillance is optimal starting in the late-term so this is generally standard of care (every 3-4 days)
- If oligohydramnios is found at 41+ weeks, induction is indicated. **CESAREAN IS NOT INDICATED UNLESS OTHER FACTORS**
- Using AFI alone can cause more unnecessary inductions, so deepest vertical pocket can also be requested in this case. Deepest vertical pocket of 2cm or less OR AFI of 5 or less indicates induction necessary
- **"Induction of labor after 42 0/7 weeks and by 42 6/7 weeks of gestation is recommended, given evidence of an increase in perinatal morbidity and mortality"**

What Do the Rules Say?

115.114. Prenatal Care.

(d) If a client has reached 42.0 weeks gestation and is not yet in labor, the midwife shall immediately either:

(1) collaborate with a physician and obtain appropriate antenatal testing, in order to continue midwifery care; or

(2) initiate transfer and document that action in the midwifery record

Options to Consider

- Collaboration and monitoring with BPP and/or NST
- “Natural” induction in the community setting (birth center study showed 91% of clients given castor oil birthed without major side effects in the community setting)
- Acupuncture. Small studies support use. Best combined
- Transfer to hospital for induction after 42.0
- Membrane stripping (consider GBS, trauma, method based on gestation)
- Foley induction (cannot be performed by LM but could call in a CNM or go to hospital for placement). Can also be combined with natural induction
- Kick counting: important to remind clients to monitor fetal movement and evaluate if there is reduction in fetal movement. Mixed research on methods. Research has repeatedly show maternal fetal movement monitoring to be effective.

Informed Choice and Client Autonomy

Ultimately it's up to the client/family with input from the midwife and thorough informed decision-making

MANA's policy statement on elevated risk:

- "Even when risk may be elevated, people choose community birth for a variety of reasons, including cultural and religious influences and an assessment of their options in other settings. As with other health care decision making, this very personal decision should remain with a family, informed by accurate, evidence-based information."
- "A mother's right to make decisions about place of birth is affirmed by American Congress of Obstetricians and Gynecologists (ACOG). In their recent committee position on planned home birth, ACOG affirmed a woman's right to make a medically informed decision about place of birth, even when risk is elevated. A birthing person's autonomy is also upheld by current thinking in obstetric ethics."
- "It is the professional responsibility of community birth practitioners to engage in a thorough shared decision-making process with their clients. All birth care providers have an obligation to fully inform potential clients of their experience level with the presenting risk factors as well as their regulated scope of practice."

You must provide the information on risks and options and CHART IT!

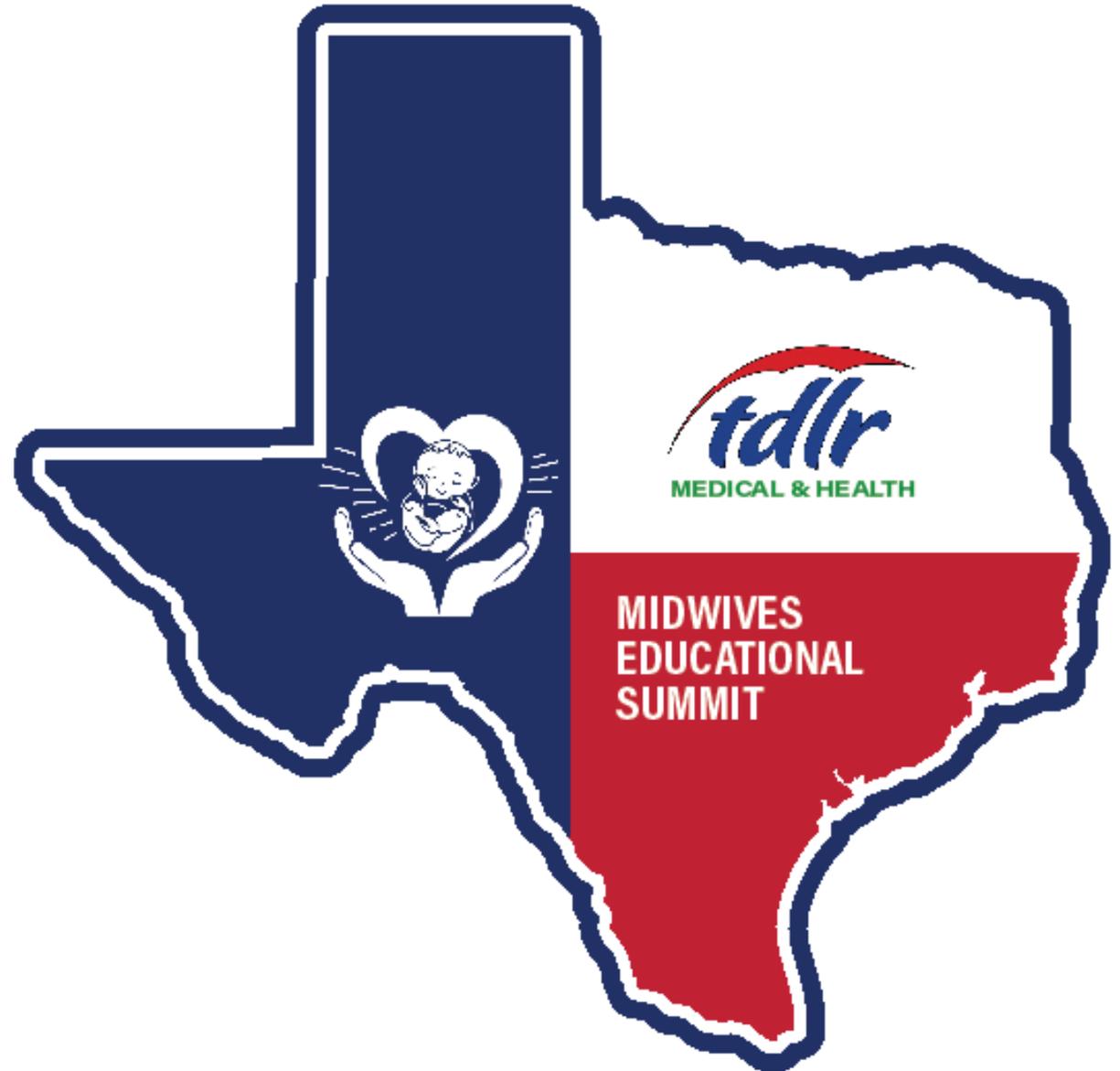
***Having a specific ICA that includes this information for postterm,
signed by the client, is even better.***

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Peer Review: Purpose, Guidelines, and Improving Midwifery

Presented by
Christy Martin, CPM, LM



Christy Martin, CPM, LM

Ms. Martin is a Certified Professional Midwife with the North American Registry of Midwives and a Licensed Midwife in the State of Texas. Christy has been practicing midwifery in the Dallas-Fort Worth metroplex for over 12 years, attending births in homes and birth centers. Christy holds a BA in Christian Ministries and an Associates degree in Nursing. After working for a few years as a RN, she began her pursuit of becoming a midwife in 2004. Ms. Martin trained with Mercy in Action and obtained an Associates degree in Midwifery from the National College of Midwifery. Active in the North Texas Midwives Association, Christy has previously served as secretary and is currently serving on the peer review core group. She also serves as secretary on the board of the Association of Texas Midwives.



Peer Review:

Purposes, Guidelines &
Improving Midwifery

WHAT IS PEER REVIEW?

Peer Review is a process in which midwives gather to present specific cases related to pregnancy, birth, postpartum and the newborn for consideration and feedback from their colleagues.

Peer Review is a tool which gives our profession opportunities to learn together and hold each other accountable to appropriate standards in the care we give.

THE VALUE OF PEER REVIEW

Peer review should have the positive effects of stimulating personal and professional development and should challenge us as midwives to think critically about each of our practices.

“As an autonomous profession we bear the responsibility to develop and maintain high standards which guide the care we give mothers and babies.”

WHAT PEER REVIEW IS NOT

Birth story circle

Group therapy session

Chance to get gossip tidbits

Shame and blame

A time to falsely assure ourselves when
outcomes are good but practices are outside
of appropriate midwifery care

NARM'S VALUES FOR PEER REVIEW

Routine

Confidential

Professional

Non-punitive

Educational

NARM REQUIREMENTS & HIPAA COMPLIANCE

Recertification Form 600, page 10 of 11

All forms must be filled out completely in English in black ink or typed.

CEU Worksheet for Peer Review

Applicant's Name: _____ Date: _____

Peer Review, mandatory five hours

Peer Review Participation or attending a Peer Review Workshop.

- One hour of credit is earned for each hour spent in peer review participation or in the peer review workshop.

Peer Review Participation

- Complete chart below.

Date of peer review									
Number of participants									
Number of cases presented									
Number of hours									

Total Peer Review Participation hours: _____

Peer Review Workshop

- Include any documentation of workshop (certificate of completion or attendance, letter of verification of attendance).

Course Title of Peer Review Workshop: _____

Date attended: _____ Number of hours completed: _____

Instructor name: _____ Phone number: _____

NARM REQUIREMENTS & HIPAA COMPLIANCE

“Consumers should know that their practitioner participates in peer review, and that, if a concern is raised, there is a platform for discussion and follow-up. Other health care practitioners can also know and recognize the professionalism involved in maintaining Community Peer Review.”

“CPMs must disclose to their clients that they participate in regular peer review, which can sometimes necessitate confidential disclosure of health information for the purpose of reviewing the midwife’s professional conduct.”

(<https://narm.org/accountability/community-peer-review-guidelines/>)

EXAMPLES OF DISCLOSURES & INFORMED CONSENT



outcomes are achieved with very low rates of intervention, such as labor induction, labor augmentation and cesarean section. These procedures are used at very high rates in low risk hospital births. We personally believe, and evidence shows, that home birth is safe, but we are not against hospitals. Hospitals are vital for women and babies with complications, and for those who simply feel uncomfortable at home. Ultimately the choice is yours.

The practice of midwifery by Certified Professional Midwives (CPMs) is regulated by the Virginia Board of Medicine. Under Virginia law CPMs are referred to as licensed midwives (LMs). In short, LM regulations require that midwives maintain CPM certification through the North American Registry of Midwives (NARM). This requires continuing education, neonatal resuscitation certification, and adult CPR certification. Also as part of our certification, CPMs are required to participate in a peer review process. During peer review, client health information will be shared in confidence with other CPMs. Virginia regulations also require additional disclosures which will be provided to you in a separate document.

I agree to allow students and apprentices of Mountain View Midwives who are involved in my care to use my records, with my name removed, as verification of skills with the North American Registry of Midwives. Yes No

I agree to allow Mountain View Midwives to discuss my treatment and care with colleagues as part of professional peer review. Yes No

I agree to allow a photo my baby or me to be posted on the Mountain View Midwives Facebook page with personal identifiers that may include my baby's name and birth weight. Yes No

I agree to allow Mountain View Midwives to use photos that I share with them for the purpose of education in presentations about midwifery and home birth. Yes No

ATTENDEES OF PEER REVIEW

Midwives

Student midwives

Birth assistants

PROCESS OF PEER REVIEW

Every midwife in attendance states:

- Total number of clients in midwife's care
- Number of upcoming due dates
- Number of postpartum clients
- Number of births done since last attended peer review
- Number of cases midwife has to present

TYPES OF CASES TO PEER REVIEW

- Consultations
- Transfer of care
- Transport to hospital
- Cases where midwife practiced outside of practice guidelines
- Cases where midwife requests input from community
- Interesting cases

INFORMATION TO PRESENT FOR A PEER REVIEW CASE

- Gravity & Parity
- Significant medical or obstetrical history or psychosocial concerns
- Relevant lab work and test results
- Significant pregnancy, birth and postpartum information
- Consultation(s) with other providers
- Present plan of care and how the plan of care may change depending on ongoing situations

PROCESS OF PEER REVIEW

- While a midwife presents a case others remain quiet
- If midwife brought copies of chart, chart is reviewed by others
- After each case, questions may be asked and suggestions given.

“Positive feedback is encouraged, concerns should be raised respectfully and with the assumption that feedback is welcome.” (NARM Candidate Information Booklet)

ASKING QUESTIONS AT PEER REVIEW

Tendency might be to say/ask:

“You should have...” “I would have...” “Why didn’t you...”

Better approach is to say/ask: “Did you consider...”

“Do you practice guidelines allow for...”

CONSIDERATION FOR MIDWIFERY COMMUNITIES

- Recommendations for follow-up may be given by individuals or by consensus

Option for recommendations to be binding

X. Some Community Peer Review groups have decided to include an agreement regarding consensus and binding recommendations. The Community Peer Review group may decide that the recommendation made for follow-up in instances of extreme concern need to be binding. If so, the recommendations must be reached by consensus and each participating midwife must agree to such binding decisions in the future. No recommendations are made that the other midwives would not themselves carry out.

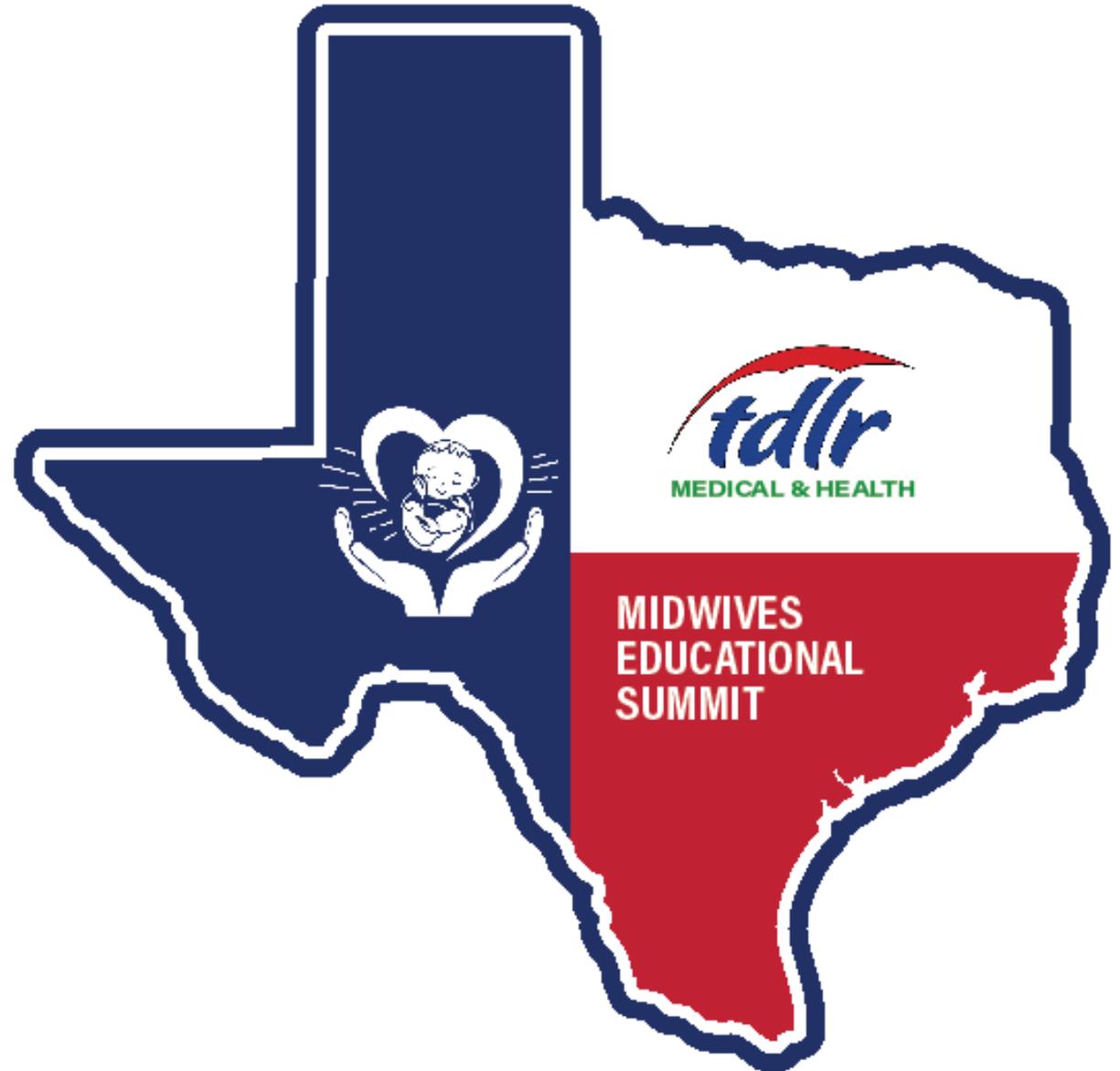
NORTH TEXAS MIDWIVES ASSOCIATION'S APPROACH

- Peer Review Coordinator
- Closed Peer Review option
- Peer Review core group
- Students may attend but must attend with a preceptor

EXAMPLE OF HOW TO PRESENT A CASE

Relationship building: Collaboration in Midwifery

Presented by
Tereé Fruga, CPM, LM and
Dr. Michael Glover, D.O.





Tereé Fruga, CPM, LM

Tereé's formal midwifery training began in 2012, but her work in birth started in 2003. The first 10 of those years were spent serving as labor support for families during birth and the immediate postpartum. For approximately 3 ½ years of that time, Tereé also served as a patient care technician in labor and delivery, postpartum, and newborn nursery. Tereé completed a rigorous midwifery clinical apprenticeship and had the privilege of being trained under the wisdom and instruction of some of the most amazing midwives this side of Texas. Tereé maintains a good relationship with her preceptors, and they continue to be a source of wisdom, counsel, and encouragement as Tereé continues to walk in her calling as a licensed midwife. Tereé has attended over 300 births. In 2015, Tereé received her national Certified Professional Midwife credential from the North American Registry of Midwives after passing the certifying exam and was also decreed a Licensed Midwife by the state of Texas. Tereé is a member of the North Texas Midwives Association. Tereé maintains current certification in CPR and Neonatal Resuscitation as a healthcare provider. Tereé has the distinct honor of being called "Mom" by 4 mighty little men and one courageous little princess. It is out of the outpouring of her first ministry of motherhood, that she is called to the sisterhood of midwifery and birth.

Dr. Michael Glover, D.O.



Dr. Glover was born in Fort Worth, Texas and was raised in his home town of Saginaw. He is a 1979 graduate of Abilene Christian University in Abilene, Texas. He received his medical training at the Texas College of Osteopathic Medicine in Fort Worth. He completed his residency in Obstetrics and Gynecology from the Philadelphia College of Osteopathic Medicine in 1994. Dr. Glover has been practicing OB/GYN for over 20 years. His current practice is with Grace Obstetrics and Gynecology in Cleburne. He has been married to his wife Michelle for 38 years. They have 3 adult children and 4 grandchildren with another on the way.

Thank you for
attending.

Please complete your survey
and turn it in as you leave.

