Midwifery – ORR 2018-031 LR
Public Comment Summary
Rules Committee Recommendations and Board Responses to October 30, 2018 Public Comments

Testimony/Comments Received and Attached to Public Comment Summary for Reference:

Matthew Allswede, MD, FACOG, Michigan Section Chair, The American College of Obstetricians and Gynecologists (ACOG);
Brett Averill, CPM, LM, Northern Michigan Home Birth
Melodee Babcock, MSN, CNM
Melissa Bayne, DO, FACOG, Spectrum Health, OBGYN Department Chief
Amy Bowditch
Jason Brown, D.C.
Abbey Brunner
Nicole Budrys
Carolyn Cronk
Ida Darragh, Executive Director, North American Registry of Midwives
Eileen Denomme, CPM, Woven in Love Maternity Services, LLC
Raymond DeVries, PhD, Professor, Center for Bioethics and Social Sciences in Medicine, U of M Medical School
Emily Dove-Medows, CNM, President, Michigan Affiliate of the American College of Nurse-Midwives (Michigan ACNM) (emailed by Moira Tannenbaum)
Lisa Ellens
Vicki Ferrier, RN
Renay Gagleard, Michigan Council for Maternal & Child Health (MCHCH)
Jennifer Gorchow, MCMCH
Faith Groesbeck, BA, CCCE, CD
Elizabeth Hawver, President, Friends of Michigan Midwives
Brooke Henning

Jennifer Holshoe and Jenn Dewaard, MI Chapter Leaders, International Cesarean Awareness Network (ICAN) of Grand Rapids
Paul Howell
Cynthia Jackson
Susan Jenkins, Chief Legal Counsel, on behalf of the Big Push for Midwives Campaign, sponsored by the National Birth Policy Coalition
Rebecca LaDuca
Katie Lavery, CNM, Everyday Blessings Midwifery
Robert Lorenz, MD
Federico Mariona, MD, MHSA, FACOG, FACS, Founding Director Division of Maternal Fetal Medicine, Professor, Department of Obstetrics & Gynecology, Wayne State University School of Medicine
Stephanie Mayne
Melissa
Michigan Midwives Association, Board of Directors
Tobi Moore, Executive Director, American Nurses Association of Michigan (ANA); Emily Dove-Medows, CNM, President, Michigan ACNM; Amy Zaagman, Executive Director, MCMCH; Gretchen Schumacher, PhD, GNP-BC, FNP, NP-C, President, Michigan Council of Nurse Practitioners (MICNP); Chris Mitchell, Senior Vice President, Michigan Health & Hospital Association (MHA); Matthew Allswede, MD, FACOG, Michigan Section Chair, ACOG; and Betty S. Chu, MD, MBA, President, Michigan State Medical Society (MSMS), and Katherine Gold, Kathleen Johnston-Calati, Jennifer Schaible, Elizabeth Leary, Sara Cramton, Chelsea Carver, Brendan Conboy, Michelle Konieczny, Christine Matoian, Elizabeth Cousineau, Kelly Wiersema, Lauren Smith, Kristina VanderMark, Fatemeh Parsian, Christopher Niehues, Christine Pipitone, Angelica Lorenzo, Whitney Nieland, Joseph Rutz, Daphne Tumaneng, Sarah Pearl, Sara Garmel, Ann Gillett-Elrington, Dawn Robinson, Despina Walsworth, Robert P. Lorenz, Paige Paladino, James A. Hall, Jenny Stimac, Robert P. Roberts, Jr., Laurence Burns, Lynda Grosjean, Samuel Bauer, Paul Nehra, Jennifer Veltman, Heidi Grabemeyer-Layman, Anne Ronk, Atinuke Akinpeloye, Melanie Beth Schweir, Thomas Edward McCurdy, Mehmet O. Bayram, Sharon O'Leary, Robert F. Flora, Michael Swirtz, Penny Cox, Lena Weinman, Anwar Jackson, Rachel Ford, Andrea Pacheco Arias, Mey Yip, Anushka Magal, Stephanie Menon, Lisa Peacock, Marg G. Lewis, Bryan Popp
Kathi Mulder, CPM, Dance of Life Midwifery, LLC
Jill Barnett Nolan
Kristen Paquin, ICAN of Greater Ann Arbor

Sandra Pera, CPM, LM
Jennifer Phillips, IBCLC
Heidi F. Pohl, RN, BSN
Nikki Polce, BS, FNS, RYT
Meghan Redder
Robert J. Sokol, MD, MI AIM Executive Committee, Michigan Alliance for Innovation on Maternal Health
Mickey Sperlich, PhD, MSW, MA, CPM, Asst. Professor, University at Buffalo School of Social Work
Helen Stockton, CPM, Mother Earth Midwifery
Linda Taft, RN, President ANA- Michigan and Tobi Lyon Moore, MBA, CAE, CFRE, Executive Director
Michelle Thomas
Carly Van Thomme
Despina Walsworth, MD, FACOG, MHSA
Nancy Ward
Amy Tracy Wells
Jason Wilson
Sarah Wilson
Laurie Zoyiopoulos, CPM

The following individuals submitted written support for licensing midwives and the midwifery rules as proposed: Babcock, Bowditch, Brunner, Cronk, DeVries, Ellens, Ferrier, Hawver, Henning, Holshoe, Jackson, Jenkins, LaDuca, Mayne, Melissa, Nolan, Paquin, Phillips, Pohl, Polce, Redder, Sperlich, Thomme, Ward, J. Wilson, and S. Wilson.

Budrys does not support licensing midwives.

Rule 338.17101 Definitions.

Rule Numbers	Commenter	Comment
Section (1)	Moore/ANA et al.	Modify the definition of "appropriate health professional" to "a physician, physician's assistant, nurse practitioner or certified nurse midwife with experience in the active practice of obstetrics, pediatrics, or emergency medicine and licensed under article 15 of the public health code."
	Allswede/ACOG	Specify that an "appropriate health professional" has appropriate obstetric expertise, holds a current

		Michigan license, and has admitting and obstetric privileges at a nearby hospital with labor and delivery services.
	Brown	Keep chiropractor in definition of "appropriate health professional," as midwives do refer patients with structural related conditions to chiropractors. It is the commenter's hope that patients will retain the right to receive care from whichever practitioner they desire. Patients receive better care when there are fewer hoops to jump through.
	Lavery	Modify "appropriate health professional" to "any appropriately qualified MD, DO, PA, or CNM licensed under article 15."
Rules Committee Response	The Rules Committee agrees with the comments to limit the type of health professionals that a midwife may refer to or consult with in Part 4 of the rules and therefore, it recommends that the general definition of "appropriate health professional," which by definition in section 17101 of the Public Health Code (Code), MCL 333.17101(a), applies to many different types of consultations, referrals, and collaborations, be deleted from R 338.17131 and moved to the general definitions in R 338.17101. In addition, the Rules Committee recommends that the definition in the general provisions includes all those licensed under Article 15. A licensed midwife may want to refer, consult or collaborate with other health professionals in addition to a physician, physician's assistant, or nurse practitioner. However, it is also recommended by the Rules Committee that a midwife only consult or refer or transfer a patient, pursuant to Part 4 in the rules to a limited list of health providers (see R 338.17134 and R 338.17135).	

NEW LANGUAGE FOR PROPOSED RULE 338.17101:

- **R 338.17101(1):**

(1) As used in these rules:

(a) "Appropriate health professional" means any individual licensed, registered or otherwise authorized to engage in a health profession under article 15 of the public health code **who is referred to, consulted with, or collaborates with a licensed midwife.**

(**b**) "Board" means the Michigan board of licensed midwifery.

(**c**) "Code" means 1978 PA 368, MCL 333.1101 to 333.25211.

(d) "CPM" means a certified professional midwife who has met the standards for certification set by the North American Registry of Midwives (NARM). The CPM credential is accredited by the National Commission for Certifying Agencies (NCCA). The CPM credential with NARM requires a midwife to:

(i) Validate education.
(ii) Pass an examination.
(iii) Complete a workshop, module or course on cultural awareness.
(iv) Meet general education requirements.
(v) Maintain current adult CPR and current neonatal resuscitation program certification (NRP) with a hands-on component.
(vi) Complete obstetric emergency skills training.
(**e)** "Department" means the Michigan department of licensing and regulatory affairs.
(**f**) "Peer review" means the process utilized by midwives to confidentially discuss patient cases in a professional forum, which includes support, feedback, follow-up, and learning objectives.
(2) Terms defined in the code have the same meanings when used in these rules.

Board Response	The Board agrees with the suggested change to limit the type of health professionals that a midwife may refer to or consult with in Part 4 of the rules, and therefore, deletes the broader definition of "appropriate health professional," which by definition in section 17101 of the Code, MCL 333.17101(a), applies to many different types of consultations, referrals, and collaborations, from R 338.17131 and moves it to the general definitions in R 338.17101. Added a definition for CPM, pursuant to comments to clarify the requirements for a CPM credential under comments to R 338.17121. See above.

Rule 338.17113 Licensed midwifery accrediting organizations.

Rule Numbers	Commenter	Comment
Section (1)	Moore/ANA et al.	Add "or its successor entity" after Midwifery Education Accreditation Council (MEAC).
(2)	Moore/ANA et al.	Add "The board may approve a petition only if the standards and evaluative criteria of the organization are determined to be equivalent to the standards of MEAC."
Rules Committee Response	The Rules Committee agrees with the commenter's suggestions to clarify that there may be a successor entity and that the Board must compare the proposed accrediting organization to the standards and evaluative criteria of MEAC.	

NEW LANGUAGE FOR PROPOSED RULE 338.17113:

- **R 338.17113(1) and (2):**

(1) The board approves the Midwifery Education Accreditation Council (MEAC), **or its successor entity,** as an accrediting organization **for an educational program or pathway**.
(2) A petition may be filed with the board for approval of a midwifery accrediting organization **for an educational program or pathway,** which will be evaluated to determine the organization's equivalence to the standards of other board approved accrediting organizations. **The board may approve a petition only if the standards and evaluative criteria of the organization are determined to be equivalent to the standards of MEAC, or its successor entity.**

Board Response	The Board agrees with the suggested change to clarify that there may be a successor entity, and that the Board must compare the proposed accrediting organization for an educational program or pathway to the standards and evaluative criteria of MEAC. See above.

Rule 338.17115 Licensed midwifery credentialing program.

Rule Numbers	Commenter	Comment
338.17115	Moore/ANA et al.	Add language that only allows approval of a credentialing program by the Board if its standards and evaluative criteria are equivalent to the North American Registry of Midwives (NARM) and replace the language "or another accrediting organization approved by the board" and instead refer to Rule 338.17113, which will limit an accrediting organization to one whose standards are equivalent to MEAC.
Rules Committee Response	The Rules Committee agrees with the suggestion to require the Board to review an application for approval of a credentialing program to the "standards and evaluative criteria," but declines to limit an accrediting organization only to one equivalent to MEAC for accrediting programs, as section 17115(1)(b) of the Code, MCL 333.17115(1)(b), requires the Board to approve an accrediting body equivalent to the National Commission for Certifying Agencies (NCCA).	

NEW LANGUAGE FOR PROPOSED RULE 338.17115:

- **R 338.17115**

The board may approve a licensed midwifery credentialing program **only** if ~~it is~~ **the program meets all of the following:**

(a) The standards and evaluative criteria are equivalent to the credential of **a** certified professional midwife (CPM) from **the** North American registry of midwives (NARM), **or its successor entity.**

(b) It satisfies ~~meets~~ the criteria of section 16148 of the code, MCL 333.16148~~, and~~**.**

(c) **It** is accredited by the national commission for certifying agencies (NCCA), **or its successor entity,** or another accrediting organization approved by the board **if the standards and evaluative criteria of the accrediting organization are determined to be equivalent to the standards of NCCA, or its successor entity.**

Board Response	The Board agrees with the suggested change to review an application for approval of a credentialing program pursuant to the "standards and evaluative criteria," but declines to limit an accrediting organization only to one equivalent to MEAC for accrediting programs, as section 17115(1)(b) of the Code, MCL 333.17115(1)(b), requires the Board to approve an accrediting body equivalent to the NCCA. The Board also agrees with the suggested change to add "or its successor entity" after a specific organization. See above.

Rule 338. 17121 Licensure.

Rule Numbers	Commenter	Comment
Section (1)	Moore/ANA et al.	Modify rule to include additional licensure criteria including proof of current CPR and neonatal resuscitation certification, obstetric emergency skills training, high school graduation or GED, minimal prenatal birth and postpartum experience, proof of current credential as certified professional midwife (CPM), and proof of passing the required examination.
	Dove-Medows ACNM	Michigan Affiliate of the American College of Nurse-Midwives does not support the suggestion to require documentation verifying the applicant has at least minimal practice experience nor proof of a passing score on the Board-approved examination.
	Allswede/ACOG	Modify rule to include additional licensure criteria including proof of current CPR and Neonatal Resuscitation Program (NRP) through the American Academy of Pediatrics (AAP) and American Heart Association (AHA) NRP in the last 2 years.
	Darragh/NARM	A CPM credential assures that licensees will have a credential accredited by the NCCA, have demonstrated the didactic education covering all knowledge deemed essential via the NCCA approved Job Analysis, have completed a supervised practicum with a registered preceptor, have obtained and maintained Cardio Pulmonary Resuscitation and Neonatal Resuscitation through

		nationally accredited hand-on classes (on line programs are not acceptable), and have taken at least one course in cultural awareness.
(2) and (3)	Moore/ANA et al.	A process of determining equivalency of programs should be established. MEAC accredited programs should be the bare minimum preparation for practice for safety of our families.
(3) and (6)	Taft and Moore/ANA	Add a process for determining equivalency. Variation in how equivalence is determined deters from assuring public health and safety in the expectation of practice of a midwife.
	Allswede/ACOG Wells Lavery	Add a rule regarding bridge certificate and its use for each type of licensure. Add a rule regarding a temporary license. Delete all provisions that allow an applicant to ask the Board to approve an equivalent credentialing or accrediting organization. Require a midwife to be a mandatory reporter, as they have access to homes and children.
Rules Committee Response	The Rules Committee declines the suggestion to list the specific licensure requirements that are already required for a CPM credential. The CPM credential, which is required by the rules and will be required on the application as well, already mandates: CPR and Neonatal Resuscitation Certification with the hands-on component, a high school diploma or GED, minimum practice experience, and a passing score on the examination. In addition, the rules already require a midwife to have obstetric emergency skills training, which is either required by MEAC accredited schools or by the bridge certificate. However, for clarity, the Rules Committee recommends that the rule be modified to more specifically state what is required for licensure by section 17115 of the Code, MCL 333.17115. The Rules Committee declines the suggested change to list the criteria for determining equivalency to NARM, MEAC, and NCCA, as a comparison by the Board will take place when a request is made, and the comparison will be made to the standards and criteria of NARM, MEAC, or NCCA as they exist at that time. However, the Board agrees that section (2), (3), and (6) should be modified to include the suggested change of "or its successor entity" and same changes made to Rules 338.17113 and 338.17115 for consistency. The Rules Committee agrees with the suggestion to add a rule regarding a temporary license to clarify the licensure requirements.	

	The Rules Committee declines the suggestion to delete all provisions that allow an applicant to ask the Board to approve an equivalent credentialing or accrediting organization, as this option is required by multiple sections in Part 171 of the Code. The Rules Committee declines to mandate that a midwife is subject to mandatory reporting, as that requirement is established by state law and therefore is not an appropriate subject for regulation by a rule.

NEW LANGUAGE FOR PROPOSED RULE 338.17121:

- **R 338.17121(1) – (6):**

(1) In addition to meeting the requirements of sections 16174 ~~and 17115~~ of the code, MCL 333.16174~~ and MCL 333.17115~~, ~~-~~an applicant for licensure ~~must~~ **shall** submit a completed application on a form provided by the department, together with the requisite fee, **and meet all of the following requirements:**~~.~~

(a) Meet 1 of the following:

(i) Submit proof to the department of completion of an educational program or pathway accredited by MEAC, or its successor entity, or by another accrediting organization approved by the board under R 333.17113.

(ii) If prior to January 1, 2020, the applicant holds a current credential of CPM from NARM, or its successor entity, or an equivalent credential from another midwifery credentialing program that is approved by the board under R 383.17115, and satisfies both of the following:

(A) Submits proof to the department that he or she holds a midwifery bridge certificate awarded by NARM, or its successor entity, or an equivalent credential from another midwifery credentialing program that meets the criteria of section 16148 of the code, MCL 333.16148.

(B) The midwifery credentialing program is accredited by the NCCA, or its successor entity, or another accrediting organization approved by the board only if the standards and evaluative criteria of the accrediting organization are determined to be equivalent to the standards of NCCA, or its successor entity.

(b) Submit proof to the department of holding a current credential of CPM from NARM, or its successor entity, or an equivalent credential from another midwifery credentialing program, that is approved by the board under R 383.17115.

(c) Submit proof to the department of successfully passing the examination developed and scored by NARM or another exam approved by the board under subrule (3) of this rule.

(d) Submit proof to the department of meeting the English language requirement under R 338.17127, if applicable.

~~(2) An applicant for licensure who has not completed an educational program or pathway accredited by MEAC may petition the~~

~~board to evaluate whether an educational program or pathway accredited by another accrediting organization is equivalent to a program or pathway accredited by MEAC.~~
~~(3) An applicant for licensure who does not hold the credential of CPM from NARM may petition the board to evaluate whether a credential is equivalent to the credential of CPM from NARM.~~
~~(4)~~ **(2)** The board approves and adopts the examination developed and scored by NARM.
~~(5)~~ **(3)** An applicant for licensure may petition the board to evaluate whether another examination meets the requirements of section 16178(1) of the code, MCL 333.16178(1).
~~(6)~~ **(4)** A licensed midwife shall have obtained his or her recredential or maintain his or her **CPM** credential ~~of CPM~~ from NARM, or equivalent credential approved by the board**, pursuant to R 338.17115**, during the license cycle.

R 338.17122 Nonrenewable temporary license.
Rule 122. (1) If an applicant holds a current CPM credential from a midwifery education program that is not MEAC accredited or accredited by an accrediting organization approved by the board under R 338.17113, he or she may apply for a nonrenewable temporary license if he or she satisfies both of the following:
(a) Meets the requirements of sections 16174 of the code, MCL 333.16174.
(b) Submits to the department a completed application, on a form provided by the department, together with the requisite fee.
(2) An individual who holds a temporary license must hold a midwifery bridge certificate from NARM or an equivalent credential approved by the board pursuant to R 338.17115, to qualify for a license when his or her temporary license expires, pursuant to section 17116 of the code, MCL 333.17116.
(3) The term of a temporary license is 24 months and is not renewable.

Board Response	The Board declines the suggested change to list the specific licensure requirements that are already required for a CPM credential in the licensure rule. The CPM credential, which is required by the rules and will be required on the application as well, already mandates: CPR and Neonatal Resuscitation Certification with the hands-on component, a high school diploma or GED, minimum practice experience, and a passing score on the examination. In addition, the rules already require a midwife to have obstetric emergency skills training, which is either required by MEAC accredited schools or by the bridge certificate. However, for clarity, the Board agrees that the rule should be clarified to more specifically state what is required for licensure in section 17115 of the Code, MCL 333.17115, and a definition of the CPM credential will be added to R 338.17101. The definition explains that the CPM includes the following: validating education, passing an examination,

	completing a workshop, module or course on cultural awareness, meeting general education requirements, maintaining current adult CPR and current neonatal resuscitation program certification with a hands-on component, and completing an obstetric emergency skills training. The Board declines the suggested change to list the requirements for determining equivalency to NARM, MEAC, and NCCA, as a comparison by the Board will take place when a request is made, and a comparison will be made to the standards and criteria of NARM, MEAC, or NCCA as they exist at that time. The Board also agrees with the suggested change to add "or its successor entity" after a specific organization. The Board agrees with the suggested change to add a rule regarding a temporary license to clarify the licensure requirements. The Board declines the suggestion to delete all provisions that allow an applicant to ask the Board to approve an equivalent credentialing or accrediting organization, as this option is required by Part 171 of the Code. The Board declines to mandate that a midwife is subject to mandatory reporting, as that requirement is established by state law and therefore is not an appropriate subject for regulation by a rule. See above.

Rule 338. 17123 Licensure by endorsement.

Rule Numbers	Commenter	Comment
Section (1)	Moore/ANA et al. Lavery	Require out of state licensees to meet the same criteria, as midwives licensed in Michigan. There is no equivalency among states, especially without noted consistent criteria to evaluate equivalency. Applicants may be reviewed for exceptions in education or certification in their licensing states.
	Taft and Moore/ANA	Remove licensure by endorsement when applicant is licensed in another state. No assurance of equivalency.
	Wells	Clarify whether a license in another state must be current.
(3) and (4)	Wells	Delete references to MCL 333.17119(2), as the reference is incorrect in this location.
Rules Committee	The Rules Committee declines to modify the criteria for out of state licensees, as the requirements for licensure by	

Response	endorsement is set by section 17119 of the Code, MCL 333.17119. The Rules Committee agrees with the suggested change to list the requirements for licensure by endorsement that are required in section 17119 of the Code, MCL 333.17119; however, the Rules Committee recommends that the list should not be so specific as to include all the requirements that are already required by a CPM credential, as having and maintaining a CPM credential is one of the requirements for licensure. As the rule will be modified to list the requirements, the Rules Committee agrees with the suggestion to delete references to MCL 333.17119(2). The Rules Committee agrees with the suggestion that the rule should require a "current" license in another state.

NEW LANGUAGE FOR PROPOSED RULE 338.17123:

- **R 338.17123(1) – (4):**

(1) An applicant who **currently holds a license** ~~is licensed~~ as a midwife in another state but who has never been licensed as a midwife in this state may apply for a license by endorsement **and is presumed to meet the requirements of section 16186 of the code, MCL 333.16186, if he or she meets the requirements of section 16174, MCL 333.16174, submits** ~~by submitting~~ a completed application, on a form provided by the department, together with the requisite fee~~.~~ **, and submits all of the following:**

~~(2) In addition to meeting the requirements of sections 16174 and 17119 of the code, MCL 333.16174 and MCL 333.17119, an applicant who meets the requirements of this rule is presumed to meet the requirements of section 16186 of the code, MCL 333.16186.~~

(a) Proof of completion of an educational program or pathway accredited by MEAC, or its successor entity, or by another accrediting organization approved by the board under R 333.17113.

(b) Proof of holding a current credential of CPM from NARM or another midwifery credentialing program approved by the board under R 333.17115.

(c) Proof of successfully passing the examination developed and scored by NARM or another exam approved by the board under R 338.17121(3).

(d) Proof there are no pending disciplinary proceedings against the applicant before a licensing agency in this state, any other state, or country, or any sanctions currently imposed against the applicant by a licensing agency in this state, any other state, or country which are based on grounds similar to those under Article 15 of the code.

(e) Proof to the department of meeting the English language requirement under R 338.17127, if applicable.

~~(3) Pursuant to section 17119(2) of the code, MCL 333.17119(2), an applicant for licensure who does not hold the credential of CPM from NARM may petition the board to evaluate whether a credential is equivalent to the credential of CPM from NARM.~~

(2) If an applicant is licensed as a midwife in a state that does not require completion of an educational program or pathway that is MEAC approved, the department may determine that the applicant has met the requirements of subrule (2)(a) of this rule if he or she satisfies both of the following:

(a) The applicant meets all the other requirements for licensure.

(b) The applicant holds a midwifery bridge certificate awarded by NARM or an equivalent credential from another midwifery credentialing program that meets the criteria of section 16148 of the code, MCL 333.16148, and is accredited by NCCA, or another accrediting organization approved by the board, if the standards and evaluative criteria of the accrediting organization are determined to be equivalent to the standards of NCCA or its successor entity.

~~(4) Pursuant to section 17119(2) of the code, MCL 333.17119(2), an applicant for licensure may petition the board to evaluate whether another examination meets the requirements of section 16178(1) of the code, MCL 333.16178(1).~~

Board Response	The Board declines the suggestion to modify the criteria for out of state licensees, as the requirements for licensure by endorsement is set by section 17119 of the Code, MCL 333.17119. The Board agrees with the suggested change to list the requirements for licensure by endorsement that are required in section 17119 of the Code, MCL 333.17119, instead of simply referring to the statute; however, the Board declines to restate the requirements for a CPM credential in this rule and instead has added a definition of the CPM credential to the definitions in R 338.17101. As the rule will be modified to list the requirements, the Board agrees with the suggested change to delete references to MCL 333.17119(2). The Board agrees with the suggested change that the rule should require a “current” license in another state. See above.

Rule 338.17125 Relicensure requirements.

Rule Numbers	Commenter	Comment
Section (1)	Moore/ANA et al.	Require an applicant for relicensure who has lapsed for more than 3 years but less than 7 years to take an examination.

	Lavery Wells	Require examination if lapsed more than 3 years and modify (1)(f), as it is confusing. The chart applies to those who do not currently hold a license in another state but rule(1)(f) refers to holding a license in another state. Change references to 3 years to 4 years for consistency with the continuing education cycle, in (d) and (e). Clarify what type of continuing education is required in (d). Clarify what will happen to an application if continuing education is not complete when the application is submitted in (d).
(2)	Moore/ANA et al. Wells	Require that the applicant hold an equivalent license to a Michigan license to relicense under (2). Change the references to 3 years to 4 years for consistency with the continuing education cycle, in (d) and (e). Clarify what type of continuing education is required in (d). Clarify what will happen to an application if continuing education is not complete when the application is submitted in (d).
Rules Committee Response	The Rules Committee declines to modify section (1)(e) to require an examination if an applicant has a lapsed Michigan license for more than 3 years and less than 7 years, as this requirement is consistent with other health professions which require the applicant to redo the examination when they have been unlicensed for more than 7 years. The Rules Committee agrees with the suggestion to modify (1)(f) to clarify that verification only applies to a previous license in another state, not a current license in another state. The Rules Committee declines to modify section (2) to require that the out of state license be equivalent to a Michigan license, as this rule is not an endorsement rule, but is a way to allow an applicant who was previously licensed in Michigan (held a CPM, had completed a MEAC accredited educational program or pathway, and the examination), to be relicensed without having greater requirements than someone who is licensed through endorsement and does not need to meet the continuing education requirements.	

	The Rules Committee agrees with the following suggestions to subrules (1) and (2): modify 3 years to 4 years in (d) and (e) for consistency with the renewal cycle; include a reference to the continuing education section in (d); and clarify how long an applicant has to submit continuing education for relicensure if they are deficient.

NEW LANGUAGE FOR PROPOSED RULE 338.17125:

- **R 338. 17125(1)(d)(e) and (f) and (2)(d) and (e):**

(1)(d) Continuing education: submit proof of having completed 30 hours of continuing education in courses and programs ~~approved by the board, including~~ **and** at least 1 hour in pain and symptom management**, 2 hours of cultural awareness, and 1 hour of pharmacology related to the practice of midwifery, as required under R 338.17141, and** which was earned within the 3-year period immediately preceding the application for relicensure. **However, if the continuing education hours submitted with the application are deficient, the applicant shall have 2 years from the date of the application to complete the deficient hours. The application will be held, and the license will not be issued until the continuing education requirements have been met.**

(e)Examination: within the 3-year period immediately preceding the application for relicensure, retake and pass the examination approved by the board pursuant to R 338.17121.

(f) Proof of license from another state ~~where licensed~~: ~~an applicant's license must be~~ ~~verified~~ **verification** by the licensing agency of all other states of the United States in which the applicant ~~holds a current license or~~ ever held a license as a midwife ~~. Verification~~ must be sent directly to the department from the licensing agency and include the record of any disciplinary action taken or pending against the applicant.

(2)(d) Continuing education: submit proof of having completed 30 hours of continuing education in courses and programs ~~approved by the board, including~~ at least 1 hour in pain and symptom management**, 2 hours of cultural awareness, and 1 hours of pharmacology related to the practice of midwifery, as required under R 338.17141, and** which was earned within the 3-year period immediately preceding the application for relicensure. **However, if the continuing education hours submitted with the application are deficient, the applicant shall have 2 years from the date of the application to complete the deficient hours. The application will be held, and the license will not be issued until the continuing education requirements have been met.**

Board Response	The Board declines the suggested change to modify section (1)(e) to require an examination if an applicant has a lapsed Michigan license for more than 3 years and less than 7 years, as this requirement is consistent with other health professions which require the applicant to redo the examination when they have been unlicensed for more

	than 7 years. The Board agrees with the suggested change to modify (1)(f) to clarify that verification only applies to a previous license in another state, not a current license in another state. The Board declines the suggested change to modify section (2) to require a license from another state to be equivalent to a Michigan license, when a licensee is relying on a license from another state when attempting to relicense in Michigan. This rule is not an endorsement rule but is a way to allow an applicant who was previously licensed in Michigan (held a CPM, had completed a MEAC accredited educational program or pathway, and passed the examination), to be relicensed without having greater requirements than someone who is licensed through endorsement and does not need to meet the continuing education requirements. The Board declines to modify 3 years to 4 years regarding continuing education, as the Department has determined that the licensure cycle will be 2 years. The Board agrees to include a reference to the continuing education section in (d), clarify the requirements, and clarify how long an applicant has to submit continuing education for relicensure if they are deficient. See above.

Rule 338. 17127 English language requirement.

Rule Numbers	Commenter	Comment
Section (1)	Wells	Clarify when an English language test is required. Clarify where English is an official language.
Rules Committee Response	The Rules Committee agrees with the suggestions to clarify when R 338.17127 applies, as there are many countries where English is used but not the official language. The Rules Committee recommends that the reference official language be deleted and replaced with "an educational program or pathway conducted in the English language."	

NEW LANGUAGE FOR PROPOSED RULE 338.17127:

- **R 338.17127(1)(ii):**

  ~~(1)~~ An applicant who attended a nonaccredited program pursuant to R 338.17121, or a program outside of the United States, shall demonstrate a working knowledge of the English language. An applicant shall demonstrate a working knowledge of the

English language by satisfying either of the following requirements:
~~(i)~~ **(a)** Submit proof that he or she has obtained a total score of not less than 80 on the test of English as a foreign language internet-based test (TOEFL-iBT) administered by the educational testing service (ETS).
~~(ii)~~ **(b)** Submit proof that he or she completed ~~an~~ **a midwifery** educational program **or pathway** ~~located in any country where English is an official language~~ **conducted in the English language**.

Board Response	The Board agrees with the suggested change to clarify when R 338.17127 applies, as there are many countries where English is used but not the official language and therefore, the Board replaces the reference to an official language with, "an educational program or pathway conducted in the English language."

Rule 338. 17131 Definitions.

Rule Numbers	Commenter	Comment
Section (a)	Moore/ANA et al.	Modify the definition of "appropriate health professional" to "a physician, physician's assistant, nurse practitioner, or certified nurse midwife with experience in the active practice of obstetrics, pediatrics, or emergency medicine and licensed under article 15 of the public health code."
	Allswwede/ACOG	Modify the definition of "appropriate health professional" to include "appropriate obstetric expertise, holds a current Michigan license, and has admitting and obstetric privileges at a nearby hospital with labor and delivery services."
	Brown	Keep chiropractor in definition of "appropriate health professional" as midwives do refer patients with structural related conditions to chiropractors. It is the commenter's hope that patients will retain the right to receive care from whichever practitioner they desire. Patients receive better care when there are fewer hoops to jump through.
	Lavery	Modify "appropriate health professional" to any appropriately qualified MD, DO, PA or CNM licensed under article 15."
(b)	Taft and Moore/ANA	Modify definition of "appropriate pharmacology training" as there is no evidence that 8 hours is a safe and sufficient amount of training considering the powerful drugs listed in Table 1 and there should be some reference or cite to the basis for the determinations in Table 1. The health and safety of two highly vulnerable populations is the rationale for this comment.

	Gagleard/MCHCH Moore/ANA et al.	Increase pharmacology training to 16 hours. Modify definition to mean "a minimum of 16 hours of training related to pharmacology applicable to midwifery practice, approved by MEAC or the board."
(f)	Taft and Moore/ ANA Moore/ANA et al.	Modify definition of "transfer" to include that the transfer has been made by mutual written consent which provides a stronger legal basis to assure transfer with the least risk of delay due to clear prior agreed upon responsibility; reference "in accordance with national guidelines for safe transfer, as indicated in section 17117(l)(e) of the Code." Modify the definition to "means to convey the responsibility for the care of a patient to another appropriate health professional in accordance with nationally recognized guidelines on safe transfer, as indicated in section 17117(1)(e), MCL 333.17117(1)(e)."
	Moore/ANA et al.	Add the following definition for emergency medical services personnel "means an individual licensed as an "emergency medical services personnel" under article 17 of the public health code."
Rules Committee Response	The Rules Committee agrees with the comments to limit the type of health professionals in Part 4 of the rules and therefore, it recommends that the general definition of appropriate health professional, which by definition in section 17101 of the Code, MCL 333.17101(a), applies to many different types of consultations, referrals, and collaborations, be deleted from R 338.17131 and moved to R 338.17101 to the general definition section and include all those licensed under Article 15 in the definition. A licensed midwife may want to refer, consult or collaborate with other health professionals in addition to a physician, physician's assistant, or nurse practitioner. However, it is also recommended by the Rules Committee that a narrower definition be used for Part 4 of the rules (see R 338.17134 and R 338.17135). The Rules Committee declines the suggestion to add more training in pharmacology, as the 8 hours is above and beyond the pharmacological training that is required by NARM; the 8-hour requirement is consistent with other states; the 8 hours is a refresher. The Rules Committee declines the suggestion to require a transferee to accept the transfer in writing as the rules may not regulate the person taking transfer of the patient. The Rules Committee declines the suggestion to reference the national guidelines for safe transfer, as the state requires	

	that the rules conform to the national guidelines where appropriate. Currently, the national guidelines largely deal with intra partum transport and only require notification. However, the Rules Committee is recommending language in R 338.17135 to clarify that transfer means to a hospital and when it can occur. The Rules Committee declines the suggestion to add a definition for emergency medical services personnel, as the licensed midwife has no control over who is sent as a response to a call for emergency services, and they can't confirm that the responders will be appropriately licensed under Article 17 of the Public Health Code.

NEW LANGUAGE FOR PROPOSED RULE 338.17131:

- **R 338.17131(a) and (f):**

As used in this part:

~~(a) "Appropriate health professional" means any individual licensed, registered or otherwise authorized to engage in a health profession under article 15 of the public health code.~~

(**a**) "Appropriate pharmacology training" means 8 hours of training related to pharmacology applicable to midwifery practice, approved by MEAC or the board.

(**b**) "Consultation" means the process by which a licensed midwife, who maintains primary management responsibility for the patient's care, seeks the advice of another appropriate health professional or member of the health care team.

(**c**) **"Emergency medical services personnel" means a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic.**

(**d**) "Futility" means care offered that would not mitigate a patient's lethal diagnosis or prognosis of imminent death.

(**e**) "Refer" means to suggest a patient seek discussion, information, aid, or treatment from a particular appropriate health professional.

(**f**) "Transfer" means to convey the responsibility for the care of a patient to **a hospital, emergency medical services personnel, or** another appropriate health professional. **Transfer may occur at any point during care, during the prenatal, intrapartum, postpartum, or neonatal period, and may be either of an emergent or non-emergent nature.**

(**g**) "Transport" means the physical movement of a patient from 1 location to another.

Board Response	The Board agrees with the suggested change to limit the type of health professionals that a midwife may refer to or consult with in Part 4 of the rules, and therefore, deletes the broader definition of "appropriate health professional," which by definition in section 17101 of the Code, MCL 333.17101(a), applies to many different types of consultations, referrals, and collaborations, from R 338.17131 and moves it to the general definitions in

	R 338.17101. The Board declines the suggested change to add more training in pharmacology, as the 8 hours is above and beyond the pharmacological training that is required by NARM; the 8-hour requirement is consistent with other states; the 8 hours is a refresher. The Board declines the suggested change to require a transferee to accept the transfer in writing as the rules may not regulate the person taking transfer of the patient. The Board declines the suggested change to reference the national guidelines for safe transfer, as the state requires that the rules conform to the national guidelines where appropriate. Currently, the national guidelines largely deal with intrapartum transport and only require notification. However, the Board agrees to clarify that the definition of "transfer" includes conveying the responsibility of the care of a patient to a hospital, emergency medical services personnel, or another appropriate health professional, and to clarify when "transfer" can occur. The Board also agrees to clarify that transfer in R 338.17135 is to a hospital or emergency services personnel. The Board agrees with the suggested change to add a definition for emergency medical services personnel to clarify what this term means as used in the rules. See above.

Rule 338.17132 Informed disclosure and consent.

Rule Numbers	Commenter	Comment
Section (1)	Darragh/NARM	All CPMs must have a care plan for transport to a hospital and have and maintain an Informed Disclosure and Shared Decision-Making Protocol for use throughout pregnancy, birth, and the postpartum period. These documents must be shared and signed by the client at the initiation of care and at any time that additional decisions are made about the care provided.
	Walsworth	Include a definition in informed consent that clarifies the differences between training of a licensed midwife and a certified nurse midwife.
(2)	Moore/ANA et al.	Modify the rule to require the licensee to provide the patient with an informed disclosure and consent process at the inception of care, require informed consent in writing, and specifically require conditions under which consultation, transfer, or transport of the patient must be initiated,

		information regarding the care team, whether the licensed midwife has entered into a collaborative relationship with an appropriate health professional, and the names and contact information of those health professionals.
(4)	Moore/ANA et al. Lavery Bayne	Delete this provision. No health professional is exempt from informed consent when a woman is in active labor or in an emergent situation. If immediate action is needed, informed consent is done verbally and later documented.
Rules Committee Response	The Rules Committee agrees with the suggestion that informed disclosure should be in writing and that information should be disclosed regarding the midwife's care team. The Rules Committee agrees with the suggestion that patients should be informed if a medication is required by law and therefore it recommends adding language to this rule requiring a licensed midwife to disclose such information to the mother. The Rules Committee declines to modify the rules to add the conditions under which a consultation, transfer or transport must be initiated as well as whether there is a collaboration relationship and the names and contact information, as the conditions under which a consultation, transfer or transport are required is already included in the rules which is part of the disclosure to the patient, and formal collaboration agreements are not common nor required by statute and often not known at the inception of care. The Rules Committee declines to recommend a change to the rules to clarify the difference in training between a licensed midwife and a certified nurse midwife, as the rules are regulations regarding licensed midwives and are not an appropriate place to differentiate the training between two different regulated health professionals. The Rules Committee agrees that (4) should be rewritten to clarify that an abbreviated informed consent may be necessary in some circumstances.	

NEW LANGUAGE FOR PROPOSED RULE 338.17132:

- **R 338.17132(1) and (4):**

(1) At the inception of care for a patient, a licensed midwife shall provide an informed disclosure **in writing** to the patient that includes all the following:

(a) A description of the licensed midwife's training, philosophy of practice, **information regarding the care team,** transfer of care plan, credentials and legal status, services to be provided, availability of a complaint process both with NARM and the state, and relevant Health Insurance Portability and Accountability Act (HIPAA) disclosures.

(b) Access to the midwife's ~~personal~~ practice guidelines.

(c) Whether the licensed midwife is permitted to administer drugs and medications pursuant to R 338.17137, ~~and~~ which medications the licensed midwife carries for potential use**, if a medication is required by law, and if certain standard medications are not available from the midwife, how and where the medications can be obtained**.

(d) Access to the board of licensed midwifery rules.

(e) Whether the licensed midwife has malpractice liability insurance coverage, and if so, the policy limitations of the coverage. The patient must be informed of the coverage and policy limitations both verbally and in writing.

(2) If during care and shared decision making, a patient chooses to deviate from a licensed midwife's recommendation, the licensed midwife shall provide the patient with an informed consent process which must include all the following:

(a) Explanation of the available treatments and procedures.

(b) Explanation of both the risks and expected benefits of the available treatments and procedures.

(c) Discussion of alternative procedures, including delaying or declining of testing or treatment, and the risks and benefits associated with each choice.

(d) Documentation of any initial refusal by the patient of any action, procedure, test, or screening that is recommended by the licensed midwife.

(3) A licensed midwife shall obtain the patient's signature acknowledging that the patient has been informed, verbally and in writing, of the disclosures.

(4) A licensed midwife ~~is exempt from the requirements of subrules (2) and (3) of this rule if the deviation occurs after the inception of active labor, or in an emergent situation, or if the change in the condition of a patient requires immediate action on the part of the licensed midwife.~~ **shall provide an abbreviated informed consent appropriate to the emergent situation with documentation to follow once the situation has stabilized.**

Board Response	The midwifery model of care supports the ethical health care principle of autonomy, which is also a building block of informed consent. In order for patients to consent, they must first be informed, and then have the freedom to accept or refuse recommended treatments or procedures, as influenced by patients' values, culture,

	and circumstances. The Board agrees with the suggested change to require informed disclosure to be in writing and that information should be disclosed regarding the midwife's care team. The Board agrees with the suggested change to inform patients if a medication is required by law and therefore the rule will require a licensed midwife to disclose such information to the mother. The Board declines the suggested change to add the conditions under which a consultation, transfer, or transport must be initiated as well as whether there is a collaboration relationship, and the names and contact information, as the conditions under which a consultation, transfer, or transport are required is already included in the rules which is part of the disclosure to the patient, and formal collaboration agreements are not common nor required by statute, and often not known at the inception of care. The Board declines the suggested change to clarify the difference in training between a licensed midwife and a certified nurse midwife, as the rules are regulations regarding licensed midwives and are not an appropriate place to differentiate the training between two different regulated health professionals. The Board agrees with the suggested change to clarify that an abbreviated informed consent may be necessary in some circumstances. See above.

Rule 338. 17133 Additional informed consent requirements.

Rule Numbers	Commenter	Comment
Section (1)(b)	Moore/ANA et al.	Add "at the time of discovery if after 34 weeks" and delete language referring to a midwife's judgment.
(2)	Moore/ANA et al.	Add language that the midwife will disclose "relevant practice guidelines, as well as his or her education, training and experience pertaining to" the management of the pregnancies listed in subrule (1) of this rule, which must include the licensed midwife's level of experience, type of special training, care philosophy, and outcome history relative to such circumstances.

	Taft and Moore/ANA	Change personal practice guidelines to professional practice guidelines. Personal guidelines may vary which is undesirable to assuring public health and safety. These items are not practice guidelines but rather qualifications and experiential outcomes.
	Allswede/ACOG	Additional informed consent does not replace adequate training to assess and manage these complications.
(4)	Moore/ANA et al.	Add language that the midwife shall disclose his or her obligation to practice within the rules and regulations of the state and his or her level of education, training and experience.
(5)	Moore/ANA et al.	Add language to (a) – (c) that requires the informed choice document to include evidence-based information regarding the potential increased risks and benefits associated with a previous cesarean birth, breech presentation, or twins or multiple gestation. Add language to (c) that requires the informed choice document to include evidence-based information regarding medical care options together and a referral to an appropriate health professional for further discussion about the circumstances surrounding a previous cesarean birth, breech presentation, or twins or multiple gestation.
	Allswede/ACOG	Suggest references be included to current outcome statistics with consideration of the reliability of the data. See the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Planned Home Birth and require a specific additional consent for vaginal birth after cesarean (VBAC). Require the midwife to be assisted at the time of delivery by a second individual who has completed the AAP/American Heart Association's Neonatal Resuscitation Program (NRP) within the previous 2 years and possesses the skills and equipment necessary to perform a full resuscitation of the newborn in accordance with the principles of NRP.
	Michigan Midwives	Change wording to provide time for a midwife to prepare a customized informed consent.

	Association	
(6)	Bayne	No health professional is exempt from informed consent when a woman is in active labor or in an emergent situation. If immediate action is needed, informed consent is done verbally and later documented. This rule seems like the home birth community is planning to counsel women into planning vaginal birth after cesareans, multiple births, and breech births in the home. ACOG has identified these situations as high-risk deliveries that are best managed at a hospital where there are immediately available high risk obstetrical, aesthetic and pediatric services. It is concerning that a state licensure board could go against these recommendations. These situations should require consultation with an OBGYN. These deliveries should not be planned in a homebirth setting.
Rule 338.17133	Averill	
Rules Committee Response	The Rules Committee agrees with the suggestion to delete the term "personal" in sections (2) and (4) in regard to guidelines. NARM requires practice guidelines that are reviewed with clients. The ANA-Michigan comment helps to reveal both divergent nomenclature and practice norms. The "personal practice guidelines" in the proposed Rule refers to a requirement of the CPM credential, as specified by NARM. These guidelines are an enumeration of individualized protocols developed by each CPM and shared with his or her clients. A CPM may be held accountable to his or her Practice Guidelines. NARM explains Practice Guidelines on http://narm.org/faq/cpm-practice-guidelines/ . The following are examples of practice guidelines. Practice guidelines are a specific description of protocols that reflect the care given by a midwife. Protocols may contain absolutes, such as, "I will not accept as a client a mother who does not agree to give up smoking," or may list conditions under which a midwife will make this decision, such as "I will accept a client who smokes only if she agrees to cut down on smoking, maintains an otherwise exceptional diet, and reads the literature on smoking which I will provide for her." Another example of a Practice Guideline might be a CPM's willingness to accept clients based on distance from his or her location (*e.g.* "100-mile radius of Pellston") or based on local geographic landmarks (*e.g.* "south of Lake Charlevoix"). Practice Guidelines express the standards, values, and ethics of the CPM. The professional guidelines referred to by ANA-Michigan are a different matter entirely; they refer to a body of clinical guidelines typically compiled by a national professional organization.[1] The CPM, developed in 1994, is a young credential. No comprehensive set of national guidelines has yet been issued. This does not signify a lack of standards upon which to base CPM practice. On the contrary, a variety of such sources exist. NARM lists several at the address referenced above including: • The MANA Standards and Qualifications for the Art and Practice of Midwifery.	

	• The MANA Statement of Values and Ethics. • The MANA Core Competencies. • The Midwives Model of Care. • NACPM Essential Documents. • Core Competencies for Basic Midwifery Practice. [1] *See*, for example, The American College of Obstetricians and Gynecologists. "Clinical Guidance & Publications." Accessed October 19, 2018. https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance. The Rules Committee declines to add the language suggested for (4) including the midwife's education, training, and experience, as this information is already required in the rules. The Rules Committee declines to add the language suggested in (5) regarding evidence-based information concerning the potential increased risks and benefits associated with the previous cesarean birth, fetus in a breech presentation, and twin or multiple gestation," as with other health professionals the midwife is capable of weighing the evidence and conveying the risks and providing choices to the patient. The Rules Committee declines to recommend adding references to current outcome statistics with consideration of the reliability of the data, specifically the ACOG Committee Opinion on Planned Home Birth, as this is an opinion by health care providers who do not participate in home births or provide midwifery care. The Rules Committee agrees with the suggestion to delete "to the patient's situation" and replace with "specific to conditions listed in subrule (1) of this rule" to clarify the intent of this provision. The Rules Committee declines to recommend that a midwife must be assisted at the time of delivery by a second individual who has completed specific training and possesses skills and equipment necessary to perform a full resuscitation of the newborn. It is not always possible to have a second individual present, and that determination should be left to the midwife and the circumstances of the situation. Further, the midwife is subject to section 16215 of the Code, MCL 333.16215, which regulates the delegation of acts, tasks, and functions to a licensed or unlicensed individual, and the midwife by law is required to be sure that the person is qualified by education, training or experience to perform the acts, tasks, or functions they undertake.

	The Rules Committee declines to require a midwife to consult with an OBGYN on every previous cesarean birth, fetus in breech position, or twin or multiple gestation, for the following reasons: • The CPM credential encompasses the ability to offer relevant advice on a case-by-case basis; a referral might be required, but the midwife and the patient together can determine whether that is the case. • Since ACOG advises patients against attempting home delivery of any kind, and all the more stringently against the three types listed above ("Planned home Birth," Number 697, April 2017), and furthermore has most recently offered only cesarean surgery as a route of birth for these three pregnancies, it seems imprudent to require patients to seek a consult in which they will be given blanket advice not to attempt an action permitted by the rules. Such a requirement would generate unnecessary additional financial and other costs to patients and constitute an undue burden on the patients and a bar to access to care, particularly in areas where medical providers are sparse. • In addition, patients have indicated that they don't wish to be required to jump through such hoops.

NEW LANGUAGE FOR PROPOSED RULE 338.17133:

- **R 338.17133(2), (4) and (5):**

(1) Additional informed consent processes are required when a patient presents to a licensed midwife under any of the following circumstances:

(a) Previous cesarean birth – at the inception of care.

(b) Fetus in a breech presentation – when it is likely in the midwife's judgment the fetus will present in breech presentation at the onset of labor.

(c) Twin or multiple gestation – at the time of discovery by the midwife.

(2) A licensed midwife shall disclose to the patient his or her ~~personal~~ practice guidelines surrounding the management of the pregnancies listed in subrule (1) of this rule, which must include the licensed midwife's level of experience, type of special training, care philosophy, and outcome history relative to such circumstances.

(3) The disclosure must contain information regarding the licensed midwife's care team and style of management to be expected under such circumstances, including a description of conditions under which the licensed midwife shall recommend transfer or transport.

(4) The licensed midwife shall practice within the limits of his or her ~~personal~~ practice guidelines described in this rule.

(5) The licensed midwife shall provide the patient with an informed choice document, **and written informed consent,** specific to ~~the patient's situation~~ **the conditions listed in subrule (1) of this rule**, which includes the potential increased risks and benefits of the following:

(a) The circumstances listed in subrule (1) of this rule.

(b) Birth outside a hospital setting associated with the circumstances listed in subrule (1) of this rule.

(c) Medical care options associated with the circumstances listed in subrule (1) of this rule, including the risks of cesarean section, both in the current pregnancy and any future pregnancies.

(6) A licensed midwife ~~is exempt from the requirements of this rule if the circumstances listed in subrule (1) of this rule are discovered after the inception of active labor, in an emergent situation, or if the change in the condition of a patient requires immediate action on the part of the licensed midwife~~ **shall provide an abbreviated informed consent appropriate to the emergent situation with documentation to follow once the situation has stabilized**.

Board Response	The Board agrees with the suggested change to delete the term "personal" in sections (2) and (4) in regard to guidelines. NARM requires practice guidelines that are reviewed with clients. The ANA-Michigan comment helps to reveal both divergent nomenclature and practice norms. The "personal practice guidelines" in the proposed Rule refers to a requirement of the CPM credential, as specified by NARM. These guidelines are an enumeration of individualized protocols developed by each CPM and shared with his or her clients. A CPM may be held accountable to his or her Practice Guidelines. NARM explains Practice Guidelines on http://narm.org/faq/cpm-practice-guidelines/ . The following are examples of practice guidelines. Practice guidelines are a specific description of protocols that reflect the care given by a midwife. Protocols may contain absolutes, such as, "I will not accept as a client a mother who does not agree to give up smoking," or may list conditions under which a midwife will make this decision, such as "I will accept a client who smokes only if she agrees to cut down on smoking, maintains an otherwise exceptional diet, and reads the literature on smoking which I will provide for her." Another example of a Practice Guideline might be a CPM's willingness to accept clients based on distance from his or her location (*e.g.* "100-mile radius of Pellston") or based on local geographic landmarks (*e.g.* "south of Lake Charlevoix"). Practice Guidelines express the standards, values, and ethics of the CPM. The professional guidelines referred to by ANA-Michigan are a different matter entirely; they refer to a body of clinical guidelines typically compiled by a national professional organization.[1] The CPM, developed in 1994, is a young credential. No comprehensive

	set of national guidelines has yet been issued. This does not signify a lack of standards upon which to base CPM practice. On the contrary, a variety of such sources exist. NARM lists several at the address referenced above including: • The MANA Standards and Qualifications for the Art and Practice of Midwifery. • The MANA Statement of Values and Ethics. • The MANA Core Competencies. • The Midwives Model of Care. • NACPM Essential Documents. • Core Competencies for Basic Midwifery Practice. [1] *See*, for example, The American College of Obstetricians and Gynecologists. "Clinical Guidance & Publications." Accessed October 19, 2018. https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance. LMs philosophy of care aligns with the position paper, "Supporting healthy and normal physiologic childbirth: a consensus statement by ACNN, MANA, and NACPM." *See* www.mana.org/pdfs/physiologic-birth-consensus-statement.pdf. This statement recognizes that normal human physiology provides a framework to understand the optimal functioning of childbirth. "A normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus." The Board declines the suggested change to add the language suggested for (4) including the midwife's education, training, and experience, as this information is already required in the rules. The Board declines the suggested change to add references to current outcome statistics with consideration of the reliability of the data, specifically the ACOG Committee Opinion on Planned Home Birth, as this is an opinion by health care providers who do not participate in home births or provide midwifery care. The Board declines the suggested change to add language to (5) regarding evidence-based information concerning the potential increased risks and benefits associated with the previous cesarean birth, fetus in a breech presentation, and twin or multiple gestation," as with other health professionals the midwife is capable of weighing the evidence and conveying the risks and providing choices to the patient. The Board declines the suggested change that a midwife must be assisted at the time of delivery by a second

	individual who has completed specific training and possesses skills and equipment necessary to perform a full resuscitation of the newborn. It is not always possible to have a second individual present, and that determination should be left to the midwife and the circumstances of the situation. Further, the midwife is subject to section 16215 of the Code, MCL 333.16215, which regulates the delegation of acts, tasks, and functions to a licensed or unlicensed individual, and the midwife by law is required to be sure that the person is qualified by education, training or experience to perform the acts, tasks, or functions they undertake. The Board declines the suggested change to require a midwife to consult with an OBGYN on every previous cesarean birth, fetus in breech position, or twin or multiple gestation, for the following reasons: • The CPM credential encompasses the ability to offer relevant advice on a case-by-case basis; a referral might be required, but the midwife and the patient together can determine whether that is the case. • Since ACOG advises patients against attempting home delivery of any kind, and all the more stringently against the three types listed above ("Planned home Birth," Number 697, April 2017), and furthermore has most recently offered only cesarean surgery as a route of birth for these three pregnancies, it seems imprudent to require patients to seek a consult in which they will be given blanket advice not to attempt an action permitted by the rules. Such a requirement would generate unnecessary additional financial and other costs to patients and constitute an undue burden on the patients and a bar to access to care, particularly in areas where medical providers are sparse. • In addition, patients have indicated that they don't wish to be required to jump through such hoops. • The CPM credential encompasses the ability to offer relevant advice on a case-by-case basis; a referral might be required, but the midwife and the patient together can determine whether that is the case. • Since ACOG advises patients against attempting home delivery of any kind, and all the more stringently against the three types listed above ("Planned home Birth," Number 697, April 2017), and furthermore has most recently offered only cesarean surgery as a route of birth for these three pregnancies, it seems imprudent to require patients to seek a consult in which they will be given blanket advice not to attempt an action permitted by the rules. Such a requirement would generate unnecessary additional financial and other costs to patients and constitute an undue burden on the patients and a bar to access to care, particularly in areas where medical providers are sparse. • Patients have indicated that they don't wish to be required to jump through such hoops. • Patients have the right to evaluate the risks and benefits of VBAC, twin and breech births at home, and

	make a decision based on these risks and benefits, combined with their own values and circumstances. Midwives do not want to force women facing these situations into unassisted births, as has happened in other states with bans. When considered from a harm-reduction perspective, if licensed midwives are not permitted to attend such births the result will be an increase in unassisted deliveries in Michigan, with untrained or unskilled attendants. • States that have refused to forbid midwife attendance at these types of home births, such as Wisconsin, have not subsequently reversed this stance. Some states with more restrictive VBAC rules have changed their rules to permit midwife attendance at home VBACs. Over half of Michigan, by geographical location, is experiencing a VBAC "ban" at local hospitals. Prohibiting licensed midwives to care for patients choosing VBAC does not protect or offer greater safety for women giving birth in Michigan. • The letters referenced below, from public comment submissions, contain support for the rules to remain as written, with regard to multiples, breech, and VBAC births. The Board must consider these public comments, as proof of the care that consumers desire from CPMs around these issues. This list does not include letters simply saying they support the rules as written. • Carolyn Cronk says that it's important to her that midwives not be prevented from doing VBAC/twins/breech and that she moved here in part because midwives could provide these. • Brit Averill is very pro VBAC and gives solid reasons. • Raymond DeVries appears to endorse the prohibited list as it is without changes. • Lisa Ellens advocates for no change to consultation for VBAC, and midwives' ability to assess and decide with client. • Faith Groesbeck advocates for not limiting the scope of midwives. • FOMM specifically mentions not limiting midwives' attendance of VBAC, encouraging midwives to "maintain the decision made by the legislature not to forbid or unduly limit..." UNDULY LIMIT = require universal consult. • Brooke Henning supports midwives attending VBAC and the rules about it as written. • Jennifer Holshoe/ICAN lists many issues and consideration for support of VBAC, including concern that "changes to these rules could limit consumer choices and access to

	care." Mentions that other parts of the rule provide guidance and checks to increase safety of home VBAC. • Susan Jenkins/Big Push comments on dangers of overregulation/micromanagement of midwives causing increased unassisted birth. She praises Michigan for having the correct balance of midwife authorization to attend these births combined with heightened informed consent. Further, Jenkins states: "As a matter of constitutional law, as well as reasonable health policy, the Big Push believes that no woman should be forced by a statute or rule to have surgery that puts her own life and health at greater risk, simply because she does not have access to a provider who will attend her birth and is legally permitted to do so. Yet this is the scenario many women face across the nation, including Michigan, because so many hospitals and physicians refuse to attend women who are attempting VBAC. The stated reasons for such these denials of care are most often fear of litigation, a situation that has contributed to the absurdly high c-section rates of over 30% in most states. Given so few if any options for in-hospital VBAC, women turn to midwives, in recognition that midwives have the expertise and experience to attend VBACs, skills that have fallen out of use in the hospital setting, as well as a thorough scientific understanding of the relative risks and benefits of VBAC versus repeat c-section." • Stephanie Mayne wrote, "Keep the rules as they are. 2/3 of OB practices are not evidence based, and they should not be consulted for matters of homebirth." • Melissa is a home VBAC supporter who wants rules kept as they are. • Jill Nolan, breech home birther, submits comments supporting the appropriateness of the level of informed consent employed in decision-making about her breech homebirth. • Kristen Paquin/ICAN supports the right to choose homebirth for VBAC. • Sandra Pera attests to difficulty of obtaining referral/consults with a "hostile" medical community in the upper peninsula. • Michelle Sperlich "strong evidence that midwifery practiced in accordance with the proposed rules contributes to positive outcomes for mothers, infants...." • Carly Vann Thomm commented on R 333.17133: "Such detailed practice requirements go well beyond those of most other health care professional rule sets and expertly balance

	public safety and the patient's ability to choose desired care." Lists many reasons to support need for access to VBAC with CPMs; "the risks of VBAC are appropriately handled through a heightened informed consent requirement." Addresses multiples/breech with "Many of the arguments for VBAC apply also to...twins...and breech." • Nancy Ward commented that VBAC supports informed consent process and CPMs providing VBAC. Discusses extreme difficulty in accessing care in medical community. The Board agrees with the suggested change to clarify in (5) that the patient will receive written informed consent and delete "to the patient's situation" and replace with "specific to conditions listed in subrule (1) of this rule" to clarify the intent of this provision. The Board agrees with the suggested change to clarify in (6) that informed consent is required. See above.

Rule 338. 17134 Consultation and referral.

Rule Numbers	Commenter	Comment
Title	Moore/ANA et al.	Change to "Required Consultation and Referral."
Section (1)	Moore/ANA et al. Moore/ANA et al. Taft and Moore/ANA Allswede/ACOG Bayne Pera	Restructure rule by putting conditions related to the mother in a different subrule from those relating to the infant. Remove "in the judgment of the licensed midwife warrant consultation or referral," as the listed symptoms require clinical judgment and diagnosis and management are outside of the scope of practice of the licensed midwife. Add "document the consultation or referral and any recommendations of the consultation, if the patient is determined to have any of the following conditions during the current pregnancy."

	Moore/ANA et al.	Antepartum Remove the following conditions and place in transfer: • Rupture of membranes prior to the 36.6 weeks of gestation without active labor. • Positive HIV antibody test. • TORCH (Toxoplasmosis, other, rubella, cytomegalovirus, and herpes simplex infections) • Documented placenta previa. • Active labor prior to 36.0 weeks of gestation. • History of myomectomy. • Marked or severe hydramnios or oligohydramnios. • Receiving opioid replacement therapy. • Second or third trimester fetal demise. Add blood pressure of 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure, hyperreflexia, new onset pitting edema, clonus, rheumatoid arthritis, and chronic pulmonary disease. In addition, Michigan Affiliate of the American College of Nurse-Midwives suggests adding [g/dL] after 9 in (vii). Intrapartum Add blood pressure exceeding 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure, persistent, severe headaches, epigastric pain or visual disturbances, and fetal heart rate anomalies. Change 72 hours to 24 hours for confirmed ruptured membranes without onset of labor. Postpartum Remove any other condition or symptom that could threaten the health of the mother as assessed by a licensed midwife exercising reasonable skill and judgment. Infant Add weight less than 2500 grams or 5 pounds, 8 ounces, lethargy, irritability, abnormal crying, and

		poor feeding. Modify failure to urinate from 36 hours to 24 hours.
	Michigan Midwives Association	Define “gestational hypertension” as systolic blood pressure greater than 140 mmHg and diastolic blood pressure greater than 90 mmHg measured on two separate occasions more than four hours apart with the absence of proteinuria.
	Zoyiopoulos	Define “gestational hypertension” as BP readings of 140/90, or higher, taken 4 hours apart.
	Allswede/ACOG	Important for immediate referral, not addressed elsewhere: (xxxi) Symptoms of ectopic pregnancy and (xxxiii) Symptoms or evidence of hydatidiform mole
	Averill	Supports leaving gestation beyond 42 weeks as a consult.
	Zoyiopoulos	(a)(xxv) Change 42 weeks to 42 completed weeks. (a)(xxxv) Change to bacterial vaginal infection unresponsive to treatment. (c)(i) Define as failure to void bladder within six hours of birth or catheterization.
	Michigan Midwives Association	Amend gestation beyond 42 weeks to gestation beyond 43 weeks. Considerable data that increase in risk at 42nd week is small and greatest increase in risk comes at the 43rd week.
	Bayne	Add vaginal birth after cesarean, multiple gestation, breech presentation at term and in labor at least to the consultation list. Add to antepartum: chronic hypertension, pre-gestational diabetes, maternal seizure disorder, uncontrolled asthma, uncontrolled hypothyroidism, hyperthyroidism, morbid obesity, advanced maternal age (especially 40 or above), bleeding disorder, and prior history of preeclampsia or eclampsia, shoulder dystocia, obstetrical hemorrhage, bleeding disorder, venous thromboembolism

		(VTE) or pulmonary embolism (PE), preterm labor, fetal demise over 20 weeks gestation, molar pregnancy, neonatal sepsis, and fetal growth restriction. (viii) Modify the condition, as there is no basis for waiting 24 hours on obtaining further medical care if a mother has a fever. (xxi) Better define "marked abnormal fetal heart tones" to fetal bradycardia, fetal tachycardia, absence of fetal variability (or beat to beat variance by Doppler) and or persistent fetal decelerations. Add to intrapartum: • Fetal heart rate abnormalities of persistent fetal bradycardia, tachycardia, decelerations, or absence of beat to beat variability. • It is odd that the rules would require consultation and possible transfer for gestational hypertension in the antepartum period but would use only severe range pressures during the intrapartum period. This is not safe. Blood pressure standard for transfer of care to the hospital in labor for evaluation should be 140 systolic or 90 diastolic if persistent for more than 4 hours. This level of blood pressure is indicated to have a work up for preeclampsia dm continuous monitoring of the neonate. Patients with mile elevation of blood pressure ae still at elevated risk of maternal ad neonatal morbidity and mortality. • It is concerning that a mother would have rupture of membranes for up to 72 hours without assessment in the hospital and intervention, especially for Group B Strep (GBS) positive or unknown. Standard of care from the Center for Disease Control is that patients who are GBS unknown receive antibiotics after 18 hours or rupture of membranes (many patients who choose homebirth decline GBS testing and are GBS unknown). • Signs of symptoms of maternal infection is not defined as it relates to GBS status. If appropriate IV antibiotics are not available in the home setting. Women who are GBS positive should be recommended to deliver in the hospital setting, or women who are GBS unknown status and under 37 weeks or GBS unknown with rupture of membranes greater than 18 hours. • Prolonged second stage of labor without ongoing progress.

		• Vaginal bleeding not consistent with bloody show. • Signs or symptoms of uterine rupture including severe abdominal pain, loss of fetal station, fetal abnormal heart tones (bradycardia, tachycardia, absence of beat to beat variability, persistent fetal decelerations), bleeding not consistent with bloody show. Add to postpartum: Hemorrhage not controlled with initial maneuvers and medications. Add neonatal evaluation if GBS positive and mother not adequately treated with antibiotics per CDC standard of care, or if GBS unknown and rupture of membranes greater than 18 hours (with or without antibiotics given).
	Donomme	Supports rules but requests that conditions be separated into moderate and severe conditions, so midwives can appropriately refer to a health provider.
	Howell	Modify gestation beyond 42 weeks to 43 weeks or remove any reference to gestation beyond 40 weeks, as there is no substantive scientific basis for this rule.
	Mulder	Modify list of conditions requiring consultation.
	Sokol	Expand the mandates for referral to include all listed in R 338.17134. Supports MCMCH recommendations.
(3)	Moore/ANA et al.	Divide (3) into two subdivisions and add a new (4) which deals with informed consent if the patient elects to not accept a referral or advice.
Rules Committee Response	The Rules Committee recommends the following: • **Title**: decline to add the word "required" to the title of the rule, as that change is redundant, titles are to be as minimum as possible, and the rule states that the "midwife shall" which connotes that it is required. • **Structure of rule**: agree to separate into two distinct subdivisions the conditions relating to the mother versus conditions relating to the infant. • Decline to separate moderate and severe conditions, as conditions are separated by stage and into conditions that are emergent or non-emergent.	

	• Agree to add language that the midwife shall document the consultation or referral and follow up with the patient regarding the consultation or referral**.**
	• **Appropriate health professional**: the Rules Committee declines the suggestion to require that an appropriate health professional have experience in the active practice of obstetrics, pediatrics, emergency medicine, or obstetric privileges at a nearby hospital with labor and delivery services, as this language would limit those who would qualify as an appropriate health professional and make it much more difficult in rural areas to find a health provider when one is needed. Ideally a physician, physician's assistant, nurse practitioner, or certified nurse midwife with experience would be the type of health professional who a midwife would turn to. However, access to this type of professional, especially in rural areas is limited. However, the Rules Committee agrees that the type of health provider who a midwife refers or consults with should be limited to a physician, physician's assistant, or advanced practice registered nurse (APRN) licensed under Article 15 of the Code.
	• **Antepartum**: decline to add to antepartum "blood pressure of 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure" because the language is antiquated. Instead, the Rules Committee recommends the following language to (i) "hypertension in pregnancy as defined as systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart with the absence of proteinuria."
	• Decline to add "vaginal birth after cesarean," "multiple gestation," and "breech presentation at term and in labor" for the following reasons:
	  • The CPM credential encompasses the ability to offer relevant advice on a case-by-case basis; a referral might be required, but the midwife and the patient together can determine whether that is the case.
	  • Since ACOG advises patients against attempting home delivery of any kind, and all the more stringently against the three types listed above ("Planned home Birth," Number 697, April 2017), and furthermore has most recently offered only cesarean surgery as a route of birth for these three pregnancies, it seems imprudent to require patients to seek a consult in which they will be given blanket advice not to attempt an action permitted by the rules. Such a requirement would generate unnecessary additional financial and other costs to patients and constitute an undue burden on the patients and a bar to access to care, particularly in areas where medical providers are sparse.
	  • Patients have indicated that they don't wish to be required to jump through such hoops.
	  • Patients have the right to evaluate the risks and benefits of VBAC, twin and breech births at home, and make a decision based on these risks and benefits, combined with their own values and circumstances.

	Midwives do not want to force women facing these situations into unassisted births, as has happened in other states with bans. When considered from a harm-reduction perspective, if licensed midwives are not permitted to attend such births the result will be an increase in unassisted deliveries in Michigan, with untrained or unskilled attendants. • States that have refused to forbid midwife attendance at these types of home births, such as Wisconsin, have not subsequently reversed this stance. Some states with more restrictive VBAC rules have changed their rules to permit midwife attendance at home VBACs. Over half of Michigan, by geographical location, is experiencing a VBAC "ban" at local hospitals. Prohibiting licensed midwives to care for patients choosing VBAC does not protect or offer greater safety for women giving birth in Michigan. • The letters referenced below, from public comment submissions, contain support for the rules to remain as written, with regard to multiples, breech, and VBAC births. The Rules Committee must consider these public comments, as proof of the care that consumers desire from CPMs around these issues. This list does not include letters simply saying they support the rules as written. • Carolyn Cronk says that it's important to her that midwives not be prevented from doing VBAC/twins/breech and that she moved here in part because midwives could provide these. • Brit Averill is very pro VBAC and gives solid reasons. • Raymond DeVries appears to endorse the prohibited list as it is without changes. • Lisa Ellens advocates for no change to consultation for VBAC, and midwives' ability to assess and decide with client. • Faith Groesbeck advocates for not limiting the scope of midwives. • FOMM specifically mentions not limiting midwives' attendance of VBAC, encouraging midwives to "maintain the decision made by the legislature not to forbid or unduly limit..." UNDULY LIMIT = require universal consult. • Brooke Henning supports midwives attending VBAC and the rules about it as written. • /Jennifer Holshoe/ICAN lists many issues and consideration for support of VBAC, including concern that "changes to these rules could limit consumer choices and access to care." Mentions that other parts of the rule provide guidance and checks to increase safety of home VBAC. • Susan Jenkins/Big Push comments on dangers of overregulation/micromanagement of midwives

	causing increased unassisted birth. She praises Michigan for having the correct balance of midwife authorization to attend these births combined with heightened informed consent. • Stephanie Mayne wrote, "Keep the rules as they are. 2/3 of OB practices are not evidence based, and they should not be consulted for matters of homebirth." • Melissa is a home VBAC supporter who wants rules kept as they are. • Jill Nolan, breech home birther, submits comments supporting the appropriateness of the level of informed consent employed in decision-making about her breech homebirth. • Kristen Paquin/ICAN supports the right to choose homebirth for VBAC. • Sandra Pera attests to difficulty of obtaining referral/consults with a "hostile" medical community in the upper peninsula. • Michelle Sperlich "strong evidence that midwifery practiced in accordance with the proposed rules contributes to positive outcomes for mothers, infants...." • Carly Vann Thomm commented on R 333.17133: "Such detailed practice requirements go well beyond those of most other health care professional rule sets and expertly balance public safety and the patient's ability to choose desired care." Lists many reasons to support need for access to VBAC with CPMs; "the risks of VBAC are appropriately handled through a heightened informed consent requirement." Addresses multiples/breech with "Many of the arguments for VBAC apply also to...twins...and breech." • Nancy Ward commented that VBAC supports informed consent process and CPMs providing VBAC. Discusses extreme difficulty in accessing care in medical community. • Decline to add the following, as suggested by Bayne, as they are already addressed in the rules: chronic hypertension, pre-gestational diabetes, maternal seizure disorder, uncontrolled asthma, uncontrolled hypothyroidism, hyperthyroidism, signs or symptoms of uterine rupture including severe abdominal pain, loss of fetal station, vaginal bleeding not consistent with bloody show, and postpartum hemorrhage not controlled with initial maneuvers and medications. • Decline to add the following conditions, as these conditions are within the midwife's scope of practice and the midwife is able to use professional judgment in treating these conditions to determine if there is any additional risk to the mother and infant: morbid obesity, advanced maternal age, prior history of preeclampsia or eclampsia, prior history of shoulder dystocia, prior history of obstetrical hemorrhage, prior history of bleeding disorder, prior history of VTE or PE, prior history of preterm labor, prior history of fetal demise over 20 weeks gestation, prior

	history of molar pregnancy, prior history of neonatal sepsis, neonatal evaluation if GBS positive and mother not adequately treated with antibiotics per CDC standard of care, if GBS unknown and rupture of membranes greater than 18 hours, and fetal growth restriction.
	• Decline to modify (viii) to a temperature for less than 24 hours, as it is possible to just have a patient with a mild sickness with a temperature that resolves.
	• Decline to modify "vaginal infection unresponsive to treatment" to "bacterial vaginal infection unresponsive to treatment," as this change would limit the condition for consultation and the Rules Committee believes any vaginal infection that falls into this condition should be on the consult list.
	• Agree to modify gestation beyond 42 weeks to 43 weeks. Under the statute midwives have the ability to order biophysical profiles and other testing to ensure that pregnancies are safe to continue. There is considerable data that the increase in risk in the 42nd week of pregnancy is small and that the greatest increase in risk comes at the 43rd week of pregnancy. Many of the other items on the consultation and referral list describe disease processes or concerning symptoms. This item is different.
	• Agree to add the following conditions to antepartum: hyperreflexia, clonus, rheumatoid arthritis, and chronic pulmonary disease.
	• The following conditions were suggested to be added to a transfer to an appropriate health professional; however, the Rules Committee recommends they be added to the consult list as more information would be helpful in these conditions before a transfer is made:
	  • Uncontrolled gestational diabetes.
	  • Hyperthyroidism treated with medication.
	  • Suspected coagulation disorder.
	  • Inflammatory bowel disease.
	  • Active genital herpes lesions at time of delivery.
	• Decline to delete the following conditions from antepartum, as these conditions may be dealt with and thereafter the patient may be an appropriate candidate for a home birth. The key is requiring the consultation or referral so that more information can be obtained through collaborative care.
	  • **Rupture of membranes prior to the 36.6 weeks of gestation without active labor.** The intent is to require a consult between 36.0 and 36.6 weeks. Medical treatment exists for the patient, after which she is sent home. There is no clear indication that thereafter she should not have a home birth if she has had an assessment and the baby reaches an appropriate gestational age for a home birth.

	• **Positive HIV antibody test**. After a consult, care can be individualized. Care for HIV patients is improving rapidly. Therefore, it may be possible to have a healthy pregnancy with such consultation and care. The Rules Committee recommends preserving the ability of a midwife to provide prenatal care even if the patient is planning a hospital delivery. • **TORCH.** Referral is appropriate, as not all babies will be affected. This condition shouldn't preclude a home birth. • **Documented placenta previa.** Partial previa can move throughout the pregnancy and the condition can resolve. • **Active labor prior to 36.0 weeks of gestation.** If a mother is referred or is the subject of a consultation the condition may be arrested, and the mother may return home. • **History of myomectomy.** Not all myomectomies preclude a home birth. This is the type of condition where the mother would benefit from a consultation or referral to obtain more information, following which the determination may be that a home birth is appropriate. • **Marked or severe hydramnios or oligohydramnios.** This condition can be adjusted and thereafter a home birth can occur. • **Second or third trimester fetal demise.** Once a consult has been achieved, a patient may wish to deliver at home to obtain familiar supportive care. • **Receiving opioid replacement therapy.** Such cases can be co-managed. • **Symptoms or clinical evidence of hepatitis.** "Clinical evidence" allows the midwife to run labs when the mother is asymptomatic. • **Intrapartum**: decline to add "blood pressure exceeding 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure because the language is antiquated. Instead, the Rules Committee recommends that the following language be used in intrapartum, "blood pressure exceeding systolic greater than 140 mm Hg and diastolic greater than 90 mm Hg measured for more than 4 hours." In addition, since a single reading or 160/110 can be a result of acute pain the Rules Committee recommends that the condition "blood pressure exceeding 160/110" currently in intrapartum be modified as follows and moved to transfer, "a single reading of greater than or equal to 160/110." • Decline to modify "ruptured membranes without onset of labor after 72 hours" to "24 hours" as the midwife is able to give standard care including antibiotics similarly to hospital treatment and still transfer the patient to the hospital at 72 hours, *Premature rupture of membranes at term in low risk women: how long should we wait in the*

	"latent phase"?, Pintucci, Armando et al, Journal of Perinatal Medicine, November 2013, 42(2): 189-196. • Decline to add "prolonged second stage of labor without ongoing progress," as recent research shows allowing more time in second stage can produce a higher rate of vaginal birth and "prolonged" is not adequately defined in current research. • Decline to modify "signs and symptoms of maternal infection" due to concern of GBS status, as expectant management is the standard of care with unknown GBS status. • Agree to add the following conditions to intrapartum: fetal heart rate abnormalities of severe bradycardia, fetal tachycardia, or sustained deceleration of fetal heart rate. Decline to add "absence of beat to beat variability" as midwives employ intermittent auscultation to trace fetal heartrate. • Decline to include bleeding not consistent with bloody show as contained elsewhere in the rules. **Postpartum**: decline to delete "lacerations requiring repair beyond the scope of practice of the licensed midwife" from the consultation/referral list, as these conditions may be dealt with and thereafter appropriate for a home birth. The key is requiring the consultation or referral so that more information, collaborative care with more opinions on the situation can occur. A transport should not be required because freestanding clinics can assist the mother, making a move to hospital unnecessary. • Decline to delete "any other condition or symptom that could threaten the health of the mother, as assessed by a licensed midwife exercising reasonable skill and judgment," as this is not an exhaustive list. • **Infant**: decline to add the following to the list of conditions that require consultation or referral for an infant: lethargy, as this is already on the transfer list; irritability, abnormal crying, and poor feeding are ambiguous and not clearly defined, as to when they occur, and they are similar to more specific items that are listed on the transfer list. • Agree to add weight less than 2500 grams or 5 pounds, 8 ounces. • Decline to modify "failure to urinate within 36 hours of birth" to "24 hours of birth." It is common for a new parent to not know when an infant has urinated and at the first 24 hour visit this status is assessed. Ninety percent of normal infants will urinate within 24 hours and 10% of normal babies will urinate within 36 hours. Anuria occurs at 48 hours. Access to care will take place before anuria occurs. • The language proposed in (4) regarding the situation where a patient elects not to accept a referral or consult is recommended with the exception of (c) which requires that "if birth is imminent that the midwife call 911 and remain with the patient until emergency services personnel arrive, transfer care, and give a verbal report of the care provided to the emergency services personnel." This section is regarding circumstances that require a

	consult or referral, not a transfer, so this provision is inconsistent with the remainder of this rule. Rule 338.171135 covers emergent situations.

NEW LANGUAGE FOR PROPOSED RULE 338.17134:

- **R 338.17134(1)-(3):**

(1) A licensed midwife shall consult with or refer a patient to ~~an appropriate health professional~~ **a physician, physician's assistant, or advanced practice registered nurse licensed under Article 15 of the code**, **document the consultation or referral, and follow up with the patient regarding the consultation or referral,** if the patient presents with any of the following conditions ~~that in the judgment of the licensed midwife warrant consultation or referral~~:

(a) Antepartum:

(i) ~~Gestational H~~**H**ypertension **in pregnancy as defined as systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart.**

(ii) Persistent, severe headaches, epigastric pain, or visual disturbances.

(iii) Persistent symptoms of urinary tract infection.

(iv) Significant vaginal bleeding before the onset of labor not associated with uncomplicated spontaneous abortion.

(v) Rupture of membranes prior to the 36.6 weeks of gestation without active labor.

(vi) Noted abnormal decrease in or cessation of fetal movement.

(vii) Hemoglobin level less than 9 and resistant to supplemental therapy.

(viii) A temperature of 100.4 degrees Fahrenheit or 38.0 degrees Celsius or greater for more than 24 hours.

(ix) Isoimmunization, Rh-negative sensitization, or any other positive antibody titer, which would have a detrimental effect on the mother or fetus.

(x) Abnormally elevated blood glucose levels unresponsive to dietary management.

(xi) Positive HIV antibody test.

(xii) TORCH (Toxoplasmosis, other, rubella, cytomegalovirus, and herpes simplex infections.)

(xiii) Symptoms of severe malnutrition, severe persistent dehydration, or protracted weight loss.

(xiv) Symptoms of deep vein thrombosis.

(xv) Documented placenta previa.

(xvi) Documented placenta overlying the site of a previous uterine scar.

(xvii) Active labor prior to 36.0 weeks of gestation.
(xviii) Fetus with diagnosed congenital abnormalities that will require immediate medical intervention at birth.
(xix) History of myomectomy.
(xx) Prior history of early preterm birth, 32 weeks or less.
(~~xx~~ **xxi**) Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations.
(~~xxi~~ **xxii**) Marked abnormal fetal heart tones.
(~~xxii~~ **xxiii**) Abnormal non-stress test or abnormal biophysical profile.
(~~xxiii~~ **xxxiv**) Marked or severe hydramnios or oligohydramnios.
(~~xxiv~~ **xxxv**) Suspected intrauterine growth restriction.
(~~xxv~~ **xxxvi**) Gestation beyond ~~42~~ **43** weeks.
(~~xxvi~~ **xxxvii**) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.
(~~xxvii~~ **xxxviii**) Suspected active alcohol use disorder.
(~~xxviii~~ **xxxix**) Suspected active substance use disorder.
(~~xxix~~ **xxx**) Receiving opioid replacement therapy.
(~~xxx~~ **xxxi**) Sexually transmitted infection.
(~~xxx~~i **xxxii**) Symptoms of ectopic pregnancy
(~~xxxii~~ **xxxiii**) Second or third trimester fetal demise.
(~~xxxiii~~ **xxxiv**) Symptoms or evidence of hydatidiform mole.
(~~xxxiv~~ **xxxv**) Thrombocytopenia with a count less than 100,000 platelets per microliter.
(~~xxxv~~ **xxxvi**) Vaginal infection unresponsive to treatment.
(~~xxxvi~~ **xxxvii**) Symptoms or clinical evidence of hepatitis.
(~~xxxvii~~ **xxxviii**) Abnormal liver or metabolic panel.
(xxxix) Significant proteinuria.
~~(xxxviii)~~ **(xl)** Abnormal PAP test results.
~~(xxxix)~~ **(xli)** Significant hematological disorders or coagulopathies, or pulmonary embolism.
(xlii) Hyperreflexia.
(xliii) Clonus.
(xliv) Rheumatoid arthritis.
(xlv) Chronic pulmonary disease.
(xlvi) Uncontrolled gestational diabetes.
(xlvii) Hyperthyroidism treated with medication.

(xlviii) Suspected coagulation disorder.

(xlix) Inflammatory bowel disease.

(l) (l) Addison's disease.

(li) Scleroderma.

(~~xl~~ **lii**) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.

(b) Intrapartum:

(i) ~~Blood pressure exceeding 160/110~~.

(ii) Persistent, severe headaches, epigastric pain or visual disturbances.

(iii) Temperature over 100.4 degrees Fahrenheit or 38.0 degrees Celsius in absence of environmental factors.

(iv) Signs or symptoms of maternal infection.

(v) Confirmed ruptured membranes without onset of labor after 72 hours.

(vi) Excessive vomiting, dehydration, acidosis, or exhaustion unresponsive to treatment.

(vii) Uncontrolled current serious psychiatric illness.

(viii) Fetal heart rate abnormalities of severe bradycardia, fetal tachycardia, or sustained deceleration of fetal heart rate.

(~~viii~~**ix**) Any other condition or symptom that could threaten the health of the mother or fetus, as assessed by a licensed midwife exercising reasonable skill and judgment.

(c) Postpartum:

(i) Failure to void bladder within 6 hours of birth **or catheterization**.

(ii) Temperature of 101.0 degrees Fahrenheit or 39 degrees Celsius for more than 12 hours.

(iii) Signs or symptoms of uterine sepsis.

(iv) Symptoms of deep vein thrombosis.

(v) Suspected perinatal mood disorder or uncontrolled current serious psychiatric illness.

(vi) Suspected active alcohol use disorder.

(vii) Suspected active substance use disorder.

(viii) Lacerations requiring repair beyond the scope of practice of the licensed midwife.

(ix) Systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart after delivery of the baby.

(~~ix~~ **x**) Any other condition or symptom that could threaten the health of the mother, as assessed by a licensed midwife exercising reasonable skill and judgment.

(2) A licensed midwife shall consult with or refer a patient to a physician, physician's assistant, or advanced practice registered nurse licensed under Article 15 of the code, document the consultation or referral, and follow up with the patient regarding the consultation or referral, if the infant presents with any of the following conditions:

~~(d) Infant:~~

(~~I~~ **a**) Abnormal metabolic infant screening.

(~~ii~~ **b**) Failed hearing screening.

(~~iii~~ **c**) Jaundice occurring outside of normal range.

(~~iv~~ **d**) Failure to urinate within 36 hours of birth.

(~~v~~ **e**) Failure to pass meconium within 48 hours of birth.

(~~vi~~ **f**) Medically significant nonlethal congenital anomalies.

(~~vii~~ **g**) Suspected birth injury.

(~~viii~~ **h**) Signs of clinically significant dehydration.

(~~ix~~ **i**) Signs and symptoms of neonatal abstinence syndrome.

(j) Weight less than 2500 grams or 5 pounds, 8 ounces, singleton.

(~~x~~ **k**) Any other abnormal infant behavior or appearance that could adversely affect the health of the infant, as assessed by a licensed midwife exercising reasonable skill and judgment.

(~~2~~**3**) When a referral to a~~n appropriate health professional~~ **physician, physician's assistant, or advanced practice registered nurse licensed under Article 15 of the code** is made, after referral the licensed midwife may, if possible, remain in communication with the ~~appropriate health professional~~ **physician, physician's assistant, or advanced practice registered nurse** until resolution of the concern.

(4) If the patient elects not to accept a referral or the physician, physician's assistant, or advanced practice registered nurse's advice, the licensed midwife shall:

(a) Obtain full informed consent from the patient and document the refusal in writing.

(b)Discuss with the patient what the continuing role of the licensed midwife will be and whether the licensed midwife will continue or discontinue care of the patient.

(~~3~~**5**) Neither consultation nor referral preclude the possibility of continued care by a licensed midwife or the possibility of an out-of-hospital birth. The licensed midwife may maintain care of the patient to the greatest degree possible. ~~The patient may elect not to accept a referral or an appropriate health professional's advice. If full informed consent has been provided, and if the refusal is documented in writing, the licensed midwife may continue or discontinue to care for the patient.~~

Board Response	• **Title**: The Board declines the suggested change to add the word "required" to the title of the rule, as that

	change is redundant, titles are to be as minimum as possible, and the rule states that the "midwife shall" which connotes that it is required. • **Structure of rule**: The Board agrees with the suggested change to separate into two distinct subdivisions the conditions relating to the mother versus conditions relating to the infant. • The Board declines the suggested change to separate moderate and severe conditions, as conditions are separated by stage and into conditions that are emergent or non-emergent. • The Board agrees with the suggested change to add language that the midwife shall document the consultation or referral and follow up with the patient regarding the consultation or referral**.** • **Appropriate health professional**: the Board declines the suggested change to require that an appropriate health professional have experience in the active practice of obstetrics, pediatrics, emergency medicine, or obstetric privileges at a nearby hospital with labor and delivery services, as this language would limit those who would qualify as an appropriate health professional and make it much more difficult in rural areas to find a health provider when one is needed. Ideally a physician, physician's assistant, nurse practitioner, or certified nurse midwife with experience would be the type of health professional who a midwife would turn to. However, access to this type of professional, especially in rural areas is limited. However, the Board agrees that the type of health provider who a midwife refers or consults with, regarding the conditions in R 338.17134, should be limited to a physician, physician's assistant, or APRN licensed under Article 15 of the Code. • **Antepartum**: The Board declines the suggested change to add "blood pressure of 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure" to antepartum, because the language is antiquated. Instead, the Board adds the following language to (i) "hypertension in pregnancy as defined as systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart." The Board declines to include the language "with the absence of proteinuria" as the condition "significant proteinuria" is being added for a consult. • The Board declines the suggested change to add "vaginal birth after cesarean," "multiple gestation," and "breech presentation at term and in labor" for the following reasons: • The CPM credential encompasses the ability to offer relevant advice on a case-by-case basis; a referral might be required, but the midwife and the patient together can determine whether that is the case.

	• Since ACOG advises patients against attempting home delivery of any kind, and all the more stringently against the three types listed above ("Planned home Birth," Number 697, April 2017), and furthermore has most recently offered only cesarean surgery as a route of birth for these three pregnancies, it seems imprudent to require patients to seek a consult in which they will be given blanket advice not to attempt an action permitted by the rules. Such a requirement would generate unnecessary additional financial and other costs to patients and constitute an undue burden on the patients and a bar to access to care, particularly in areas where medical providers are sparse.
	• Patients have indicated that they don't wish to be required to jump through such hoops.
	• Patients have the right to evaluate the risks and benefits of VBAC, twin and breech births at home, and make a decision based on these risks and benefits, combined with their own values and circumstances. Midwives do not want to force women facing these situations into unassisted births, as has happened in other states with bans. When considered from a harm-reduction perspective, if licensed midwives are not permitted to attend such births the result will be an increase in unassisted deliveries in Michigan, with untrained or unskilled attendants.
	• States that have refused to forbid midwife attendance at these types of home births, such as Wisconsin, have not subsequently reversed this stance. Some states with more restrictive VBAC rules have changed their rules to permit midwife attendance at home VBACs. Over half of Michigan, by geographical location, is experiencing a VBAC "ban" at local hospitals. Prohibiting licensed midwives to care for patients choosing VBAC does not protect or offer greater safety for women giving birth in Michigan.
	
	• The letters referenced below, from public comment submissions, contain support for the rules to remain as written, with regard to multiples, breech, and VBAC births. The Board must consider these public comments, as proof of the care that consumers desire from CPMs around these issues. This list does not include letters simply saying they support the rules as written.
	
	  • Carolyn Cronk says that it's important to her that midwives not be prevented from doing VBAC/twins/breech and that she moved here in part because midwives could provide these.
	  • Brit Averill is very pro VBAC and gives solid reasons.

	• Raymond DeVries appears to endorse the prohibited list as it is without changes. • Lisa Ellens advocates for no change to consultation for VBAC, and midwives' ability to assess and decide with client. • Faith Groesbeck advocates for not limiting the scope of midwives. • FOMM specifically mentions not limiting midwives' attendance of VBAC, encouraging midwives to "maintain the decision made by the legislature not to forbid or unduly limit..." UNDULY LIMIT = require universal consult. • Brooke Henning supports midwives attending VBAC and the rules about it as written. • Jennifer Holshoe/ICAN lists many issues and consideration for support of VBAC, including concern that "changes to these rules could limit consumer choices and access to care." Mentions that other parts of the rule provide guidance and checks to increase safety of home VBAC. • Susan Jenkins/Big Push comments on dangers of overregulation/micromanagement of midwives causing increased unassisted birth. She praises Michigan for having the correct balance of midwife authorization to attend these births combined with heightened informed consent. Further, Jenkins states: "As a matter of constitutional law, as well as reasonable health policy, the Big Push believes that no woman should be forced by a statute or rule to have surgery that puts her own life and health at greater risk, simply because she does not have access to a provider who will attend her birth and is legally permitted to do so. Yet this is the scenario many women face across the nation, including Michigan, because so many hospitals and physicians refuse to attend women who are attempting VBAC. The stated reasons for such these denials of care are most often fear of litigation, a situation that has contributed to the absurdly high c-section rates of over 30% in most states. Given so few if any options for in-hospital VBAC, women turn to midwives, in recognition that midwives have the expertise and experience to attend VBACs, skills that have fallen out of use in the hospital setting, as well as a thorough scientific understanding of the relative risks and benefits of VBAC versus repeat c-section." • Stephanie Mayne wrote, "Keep the rules as they are. 2/3 of OB practices are not evidence based, and they should not be consulted for matters of homebirth."

	• Melissa is a home VBAC supporter who wants rules kept as they are. • Jill Nolan, breech home birther, submits comments supporting the appropriateness of the level of informed consent employed in decision-making about her breech homebirth. • Kristen Paquin/ICAN supports the right to choose homebirth for VBAC. • Sandra Pera attests to difficulty of obtaining referral/consults with a "hostile" medical community in the upper peninsula. • Michelle Sperlich "strong evidence that midwifery practiced in accordance with the proposed rules contributes to positive outcomes for mothers, infants...." • Carly Vann Thomm commented on R 333.17133: "Such detailed practice requirements go well beyond those of most other health care professional rule sets and expertly balance public safety and the patient's ability to choose desired care." Lists many reasons to support need for access to VBAC with CPMs; "the risks of VBAC are appropriately handled through a heightened informed consent requirement." Addresses multiples/breech with "Many of the arguments for VBAC apply also to...twins...and breech." • Nancy Ward commented that VBAC supports informed consent process and CPMs providing VBAC. Discusses extreme difficulty in accessing care in medical community. • The Board declines the suggested change to add the following, as suggested by Bayne, as they are already addressed in the rules or this document: chronic hypertension, pre-gestational diabetes, maternal seizure disorder, uncontrolled asthma, hyperthyroidism, signs or symptoms of uterine rupture including severe abdominal pain, loss of fetal station, vaginal bleeding not consistent with bloody show, and postpartum hemorrhage not controlled with initial maneuvers and medications. • The Board declines the suggested change to add the following conditions, as these conditions are within the midwife's scope of practice and the midwife is able to use professional judgment in treating these conditions to determine if there is any additional risk to the mother and infant or they are addressed elsewhere in the rules: morbid obesity, advanced maternal age, prior history of preeclampsia or eclampsia, prior history of shoulder dystocia, prior history of obstetrical hemorrhage, prior history of bleeding disorder, prior history of VTE or PE, prior history of fetal demise over 20 weeks gestation, prior history of molar pregnancy, prior history of neonatal sepsis, neonatal evaluation if GBS positive and mother not adequately treated with antibiotics per CDC standard of care, if GBS unknown and rupture of membranes greater than 18 hours, and fetal growth restriction.

	• The Board declines the suggested change to modify (viii) to a temperature for less than 24 hours, as it is possible to have a patient with a mild sickness with a temperature that resolves.
	• The Board declines the suggested change to modify "vaginal infection unresponsive to treatment" to "bacterial vaginal infection unresponsive to treatment," as this change would limit the condition for consultation and the Board believes any vaginal infection that falls into this condition should be on the consult list.
	• The Board agrees with the suggested change to modify gestation beyond 42 weeks to 43 weeks. Under the statute midwives have the ability to order biophysical profiles and other testing to ensure that pregnancies are safe to continue. There is considerable data that the increase in risk in the 42nd week of pregnancy is small and that the greatest increase in risk comes at the 43rd week of pregnancy. Many of the other items on the consultation and referral list describe disease processes or concerning symptoms. This item is different.
	• The Board agrees with the suggested change to add the following conditions to antepartum: hyperreflexia, clonus, rheumatoid arthritis, chronic pulmonary disease, and prior history of early preterm birth, 32 weeks or less.
	• The Board declines the suggested change to transfer the following conditions to an appropriate health professional; however, the Board adds them to the consult list as more information would be helpful in these conditions before a transfer is made:
	  • Uncontrolled gestational diabetes.
	  • Hyperthyroidism treated with medication.
	  • Suspected coagulation disorder.
	  • Inflammatory bowel disease.
	• The Board declines the suggested change to delete the following conditions from antepartum, as these conditions may be dealt with and thereafter the patient may be an appropriate candidate for a home birth. The key is requiring the consultation or referral so that more information can be obtained through collaborative care.
	  • **Rupture of membranes prior to the 36.6 weeks of gestation without active labor.** The intent is to require a consult between 36.0 and 36.6 weeks. Medical treatment exists for the patient, after which she is sent home. There is no clear indication that thereafter she should not have a home birth if she has had an assessment and the baby reaches an appropriate gestational age for a home birth.

	• **Positive HIV antibody test**. After a consult, care can be individualized. Care for HIV patients is improving rapidly. Therefore, it may be possible to have a healthy pregnancy with such consultation and care. The Board desires to preserve the ability of a midwife to provide prenatal care even if the patient is planning a hospital delivery. • **TORCH.** Referral is appropriate, as not all babies will be affected. This condition shouldn't preclude a home birth. • **Documented placenta previa.** Partial previa can move throughout the pregnancy and the condition can resolve. • **Active labor prior to 36.0 weeks of gestation.** If a mother is referred or is the subject of a consultation the condition may be arrested, and the mother may return home. • **History of myomectomy.** Not all myomectomies preclude a home birth. This is the type of condition where the mother would benefit from a consultation or referral to obtain more information, following which the determination may be that a home birth is appropriate. • **Marked or severe hydramnios or oligohydramnios.** This condition can be adjusted and thereafter a home birth can occur. • **Second or third trimester fetal demise.** Once a consult has been achieved, a patient may wish to deliver at home to obtain familiar supportive care. • **Receiving opioid replacement therapy.** Such cases can be co-managed. • **Symptoms or clinical evidence of hepatitis.** "Clinical evidence" allows the midwife to run labs when the mother is asymptomatic. • **Intrapartum**: The Board declines the suggested change to add "blood pressure exceeding 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure" because the language is antiquated. The priority in intrapartum is to deliver the baby. However, if a higher reading continues in postpartum the licensed midwife should proceed with a consult. The Board is not aware of protocols nor guidelines regarding blood pressure and hypertension that suggest in or out of hospital care. Therefore, the following language will instead be added to postpartum, "systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart after delivery of the baby." As a result of these changes regarding blood pressure readings, and since a single reading or 160/110 can be a result of acute pain, the Board will add "a single reading of greater than or equal to 160/110" to transfer.

	• The Board declines the suggested change to modify "ruptured membranes without onset of labor after 72 hours" to "24 hours" as the midwife is able to give standard care including antibiotics similarly to hospital treatment and still transfer the patient to the hospital at 72 hours, *Premature rupture of membranes at term in low risk women: how long should we wait in the "latent phase"?*, Pintucci, Armando et al, Journal of Perinatal Medicine, November 2013, 42(2): 189-196. • The Board declines the suggested change to add "prolonged second stage of labor without ongoing progress," as recent research shows allowing more time in second stage can produce a higher rate of vaginal birth and "prolonged" is not adequately defined in current research. • The Board declines the suggested change to modify "signs and symptoms of maternal infection" due to concern of GBS status, as expectant management is the standard of care with unknown GBS status. • The Board agrees with the suggested change to add the following conditions to intrapartum: fetal heart rate abnormalities of severe bradycardia, fetal tachycardia, or sustained deceleration of fetal heart rate. The Board declines the suggested change to add "absence of beat to beat variability" as midwives employ intermittent auscultation to trace fetal heartrate. • The Board declines the suggested change to include bleeding not consistent with bloody show as contained elsewhere in the rules. • **Postpartum**: The Board declines the suggested change to delete "lacerations requiring repair beyond the scope of practice of the licensed midwife" from the consultation/referral list, as these conditions may be dealt with in an ambulatory setting by an appropriate provider. The key is requiring the consultation or referral so that more information, collaborative care with more opinions on the situation can occur. A transport should not be required because freestanding clinics can assist the mother, making a move to the hospital unnecessary. • The Board declines the suggested change to delete "any other condition or symptom that could threaten the health of the mother, as assessed by a licensed midwife exercising reasonable skill and judgment," as this is not an exhaustive list. • The Board declined the suggested change to add "blood pressure exceeding 140/90 or an increase of 30 mm HG systolic or 15 mm Hg diastolic over the usual blood pressure" in intrapartum because the language is antiquated. The priority in intrapartum is to deliver the baby. However, if a higher reading continues in postpartum the licensed midwife should proceed with a consult. The Board is not aware of protocols nor guidelines regarding blood pressure and hypertension that suggest in or out of hospital care.

	Therefore, the following language will instead be added to postpartum, "systolic blood pressure greater than 140 mm Hg and diastolic blood pressure greater than 90 mm Hg measured on two separate occasions more than four hours apart after delivery of the baby." • **Infant**: the Board declines the suggested change to add the following to the list of conditions that require consultation or referral for an infant: lethargy, as this is already on the transfer list; irritability, abnormal crying, and poor feeding are ambiguous and not clearly defined, as to when they occur, and they are similar to more specific items that are listed on the transfer list. • The Board agrees with the suggested change to add weight less than 2500 grams or 5 pounds, 8 ounces, singleton. • The Board declines the suggested change to modify "failure to urinate within 36 hours of birth" to "24 hours of birth." It is common for a new parent to not know when an infant has urinated and at the first 24 hour visit this status is assessed. Ninety percent of normal infants will urinate within 24 hours and 10% of normal babies will urinate within 36 hours. Anuria occurs at 48 hours. Access to care will take place before anuria occurs. The Board agrees with the suggested change in (4) regarding the situation where a patient elects not to accept a referral or consult with the exception of (c) which requires that "if birth is imminent that the midwife call 911 and remain with the patient until emergency services personnel arrive, transfer care, and give a verbal report of the care provided to the emergency services personnel." This section is regarding circumstances that require a consult or referral, not a transfer, so this provision is inconsistent with the remainder of this rule. Rule 338.171135 covers emergent situations. See above.

LARA's Response	**Pursuant to the Department Director's authority to approve the proposed draft rules during the rule promulgation process, MCL 333.17112, 333.17117, 333.16145, and 333.16175, the Department Director disagrees with the commenter's suggested change and the Board's decision to modify gestation beyond "42 weeks" to "43 weeks" in R 338.17134(1)(a)(xxvi).** **Pursuant to the Department Director's authority to approve the proposed draft rules during the rule promulgation process, MCL 333.17112, 333.17117, 333.16145, and 333.16175, the Department Director**

	disagrees with the Board's decision to not accept the commenter's suggested change to modify "ruptured membranes without onset of labor after 72 hours" to "ruptured membranes without onset of labor after 24 hours" in R 338.17134(1)(b)(iv). **Please see Memorandum from Kim Gaedeke, LARA Chief Deputy, dated March 26, 2019.**

Rule 338. 17135 Emergent transfer of care.

Rule Numbers	Commenter	Comment
Title	Moore/ANA et al.	Add "Required."
	Moore/ANA et al.	The commenter suggests that this rule be divided into transfers to an appropriate health professional and to a hospital. The commenter suggested these new conditions, not otherwise included in the current draft, be included in the proposed list of transfers to an appropriate health professional: • Uncontrolled gestational diabetes. • Hyperthyroidism treated with medication. • Uncontrolled hypothyroidism. • Suspected coagulation disorder. • Inflammatory bowel disease. • Active genital herpes lesions at time of delivery. • Addison's disease. • Cushing's disease. • Systemic lupus erythematosus. • Antiphospholipid syndrome. • Scleroderma. • Periarteritis nodosa. • Continued daily tobacco use into the second trimester • Primary genital herpes infection in pregnancy

	Dove-Medows ACNM	The Michigan Affiliate of the American College of Nurse-Midwives suggests that the 2014 National Homebirth Summit's Best Practice Guidelines: Transfer from Planned Home Birth to Hospital which support joint accountability to assure optimal processes are in place for communication and collaboration when a transition is needed form a homebirth to a hospital.
Section (1)	Taft and Moore/ANA	The commenter asked who receives notification in this provision. Recommending a written transfer agreement.
	Pera	Change "may" to "shall."
	Averill	Does not support non-cephalic presentation at or beyond 38 weeks for automatic transfer of care as restrictive, should be a consultation. Unresolved non-cephalic presentation at the time of delivery is already listed as a contraindication to home birth.
	Bayne	(xi) Preeclampsia or eclampsia should be modified to "blood pressure greater or equal to 140 systolic or 90 diastolic greater than 4 hours apart, blood pressure of 160 systolic or greater or blood pressure 110 diastolic or greater, proteinuria (300 mg in 24 hour collection, 0.3 or urine protein/creatinine ratio, dipstick +1 or greater), pulmonary edema, liver enzymes greater than twice normal, serum creatinine 1.1 or double baseline, thrombocytopenia less than 100,000, cerebral/visual disturbances, right upper quadrant or mid epigastric pain.
	Stockton	(vii) Clarify if this includes chronic controlled cardiac arrhythmias. (xvii) Clarify what is meant by "consistent."
(2)	Allswede/ACOG	The law requires the Board to "identify or create a standard form and recommend use of the standard form to collect information on a patient whose care is transferred either temporarily or permanently to a hospital or physician." • Suggest licensed midwife's client care plan must incorporate the conditions under which consultation, including transfer or care or transport of the client, may be implemented. • Transfer of care plan should include procedures and processes to be undertaken in the event of an emergency for the mother, newborn or both; identify the hospital nearest to the address of the planned home birth that has a labor and delivery unit; include a care plan for the

		newborn; and identify a pediatric health care practitioner who will be notified after delivery. • A licensed midwife shall use the standard form approved by the board/LARA for all cases in which a transfer occurs during prenatal, care, labor, or postpartum. • After a decision to transport a patient has been made, the licensed midwife shall call the receiving health care provider to inform them of the incoming patient and accompany the patient to the hospital. On arrival at the hospital, the licensed midwife shall provide hospital staff with the standard form, complete medical records of the patient and newborn and a verbal summary of the care provided to the patient and newborn.
	Moore/ANA et al.	Add a new rule 338.17135A to identify what is required in a transfer of care plan, as follows: "A licensed midwife shall create a transfer of care plan that minimally includes the following: (a) Conditions under which the midwife will transfer care to an appropriate health professional. (b) Identification of hospitals to which the patient may be transported. (c) Protocols for contacting 9-1-1 or other emergency medical services personnel. (d) Protocols for implementing emergency medical procedures including but not limited to cardiopulmonary resuscitation and administration of oxygen. (e) Protocols for accompanying the patient to a hospital if transport in a private vehicle is the most expedient method for accessing medical services. (f) Protocols for notifying the emergency room or labor and delivery unit of the designated hospital of the imminent transport and providing the staff at the receiving facility with the patient's complete medical record and verbal report on the patient's status. (g) Protocols for care and appropriate attendant for infant in need of transport while maintaining appropriate care of maternal patient."
	Stockton	Add after emergency care plan, "or current emergency best practice applicable to training."
Rules Committee Response	The Rules Committee recommends the following: • **Title**: decline to add the word "required" to the title of the rule, as that change is redundant. Titles are to be as minimum as possible, and the rule states that the "midwife shall," which connotes that it is required. • Agree to add language to clarify that all transfers are made to a hospital. • **Structure of rule**: agree to separate out the conditions relating to the mother versus conditions relating to the	

	infant. • Decline to divide into transfers to an appropriate health professional and to a hospital, as many of the listed conditions are already included in the consult or transfer section. • **Conditions Mother:** agree to add the following conditions suggested to be included in the transfer to an appropriate health professional list, be added to consultation, R 338.17134, or the prohibited list, R 338.17136: Consult - uncontrolled gestational diabetes, suspected coagulation disorder, inflammatory bowel disease, active genital herpes lesions at time of delivery, Addison's disease - (requires care throughout pregnancy), and scleroderma - (risk depends on whether localized or systemic). Prohibited: hyperthyroidism treated with medication, uncontrolled hypothyroidism, primary genital herpes infection in pregnancy, Cushing's disease - (adds risk to the pregnancy), systemic lupus erythematosus, antiphospholipid syndrome – (commonly diagnosed through reoccurring miscarriage and needs high risk specialist), and polyarteritis nodosa (assuming polyarteritis nodosa was intended for the suggested disease of periarteritis nodosa). • Decline to add hyperthyroidism treated with medication and uncontrolled hypothyroidism and instead recommend adding to the prohibited conduct list. • Recommend adding the condition "blood pressure exceeding 160/110" currently in intrapartum be modified, as follows and moved to transfer, "a single reading of greater than or equal to 160/110." • Decline to add continued daily tobacco use into the second trimester to consult, or transfer, as this condition needs support and counseling, and the midwifery model of care has a better record of cessation than other standards of care. • Decline to add primary genital herpes infection in pregnancy to the transfer list and instead add it to the prohibited contact list and add genital herpes lesions at the time of delivery to the consult list. • Decline to modify the rule pursuant to Averill's comment regarding non-cephalic presentation at or beyond 38 weeks, as the rule has been misquoted. • Decline to modify "symptoms of preeclampsia or eclampsia" to the language suggested by Bayne, as some of the labs in the suggested language are impossible to carry out at home, the suggestion is inconsistent, as some parts are more appropriate for consultation not transfer, and parts of the suggested language have already been addressed by modifying the consult and transfer list of conditions. • Decline to modify "symptomatic cardiac arrhythmias or chest pain" to include "chronic controlled cardiac arrhythmias," as any symptom requires a transfer.

	• Decline to add "other diseases and disorder, as determined by the Department," as the Board has a medical background and understanding of the midwifery profession and model of care and any emergency can be handled by an emergency rule if necessary. • Decline to add the patient requests transfer, because this is the ongoing standard of care. A patient may transfer their case at any time. • **Conditions Infant**: decline to add "persistent breathing at a rate of more than 60 breaths per minute" and "temperature persistently over 99.0 degrees Fahrenheit or less than 97.6 degrees Fahrenheit" as these conditions are already included in "clinically significant abnormalities in vital signs, muscle tone, or behavior." • Decline to add abnormal crying, as ambiguous. • **(2**): Agree to add language to (2) suggested by Moore/ANA et al., except for the language "appropriate health professional is completed," as this section addresses transport to a hospital. • **(2):** Decline to modify the language in (2) to refer to emergency care plan or "current emergency best practice applicable to training," as the Rules Committee recommends a specific plan be used, not a best practice. • **(3):** Decline to add "and the licensed midwife, an appropriate health care professional or emergency medical services personnel accompanies the patient" in (3), as there are circumstances where it will be faster to get a patient to the hospital by some other means other than waiting for the midwife, an emergency medical services personal, or health care professional to accompany the patient during the drive to the hospital. Each transfer involving both a mother and infant are case-specific; the midwife's professional judgment must be used, not a standard protocol that will not be appropriate for all transfers. These rules already require a midwife to convey pertinent information to the hospital regarding the transported patient. • **(4):** Decline to change "may" to "shall" in (4) and add "until the licensed midwife is able to complete the transfer care to emergency medical services personnel or an appropriate health professional, as provided in subrule (4), as the purpose of the rule is to allow the midwife to continue to treat the patient when a transfer is not imminent for a variety of reasons listed in the rule. • Decline to add a new R 338.17135A to identify what is required of a transfer of care plan, as the conditions under which a consultation, transfer, or transport takes place as well as whether there is a collaboration relationship and the names and contact information are already included in the rules, which is already part of the disclosure. The Transfer of Care Form from the Home Birth Summit has been painstakingly reviewed by the Rules Committee and Board. The form includes the conditions under which the midwife will transfer care and includes hospitals to which the patient may be transported, as well as protocols for contacting 9-1-1. The protocols for implementing

	emergency medical procedures are included in NARM's training procedures. All CPMs must have a care plan for transport to a hospital and must maintain an informed disclosure and shared decision-making protocol that they use throughout the entire process with a patient. At the initiation of care and throughout the process the CPM is required to share these documents with the patient and have the patient consent.

NEW LANGUAGE FOR PROPOSED RULE 338.17135:

- **R 338.17135(1), (2), and (4):**

(1) In **the following** emergent circumstances**,** a licensed midwife ~~may~~ **shall immediately arrange for transport of the patient to a hospital and notify hospital staff of the** transfer ~~the~~ **of** care of **the** patient ~~to an appropriate health professional~~. ~~The following conditions require immediate notification and emergency transfer to a hospital~~:

(a) Mother:

(i) Seizures.

(ii) Unconsciousness.

(iii) Respiratory distress or arrest.

(iv) Maternal shock unresponsive to treatment.

(v) Symptoms of maternal stroke.

(vi) Symptoms of suspected psychosis.

(vii) Symptomatic cardiac arrhythmias or chest pain.

(viii) Prolapsed umbilical cord.

(ix) Symptoms of uterine rupture.

(x) Symptoms of placental abruption.

(xi) Symptoms of preeclampsia or eclampsia.

(xii) Severe abdominal pain inconsistent with normal labor.

(xiii) Symptoms of pulmonary or amniotic fluid embolism.

(xiv) Symptoms of chorioamnionitis that include the presence of a fever greater than 100.4 degrees Fahrenheit or 38.0 degrees Celsius and 2 of the following 3 signs: uterine tenderness, maternal or fetal tachycardia, or foul/purulent amniotic fluid.

(xv) Unresolved fetal malpresentation not compatible with spontaneous vaginal delivery.

(xvi) Hemorrhage non-responsive to therapy.

(xvii) Uterine inversion.

(xviii) Persistent uterine atony.

(xix) Symptoms of anaphylaxis.
(xx) Failure to deliver placenta within 2 hours in the third stage.
(xxi) Persistent abnormal vital signs.
(xxii) Significant abnormal bleeding prior to delivery, with or without abdominal pain.
(xxiii) Fetal distress evidenced by abnormal fetal heart tones when birth is not imminent.
(xxiv) A single blood pressure reading of greater than or equal to 160/110.
(xxv) Genital herpes lesions at the time of delivery if the lesions cannot be covered by an occlusive dressing.

(b) Infant:
(i) Persistent cardiac irregularities.
(ii) Persistent central cyanosis, pallor, or abnormal perfusion.
(iii) Persistent lethargy or poor muscle tone.
(iv) Seizures.
(v) Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.
(vi) Non-transient respiratory distress.
(vii) Significant signs or symptoms of infection.
(viii) Evidence of unresolved hypoglycemia.
(ix) Abnormal, bulging, or depressed fontanel.
(x) Significant evidence of prematurity.
(xi) Clinically significant abnormalities in vital signs, muscle tone, or behavior.
(xii) Failed critical congenital heart defect screening.
(xiii) Persistent inability to suck.
(xiv) Clinically significant abdominal distension.
(xv) Clinically significant projectile vomiting.
(xvi) Contact with genital herpes lesions at birth.

(2) **As required under subrule (1) of this rule,** ~~The~~ **a** licensed midwife shall initiate immediate transport according to the licensed midwife's emergency care plan; provide necessary emergency stabilization until ~~emergency medical services arrive or~~ transfer **to a hospital or emergency medical services personnel** is completed; provide pertinent information to the ~~appropriate health professional~~ **receiving provider assuming care of the patient or patients**; and is encouraged to fill out a patient transfer form provided by the department.

(3) Transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services.

(4) A licensed midwife **if present,** ~~may continue~~ **is allowed** to provide care to a patient with any of the complications or conditions set forth in this rule under any of the following circumstances:
(~~i~~ **a**) If no ~~appropriate health professional or other equivalent~~ **emergency** medical services **personnel** are available.
(~~ii~~ **b**) If delivery occurs during transport.
(~~iii~~ **c**) If the patient refuses to be transported to the hospital.
(~~iv~~ **d**) If the transfer or transport entails futility, or extraordinary and unnecessary human suffering.
(5) The licensed midwife may remain in consultation with the appropriate health professional after a transfer is made.
(6) If authorized by the patient, a licensed midwife may be able to be present during the labor and childbirth, and care may return to the midwife upon discharge.

Board Response	• **Title**: The Board declines the suggested change to add the word "required" to the title of the rule, as that change is redundant. Titles are to be as minimum as possible, and the rule states that the "midwife shall," which connotes that it is required. • The Board agrees with the suggested change to add language to clarify that all transfers are made to a hospital. • **Structure of rule**: The Board agrees with the suggested change to separate out the conditions relating to the mother versus conditions relating to the infant. • The Board declines the suggested change to divide the transfer rule into transfers to an appropriate health professional and transfers to a hospital, as many of the listed conditions are already included in the consult or transfer section. • **Conditions Mother:** The Board agrees with the suggested change to add the following conditions to the Rules, consult list, R 338.17134, or the prohibited list, R 338.17136: Consult – uncontrolled gestational diabetes, suspected coagulation disorder, inflammatory bowel disease, Addison's disease - (requires care throughout pregnancy), and scleroderma - (risk depends on whether localized or systemic). Prohibited: known uncontrolled hypothyroidism, Cushing's disease - (adds risk to the pregnancy), systemic lupus erythematosus, antiphospholipid syndrome – (commonly diagnosed through reoccurring miscarriage and needs high risk specialist), and polyarteritis nodosa (assuming polyarteritis nodosa was intended for the suggested disease of periarteritis nodosa).

	• The Board agrees with the suggested change to add the condition "a single reading of greater than or equal to 160/110" to transfer (see Board response to R 338.17134.) • The Board declines the suggested change to add continued daily tobacco use into the second trimester to consult, or transfer, as this condition needs support and counseling, and the midwifery model of care has a better record of cessation than other standards of care. • The Board declines the suggested change to add "primary genital herpes infection in pregnancy" to the transfer list and instead adds it to the prohibited contact list, and adds "genital herpes lesions at the time of delivery if the lesions cannot be covered by an occlusive dressing" to the transfer list for the mother, and "contact with genital herpes lesion at birth" to the transfer list for the infant. • The Board declines the suggested change to modify the rule pursuant to Averill's comment regarding non-cephalic presentation at or beyond 38 weeks, as the rule has been misquoted. • The Board declines the suggested change to modify "symptoms of preeclampsia or eclampsia" to the language suggested by Bayne, as some of the labs in the suggested language are impossible to carry out at home, the suggestion is inconsistent, as some parts are more appropriate for consultation not transfer, and parts of the suggested language have already been addressed by modifying the consult and transfer list of conditions. • The Board declines the suggested change to modify "symptomatic cardiac arrhythmias or chest pain" to include "chronic controlled cardiac arrhythmias," as any symptom requires a transfer. • The Board declines the suggested change to add "other diseases and disorder, as determined by the Department," as the Board has a medical background and understanding of the midwifery profession and model of care and any emergency can be handled by an emergency rule if necessary. • The Board declines the suggested change to add "the patient requests transfer", because this is the ongoing standard of care. A patient may transfer their case at any time. • **Conditions Infant**: The Board declines the suggested change to add "persistent breathing at a rate of more than 60 breaths per minute" and "temperature persistently over 99.0 degrees Fahrenheit or less than 97.6 degrees Fahrenheit" as these conditions are already included in "clinically significant abnormalities in vital signs, muscle tone, or behavior." • The Board declines the suggested change to add abnormal crying, as ambiguous. • **(2**): The Board agrees with the suggested change to add language to (2) suggested by Moore/ANA et al., except for the language "appropriate health professional is completed," as this section addresses transport

	to a hospital. In addition, the rule will be further clarified by deleting: "emergency medical services arrive or" and adding that a transfer may occur "to a hospital" to clarify that the licensed midwife shall provide care until a transfer is complete to the hospital or emergency medical services personnel. The phrase, assuming care of the patient or patients will be added to clarify "provider." • **(2):** The Board declines the suggested change to modify the language in (2) to refer to emergency care plan or "current emergency best practice applicable to training," as a specific plan should be used, not a best practice. • **(3):** The Board declines the suggested change to add "and the licensed midwife, an appropriate health care professional or emergency medical services personnel accompanies the patient" in (3), as there are circumstances where it will be faster to get a patient to the hospital by some other means other than waiting for the midwife, an emergency medical services personal, or health care professional to accompany the patient during the drive to the hospital. Each transfer involving both a mother and infant are case-specific; the midwife's professional judgment must be used, not a standard protocol that will not be appropriate for all transfers. These rules already require a midwife to convey pertinent information to the hospital regarding the transported patient. • **(4):** The Board declines the suggested change to replace "may" to "shall" in (4) and add "until the licensed midwife is able to complete the transfer care to emergency medical services personnel or an appropriate health professional, as provided in subrule (4)", as the purpose of the rule is to allow the midwife to continue to treat the patient when a transfer is not imminent for a variety of reasons listed in the rule. However, the following language will be added to the first line of (4) to clarify the rule, "A licensed midwife if present, is allowed to provide care." The Board declines the suggested change to add a new rule, R 338.17135A, to identify what is required of a transfer of care plan, as the conditions under which a consultation, transfer, or transport takes place as well as whether there is a collaboration relationship and the names and contact information are already included in the rules, which is a part of the disclosure. The Transfer of Care Form from the Home Birth Summit has been painstakingly reviewed by the Rules Committee and Board. The form includes the conditions under which the midwife will transfer care and includes hospitals to which the patient may be transported, as well as protocols for contacting 9-1-1. The protocols for implementing emergency medical procedures are included in NARM's training procedures. All CPMs must have a care plan for transport to a hospital and must maintain an informed disclosure and shared decision-making protocol that they use throughout the entire process with a patient. At the

	initiation of care and throughout the process the CPM is required to share these documents with the patient and have the patient consent. See above.

Rule 338. 17136 Prohibited conduct.

Rule Numbers	Commenter	Comment
R 338.17136	Moore/ANA et al. Allswede/ACOG	Add the following to the list of prohibited conduct: • Pharmacological induction or augmentation of labor or artificial rupture of membranes prior to onset of labor. • Previous uterine surgery. • Cesarean section (VBAC) or myomectomy. Do not allow frenulum revisions, currently allowed in the rule. This is not a standard NARM taught skill. It requires additional education not addressed in the licensing criteria.
	Allswede/ACOG	Add to list of prohibited conduct: • Uncontrolled postpartum hemorrhage; preeclampsia, thromboembolism. • Uterine Infection. • Postpartum mental health disorder. • Use of prohibited medical devices: laminaria, uterine hemorrhage balloons, and urinary catheters should be addressed.
	Averill	Will support reasonable regulations, as well as specific risk criteria such as VBAC being contraindicated in patients with a history of other than low transverse incision and placenta overlying prior incision but does not support VBAC/prior uterine surgery as an absolute contraindication to home birth. This will not protect or offer greater safety for birthing people in Michigan and it violates patient autonomy. Over ½ of the state is in an area that is experiencing a VBAC "ban" at local hospitals. This is an unethical and illegal practice. Consider the legal and

		ethical concerns and consider religious and cultural groups, as well as harm reduction; unassisted deliveries and VBAC deliveries with non-licensed midwives will continue given the complete absence of choice for these patients. Northern Michigan has a higher than national average cesarean delivery rate, and a lower than average VBAC success rate. Midwives should make shared decisions with their clients based on evidence, risk, skill level of the practitioner and client choice. Michigan is 8th in the country for maternal mortality. Will not improve statistics by eliminating access to VBAC friendly care providers in rural areas, and areas where physicians refuse to attend trial of labor after cesarean section (TOLAC). The morbidities and mortalities associated with repeat cesarean delivery along with a ban on VBAC birth at both hospitals and home is an example of why women's rights, autonomy and the ability to make autonomous decisions about our bodies is stated as a hallmark of patient care by ACOG and every other medical organization. Add HIV to list. Any pregnancy that is not a normal pregnancy should be on the list for a consultation and the highest risk conditions should be transferred.
	Bayne Lorenz	
Rules Committee Response	Midwives are increasingly providing prenatal care to patients who may or may not ultimately deliver in a hospital setting. The board does not wish to prevent such patients from obtaining accessible, intensive, personalized care for the prenatal period by prohibiting midwives entirely from providing such care. This is particularly important for patients whose access to care is diminished by distance or other life circumstances. Example: Jennie Joseph, L.M., C.P.M (Florida) operates a clinic that offers care to any pregnant patient; many of her patients go on to deliver in a hospital setting, with vastly improved outcomes as a result of their prenatal care. Therefore, the Rules Committee recommends the following: • Agree to strike "frenulum revisions," as this is rule contains a list of prohibited conduct not a list of exceptions to prohibited conduct. • Add "hyperthyroidism treated with medication," "uncontrolled hypothyroidism," and "primary genital herpes infection in pregnancy" instead of adding to transfer. • Decline to add "previous uterine surgery," as care given during the prenatal period by a licensed midwife does not increase risk and prohibiting licensed midwife care will not produce better outcomes.	

	• Decline to add "pharmacological induction or augmentation of labor or artificial rupture of membranes prior to onset of labor," as pharmacological induction or augmentation of labor are already prohibited by statute and rule. • Decline to add "prohibiting artificial rupture of membranes prior to onset of labor," as, although a last option, it may be used in rare instances to provide for a safe home birth, and therefore should not be prohibited. • Decline to add uncontrolled postpartum hemorrhage, preeclampsia, thromboembolism, uterine infection, postpartum metal health disorder, and HIV to the prohibited conduct list, as these conditions are appropriately included in consultation or transfer. • Decline to add use of prohibited medical devices: laminaria, uterine hemorrhage balloons, and urinary catheters, as there is a lack of evidence that these are harmful, and by law the midwife must be trained to perform any act, task, or function they undertake.

NEW LANGUAGE FOR PROPOSED RULE 338.17136:

- **R 338.17136:**

An individual covered by these rules shall not perform the following acts:

(a) Except as provided in R 338.17137, administer prescription drugs or medications.

(b) Use vacuum extractors or forceps.

(c) Prescribe medications.

(d) Perform surgical procedures other than episiotomies, repairs of perineal lacerations, **and** clamping and cutting the umbilical cord~~, and frenulum revisions~~.

(e) Knowingly accept sole responsibility for prenatal or intrapartum care of a patient with any of the following risk factors:

(i) Chronic significant maternal cardiac, pulmonary, renal, or hepatic disease.

(ii) Malignant disease in an active phase.

(iii) Insulin dependent diabetes mellitus.

(iv) Active tuberculosis.

(v) Active syphilis.

(vi) Confirmed AIDS status.

(vii) Current seizure disorder requiring medication.

(viii) History of previous uterine rupture.

(ix) Monoamniotic twins.

(x) Opioid use disorder.

(xi) Known uncontrolled hypothyroidism.
(xii) Cushing's disease.
(xiii) Systemic lupus erythematosus.
(xiv) Antiphospholipid syndrome.
(xv) Polyarteritis nodosa.
(xvi) Primary genital herpes infection in pregnancy.

Board Response	Midwives are increasingly providing prenatal care to patients who may or may not ultimately deliver in a hospital setting. The board does not wish to prevent such patients from obtaining accessible, intensive, personalized care for the prenatal period by prohibiting midwives entirely from providing such care. This is particularly important for patients whose access to care is diminished by distance or other life circumstances. Example: Jennie Joseph, L.M., C.P.M (Florida) operates a clinic that offers care to any pregnant patient; many of her patients go on to deliver in a hospital setting, with vastly improved outcomes as a result of their prenatal care.
	
	• The Board agrees with the suggested change to strike "frenulum revisions," as this rule contains a list of prohibited conduct not a list of exceptions to prohibited conduct.
	• The Board agrees with the suggested change to add "known uncontrolled hypothyroidism," and "primary genital herpes infection in pregnancy" to prohibited conduct.
	• The Board declines the suggested change to add "hyperthyroidism treated with medication." It will be added to the consult list as more information would be helpful before a transfer is made.
	• The Board declines the suggested change to add "previous uterine surgery," for the following reasons:
	  • As care given during the prenatal period by a licensed midwife does not increase risk and prohibiting licensed midwife care will not produce better outcomes.
	  • Patients have the right to evaluate the risks and benefits of VBAC, twin and breech births at home, and make a decision based on these risks and benefits, combined with their own values and circumstances. Midwives do not want to force women facing these situations into unassisted births, as has happened in other states with bans. When considered from a harm-reduction perspective, if licensed midwives are not permitted to attend such births the result will be an increase in unassisted

	deliveries in Michigan, with untrained or unskilled attendants. • States that have refused to forbid midwife attendance at these types of home births, such as Wisconsin, have not subsequently reversed this stance. Some states with more restrictive VBAC rules have changed their rules to permit midwife attendance at home VBACs. Over half of Michigan, by geographical location, is experiencing a VBAC "ban" at local hospitals. Prohibiting licensed midwives to care for patients choosing VBAC does not protect or offer greater safety for women giving birth in Michigan. • The letters referenced below, from public comment submissions, contain support for the rules to remain as written, with regard to multiples, breech, and VBAC births. The Board must consider these public comments, as proof of the care that consumers desire from CPMs around these issues. This list does not include letters simply saying they support the rules as written. • Carolyn Cronk says that it's important to her that midwives not be prevented from doing VBAC/twins/breech and that she moved here in part because midwives could provide these. • Brit Averill is very pro VBAC and gives solid reasons. • Raymond DeVries appears to endorse the prohibited list as it is without changes. • Lisa Ellens advocates for no change to consultation for VBAC, and midwives' ability to assess and decide with client. • Faith Groesbeck advocates for not limiting the scope of midwives. • FOMM specifically mentions not limiting midwives' attendance of VBAC, encouraging midwives to "maintain the decision made by the legislature not to forbid or unduly limit..." UNDULY LIMIT = require universal consult. • Brooke Henning supports midwives attending VBAC and the rules about it as written. • Jennifer Holshoe/ICAN lists many issues and consideration for support of VBAC, including concern that "changes to these rules could limit consumer choices and access to care." Mentions that other parts of the rule provide guidance and checks to increase safety of home VBAC. • Susan Jenkins/Big Push comments on dangers of overregulation/micromanagement of midwives causing increased unassisted birth. She praises Michigan for having the correct balance of midwife authorization to attend these births combined with heightened

	informed consent. Further, Jenkins states: "As a matter of constitutional law, as well as reasonable health policy, the Big Push believes that no woman should be forced by a statute or rule to have surgery that puts her own life and health at greater risk, simply because she does not have access to a provider who will attend her birth and is legally permitted to do so. Yet this is the scenario many women face across the nation, including Michigan, because so many hospitals and physicians refuse to attend women who are attempting VBAC. The stated reasons for such these denials of care are most often fear of litigation, a situation that has contributed to the absurdly high c-section rates of over 30% in most states. Given so few if any options for in-hospital VBAC, women turn to midwives, in recognition that midwives have the expertise and experience to attend VBACs, skills that have fallen out of use in the hospital setting, as well as a thorough scientific understanding of the relative risks and benefits of VBAC versus repeat c-section." • Stephanie Mayne wrote, "Keep the rules as they are. 2/3 of OB practices are not evidence based, and they should not be consulted for matters of homebirth." • Melissa is a home VBAC supporter who wants rules kept as they are. • Jill Nolan, breech home birther, submits comments supporting the appropriateness of the level of informed consent employed in decision-making about her breech homebirth. • Kristen Paquin/ICAN supports the right to choose homebirth for VBAC. • Sandra Pera attests to difficulty of obtaining referral/consults with a "hostile" medical community in the upper peninsula. • Michelle Sperlich "strong evidence that midwifery practiced in accordance with the proposed rules contributes to positive outcomes for mothers, infants...." • Carly Vann Thomm commented on R 333.17133: "Such detailed practice requirements go well beyond those of most other health care professional rule sets and expertly balance public safety and the patient's ability to choose desired care." Lists many reasons to support need for access to VBAC with CPMs; "the risks of VBAC are appropriately handled through a heightened informed consent requirement." Addresses multiples/breech with "Many of the arguments for VBAC apply also to...twins...and breech." • Nancy Ward commented that VBAC supports informed consent process and CPMs

	providing VBAC. Discusses extreme difficulty in accessing care in medical community. • The Board declines the suggested change to add pharmacological induction or augmentation of labor, as section 17111 of the Code, MCL 333.17111, only allows the use of medications that are listed in this section or otherwise allowed by rule. • The Board declines the suggested change to add "prohibiting artificial rupture of membranes prior to onset of labor," as, although a last option, it may be used in rare instances to provide for a safe home birth, and therefore should not be prohibited. • The Board declines the suggested change to add uncontrolled postpartum hemorrhage, preeclampsia, thromboembolism, uterine infection, postpartum metal health disorder, and HIV to the prohibited conduct list, as these conditions are appropriately included in consultation or transfer. • The Board declines the suggested change to add use of prohibited medical devices: laminaria, uterine hemorrhage balloons, and urinary catheters, as there is a lack of evidence that these are harmful, and by law the midwife must be trained to perform any act, task, or function they undertake. See above.

Rule 338. 17137 Administration of prescription drugs or medications.

Rule Numbers	Commenter	Comment
R 338.17137	Taft and Moore/ANA	The rule is not clear whether the licensee is required to use the drugs listed if they have them. Also, the commenter is requesting that the table be updated as needed.
Section (1)	Moore/ANA et al.	Modify "appropriate health professional" to "a physician or certified nurse-midwife with experience in the active practice of obstetrics." Require that any other drugs or medications be authorized by rule and not solely by a Board's decision. Divide the table into two segments, administration to the mother and administration to the infant, identify the source for the document, and identify the party responsible for ensuring the accuracy of the table, as well as a timeline for review and updating.

		Add (3): "A licensed midwife who does not administer a prescription drug or medication to a newborn pursuant to the American Academy of Pediatrics standards as described in Guidelines for Perinatal Care shall inform and recommend that the patient receive such drug or medication from an appropriate health professional as soon as possible."
	Michigan Midwives Association	Regarding 0.5% erythromycin ointment, change to within 1 hour of birth so that the recommended treatment is given in accordance with Michigan law. Consider adding Valtrex/valacyclovir for herpes simplex virus (HSV) prophylaxis during the antepartum period for previously diagnosed non-primary HSV outbreak prophylaxis. The medication is standard of care for HSV prophylaxis during pregnancy and allowing a midwife to provide a course of care to a patient allows for greater access to prophylactic treatment without requiring diagnosis which might be outside the scope of practice for a midwife. Modify epinephrine to allow for generic epinephrine auto injecting devices and for multi-dose vial of epinephrine for use in severe maternal allergic reactions.
	Lavery	Recommend dividing the table into two tables, one for the mother and one for the infant.
	Stockton	Add antibiotics such as azithromycin for chlamydia, Rocephin for gonorrhea, and Diflucan, miconazole, and other treatments for yeast bacterial vaginitis/gardenella and urinary tract infections, and contraceptive services in the form of medications and IUD insertion and removal.
Rules Committee Response	The Rules Committee declines to limit the type of appropriate health professional that may prescribe a standing order in this rule, as it will be difficult in rural areas to obtain the standing prescription, as has been authorized by statute. Ideally a licensed midwife would turn to a physician or certified nurse midwife with obstetric experience for the prescription; however, access to this type of professional, especially in rural areas will be limited. The Rules Committee agrees to delete the provision that allows the Board to authorize specific medications for use by a midwife without a rule change, as allowing the Board to make such a change without also changing Table 1 in the rules, which may only be changed with a rule change, would be confusing for licensees. Further, if an emergency arises regarding a drug, the rules can be modified more quickly with the emergency rule process.	

	The Rules Committee agrees to divide Table 1 into two segments. The Rules Committee declines to add provision (3) suggested above. Pursuant to section 17111 of the Code, MCL 333.17111, a licensed midwife is not required to use these medications, but if they wish to offer the medications to the patient, they must meet the requirements of section 17111 of the Code, MCL 333.17111 and this rule. The Rules Committee recommends that a reference to the statute be added to further support the intent of the rule and to clarify that the licensed midwife is not required to use these medications. It is also recommended that language be added to R 338.17132 regarding informed consent, to clarify that a licensed midwife is required to inform patients where to access medications if they are not offered by the midwife, and that pursuant to statute, that an infant must be given eye prophylaxis or referred to someone who can provide the treatment. The Rules Committee declines to allow the Table to be updated outside of the rule process, as that is not consistent with rule promulgation. The Table will be updated by the Department and Board, as required by statute. If necessary, there is an emergency procedure to modify a rule if the circumstances warrant use of this process. The Rules Committee agrees with the suggestion to modify Table 1 to apply 0.5% erythromycin ointment within 1 hour of birth so that the recommended treatment is given in accordance with Michigan law. The Rules Committee declines the following suggestions to authorize the use of medications or contraception, as outside of the midwife's scope of practice: Valtrex/valacyclovir for HSV prophylaxis during the antepartum period for previously diagnosed non-primary HSV outbreak prophylaxis and azithromycin for chlamydia; Rocephin for gonorrhea and Diflucan; miconazole and other treatments for yeast bacterial vaginitis/gardenella and urinary tract infections; and contraceptive services in the form of medications and IUD insertion and removal. The comment regarding modifying epinephrine has already been made in the rules. The Rules Committee declines the suggestion to add references to the table, as a reference for each determination in the table is not necessary, as the Board can determine if the amounts are acceptable in their discussion and approval of the rules.

	The Board has established the basis for the information in Table 1 but does not recommend that this information be included in the rules. It is attached for informational purposes.

NEW LANGUAGE FOR PROPOSED RULE 338.17137:

- **R 338. 17137(1):**

(1) Pursuant to section 17111 of the code, MCL 333.17111, ~~A~~ **a** licensed midwife who has appropriate pharmacology training and holds a standing prescription from an appropriate health professional with prescriptive authority, ~~may,~~ ~~but is not required to,~~ **is permitted to** administer the following prescription drugs and medications~~.~~ **:**

(a) Prophylactic vitamin K to an infant, either orally or through intramuscular injection.
(b) Antihemorrhagic agents to a postpartum mother after the birth of the infant.
(c) Local anesthetic for the repair of lacerations to a mother.
(d) Oxygen to a mother or infant.
(e) Prophylactic eye agent to an infant.
(f) Prophylactic Rho(D) immunoglobulin to a mother.
(g) Agents for group B streptococcus prophylaxis, recommended by the federal centers for disease control and prevention, to a mother.
(h) Intravenous fluids, excluding blood products, to a mother.
(i) Antiemetics to the mother.
(j) Epinephrine.
~~(k) Any other drug or medication authorized by the board.~~

(2) Administration of any of the drugs included in subrule (1) of this rule must be in accordance with this rule. The indications, dose, route of administration, duration of treatment, and contraindications relating to the administration of drugs or medications identified under subrule (1) of this rule are shown in Table 1:

Board Response	The Board declines the suggested change to limit the type of appropriate health professional that may prescribe a standing order, as it will be difficult in rural areas to obtain the standing prescription, which has been authorized by statute. Ideally a licensed midwife would turn to a physician or certified nurse midwife with obstetric experience for the prescription; however, access to this type of professional, especially in rural areas will be limited. The Board agrees with the suggested change to delete the provision that allows the Board to authorize specific

	medications for use by a midwife without a rule change, as allowing the Board to make such a change without also changing Table 1 in the rules, which may only be changed with a rule change, would be confusing for licensees. Further, if an emergency arises regarding a drug, the rules can be modified more quickly with the emergency rule process. The Board agrees with the suggested change to divide Table 1 into two segments. The Board declines the suggested change to add provision (3) suggested above. Pursuant to section 17111 of the Code, MCL 333.17111, a licensed midwife is not required to administer these medications, but they must meet the requirements of section 17111 of the Code, MCL 333.17111, and this rule. To clarify the rules, the Board adds that the licensed professional must offer eye prophylaxis or refer the patient to someone who can provide the treatment to R 338.17132. The Board declines the suggested change to allow the Table to be updated outside of the rule process, as that is not consistent with rule promulgation. The Table will be updated by the Department and Board, as required by statute. If necessary, there is an emergency procedure to modify a rule if the circumstances warrant use of this process. The Board agrees with the suggested change to add the following to the Table: apply 0.5% erythromycin ointment within 1 hour of birth, so that the recommended treatment is given in accordance with Michigan law. The Board declines the following suggested changes to authorize the use of medications or contraception, as outside of the midwife's scope of practice: Valtrex/valacyclovir for HSV prophylaxis during the antepartum period for previously diagnosed non-primary HSV outbreak prophylaxis and azithromycin for chlamydia; Rocephin for gonorrhea and Diflucan; miconazole and other treatments for yeast bacterial vaginitis/gardnerella and urinary tract infections; and contraceptive services in the form of medications and IUD insertion and removal. The comment regarding modifying epinephrine has already been made in the rules. The Board declines the suggested change to add references to the table, as a reference for each determination in

	the table is not necessary. The Board can determine if the amounts are acceptable in their discussion and approval of the rules. The Board has established the basis for the information in Table 1 but does not recommend that this information be included in the rules. It is attached for informational purposes. See above.

Rule 338. 17138 Report patient's data.

Rule Numbers	Commenter	Comment
338.17138	Allswede/ACOG	There is insufficient reporting and monitoring requirements in the current rules to ensure that appropriate care is being provided by licensees. MANA registry does not provide sufficient access to practitioner outcomes to ensure quality of care oversight. Outcome information should be available to LARA. ACOG would like to review and comment on the transfer form. Rules should specify the duties of the Board and LARA to collect, review, and report outcomes. • Require LARA to maintain confidentiality, report to Board and Legislature annually on all licensees who have met reporting requirements, and aggregate information collected by a certain date each year. LARA monitor consumer complaints, investigations, and disciplinary process. • Require midwife to report for license renewal with penalties for failure to report. With regard to the midwife's patient or someone the midwife supervised, report: total clients served as primary care giver, number served with collaborative care or with backup from a physician or surgeon, number of live births and stillbirths attended as primary caregiver and county, women whose primary care was transferred to another health care practitioner during the antepartum period, reason, number, and outcome for each elective hospital transfer, urgent or emergency transport of expectant mother prior to labor, urgent or emergency transport of an infant or mother during or after labor or birth, number of planned out of hospital births at onset of labor, and number completed in an out of hospital setting, description of

		complications resulting in morbidity or mortality of mother or neonate, and other information prescribed by the Board. • Require midwife to report to LARA and MDCH adverse incidents in all attempted and completed planned out of hospital births including maternal death within 42 days after delivery, transfer to patient to ICU, patient experiencing hemorrhagic shock or requiring transfusion of more than 4 units of blood or blood products, fetal or newborn death, including stillbirth associated with an obstetrical delivery, transfer of newborn to neonatal intensive care unit due to traumatic physical or neurological birth injury, including any degree of brachial plexus injury, transfer of newborn to neonatal ICU within first 72 hours after birth if newborn remains in unit for more than 72 hours, any other injury as determined by department rule. • Require hospitals that receive emergency transfer of mother or newborn to report transfer and outcomes to the Midwifery Board, LARA, and Board of Medicine, and Osteopathic Medicine. Provide explicit permission for health care professionals and hospitals to submit clinical and demographic data on home birth transfers to LARA. • Peer review should be required and tied to outcomes reporting and license renewal.
Rules Committee Response	The Rules Committee declines to require the Board, LARA, hospitals, and midwives to report and collect the statistics aforementioned for the following reasons: there are already reporting requirements in place for LARA in regards to the health professions; the Board may not require LARA or MDCH, by rule or otherwise, to collect and report statistics related to midwives; the Code already regulates the process of complaints, investigations, and discipline for all health professions which is monitored by LARA; the Board does not have the authority to require hospitals to report data on midwives; the Legislature has authorized the Board to require a midwife to report to MANA's Statistical Registry or a similar registry approved by the Board; the patient has the right by statute to refuse to consent to their data being reported; the small number of midwifery patients may put the privacy of the patients at risk and there is no legislative requirement for the type of statistical collection suggested by the commenter.	

Board Response	The Board declines the suggested change to require the Board, LARA, hospitals, and midwives to report and collect the statistics aforementioned for the following reasons: there are already reporting requirements in place for LARA in regards to the health professions; the Board may not require LARA or MDCH, by rule or otherwise, to collect and report statistics related to midwives; the Code already regulates the process of

	complaints, investigations, and discipline for all health professions which is monitored by LARA; the Board does not have the authority to require hospitals to report data on midwives; the Legislature has authorized the Board to require a midwife to report to MANA's Statistical Registry or a similar registry approved by the Board, which is included in the rules; the patient has the right by statute to refuse to consent to their data being reported; the small number of midwifery patients may put the privacy of the patients at risk, and there is no legislative requirement for the type of statistical collection suggested by the commenter.

Rule 338. 17141 License renewals; requirements; applicability.

Rule Numbers	Commenter	Comment
Section (2)	MCMCH Moore/ANA et al. Lavery	Change license cycle to two years consistent with the Board of Nursing. A four-year cycle is too long and there is no consequence to not renewing a license over a period of nearly seven years.
	Wells	Clarify the time frame when the continuing education must be completed and submitted.
	Moore/ANA et al.	Require 25 hours of continuing education every license cycle to include 20 by obtaining and maintaining the credential of CPM from NARM or equivalent credential approved by the board, 1 hour related to pain and symptom management, 2 hours on cultural awareness, and 1 in pharmacology.
	Allswede/ACOG	Require accredited CEU's, 4 hours of peer review, submission of required annual outcomes reports. Require accredited courses.
	Gorchow/MCMCH	All CPMs must recertify every 3 years and must obtain 25 ours of continuing education and 5 hours of peer review. Recertification also requires that CPR and NRP certifications are up to date.
Rules Committee Response	The Rules Committee declines the commenter's suggestions to limit the cycle to two years, as this is a Department decision per section 17121 of the Code, MCL 333.17121. The Rules Committee declines to modify the amount of required continuing education every two years to 20 or 25 hours	

	but does agree to adding one hour of pharmacology every 4-year cycle. Currently, the CPM certification and recertification with NARM requires 30 continuing education hours over 3 years, which is close to the suggested modification of approximately 12 per year. Additionally, a CPM is required for state licensure, CPMs must recertify every 3 years and must obtain 25 hours of continuing education and 5 hours of peer review, recertification with NARM requires that CPR and NRP certifications are up to date, and section 17117 of the Code, MCL 333.17117, requires the Department to accept the CPM credential as meeting the continuing education requirements. The Rules Committee declines to require all continuing education to be through accredited courses, as the Legislature determined that NARM recertification meets the continuing education requirements and therefore requiring all continuing education to be through accredited courses is contrary to the Code.

NEW LANGUAGE FOR PROPOSED RULE 338.17141:

- **R 338.17141(2):**

(1) In addition to meeting the requirements of section 16201 of the code, MCL 333.16201, an applicant for renewal shall submit a completed application on a form provided by the department, together with the requisite fee and, prior to renewal, shall hold the credential of CPM from NARM, or equivalent credential approved by the board.

(2) Pursuant to section 16201 of the code, MCL 333.16201, an applicant for license renewal who has been licensed for the **4 2**-year period immediately prior to renewal shall accumulate all of the following, during the prior **4 2** years ~~and before renewal~~ **by the end of the license cycle**:

(a) At least 30 hours of continuing education that is met by obtaining ~~and~~ **or** maintaining, the credential of CPM from NARM, or an equivalent credential approved by the board.

(b) One hour of continuing education in pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2). Acceptable methods of continuing education in pain and symptom management includes online and in person presentations, courses or programs and may include, but is not limited to, the following subject areas: behavior management, psychology of pain, behavior modification, stress management, and clinical applications**,** as they relate to professional practice.

(c) Two hours of continuing education on cultural awareness that include examination of disparate maternal infant mortality and morbidity experienced by the African American and indigenous populations. Acceptable methods of continuing education in cultural awareness include online and in person presentations, courses, programs, or reading an article that is published in a peer review journal, health care journal, or professional or scientific journal.

(d) One hour of continuing education in pharmacology applicable to the practice of midwifery.

(3) "Continuing education hour" as used in these rules means the cumulative number of program minutes divided by 60. When the fractional part of an hour is 55 minutes or more, it counts as 1 hour. Any portion of an hour between 30 and 54 minutes counts as half of an hour. Any part of an hour less than 30 minutes will be discarded. Breaks are not counted.
(4) Submission of an application for renewal constitutes the applicant's certification of compliance with the requirements of this rule.
(5) A licensee shall retain documentation of meeting the requirements of this rule for a period of 4 years from the date of applying for license renewal.
(6) The board may require an applicant or licensee to submit evidence to demonstrate compliance with this rule.
(7) A self-certification statement by an individual that includes the title of the article, author, publication name, date, volume, and issue of publication, as applicable, is acceptable evidence of reading an article that is published in a peer review journal, health care journal, or professional or scientific journal.
(8) Failure to comply with this rule is a violation of section 16221(h) of the code, MCL 333.16221(h).
(9) A request for a waiver under section 16205 of the code, MCL 333.16205, must be received by the department prior to the expiration date of the license. A CPM credential from NARM, or equivalent credential approved by the board, may not be waived.
(10) The requirements of this part do not apply to an applicant during an initial **1-year** licensure cycle.

Board Response	As requested in public comment, the Department has modified the proposed term of the licensure cycle from 4 years to 2 years, which required the change in (a) from "and" to "or" to clarify that the CPM credential, which must be renewed every 3 years, meets the continuing education requirements whether it was obtained in the proceeding 2-year cycle or maintained in the proceeding 2-year cycle, as required by the Code. Due to the change in the cycle by the Department, to clarify subrule (10), the Board is adding "1year" to make it clear that continuing education requirements to not apply to the initial 1-year initial cycle but do apply to the 2-year licensure cycle. The Board declines the suggested change to modify the amount of required continuing education every two years to 20 or 25 hours but does agree to adding one hour of pharmacology every 2-year cycle. Currently, the CPM certification and recertification with NARM requires 30 continuing education hours over 3 years, which is close to the suggested modification of approximately 12 per year. Additionally, a CPM is required for state licensure, CPMs must recertify every 3 years and must obtain 25 hours of continuing education and 5 hours of

	peer review, recertification with NARM requires that CPR and NRP certifications are up to date, and section 17117 of the Code, MCL 333.17117, requires the Department to accept the CPM credential as meeting the continuing education requirements. The Board declines the suggested change to require all continuing education to be through accredited courses, as the Legislature determined that NARM recertification meets the continuing education requirements and therefore requiring all continuing education to be through accredited courses is contrary to the Code.