State Budget Office
Office of Regulatory Reinvention
111 S. Capitol Avenue; 8th Floor, Romney Building
Lansing, MI 48933
Phone: (517) 335-8658 FAX: (517) 335-9512

AGENCY REPORT TO THE JOINT COMMITTEE ON ADMINISTRATIVE RULES (JCAR)

Under the Administrative Procedures Act (APA), 1969 PA 306, the agency that has the statutory authority to promulgate the rules must complete and submit this form electronically to the Office of Regulatory Reinvention (ORR) at **orr@michigan.gov**.

1. Agency Information:

Agency name:	Department of Licensing and Regulatory Affairs
Division/Bureau/Office:	Bureau of Professional Licensing
Name, title, phone number, and e-mail of person completing this form:	Andria M. Ditschman 517-241-9255 DitschmanA@michigan.gov
Name of Departmental Regulatory Affairs Officer reviewing this form:	Liz Arasim Department of Licensing and Regulatory Affairs

2. Rule Set Information:

ORR assigned rule set number:	2018-031 LR
Title of proposed rule set:	Board of Midwifery

3. Purpose for the proposed rules and background:

The proposed rules are required by Part 171 of the Public Health Code, MCL 333.17101 to MCL 333.17123, effective April 4, 2017, which established the formation of the Michigan Board of Midwifery (Board) and required the Board to enact rules within 24 months after the effective date of Part 171 to license midwives. For purposes of the proposed rules and this Report, the terms “midwife”, “licensed midwife”, and “midwives” are defined as individual’s licensed under Part 171 of the Public Health Code to engage in the practice of midwifery, and do not include nurse midwives licensed under part 172 of the Public Health Code. In addition, the “practice of midwifery” as used in these rules and this report does not include nurse midwives licensed under part 172 of the Public Health Code. Further, section 17105 of the Public Health Code, MCL 333.17105, provides exemptions to the requirement that individuals shall not engage in the practice of midwifery unless licensed under this part or otherwise authorized by this article.

All of the proposed rules are new; therefore, midwives as defined above, were not previously licensed nor were they subject to continuing education or any of the other limitations in the proposed rules. The proposed rules will license midwives, require minimum education and certification, require an examination, require informed disclosure and consent, require consultation and transfer of a client in certain circumstances, limit the drugs and medications used by a midwife, and specify the requirements for a lapsed license or renewal of a license. The system of licensure will prohibit an unlicensed individual from performing an act, task, or function, unless otherwise exempted, within the practice of midwifery unless trained to perform that act, task, or function and it is consistent with the law and the proposed rules.

Licensing: The proposed rules will implement the system of licensure for midwives that Public Act 417 of 2016 required and has been established in Part 171 of the Public Health Code, MCL

333.17101 to MCL 333.17123, which requires an applicant to: complete and pay for an educational program or pathway; complete and pay for the credential of Certified Professional Midwife (CPM) from North American Registry of Midwives (NARM) or a credential approved by the Board; pass and pay for an examination approved by the Board; pay a licensing processing fee of $450 or $75, depending on when the fee is paid; submit proof to the department of meeting the English language requirement; and pay an annual licensing fee of $200. The proposed rules will also implement a nonrenewable temporary license under Part 171 of the Public Health Code for an applicant who holds a current CPM credential from a midwifery education program that is not Midwifery Education Accreditation Council (MEAC) accredited in order to obtain a midwifery bridge certificate from NARM to qualify for a full license. The proposed rules are necessary, suitable, and the least burdensome requirements on licensees to ensure that licensees are educated and safe to practice.

Relicensure and Continuing Education: The proposed rules will require applicants who have let their license lapse to meet specific requirements depending on the length of time they have been unlicensed. The requirements include an application and fee, good moral character, a background check, 30 hours of continuing education which can be met by maintaining the CPM credential from NARM, an examination, and proof of no disciplinary action from another state. The applicant will pay a licensing fee, fees for attendance at continuing education (one hour of pain and symptom management, two hours of cultural awareness, and one hour of pharmacology), an examination fee, if applicable, and the fee to maintain their CPM from NARM. All of the relicensure requirements are the minimum necessary to ensure that licensees are educated and safe to practice.

Practice, Conduct, and Classification of Conditions: The proposed rules specify what is required for informed disclosure and informed consent and when they are required as well as when a licensed midwife must consult with, refer, or transfer a patient to a physician, physician's assistant, advanced practice registered nurse, or hospital. The proposed rules also list prohibited conduct, specify the type and when drugs and medications may be administered, and require a licensee to report a patient's data to the statistics registry maintained by Midwives Alliance of North America's Division of Research (MANA DOR). The burdens of providing informed disclosure and obtaining informed consent, and reporting data are minimally burdensome on licensees and will protect the public health, safety, and welfare.

4. Summary of proposed rules:

The purpose of the proposed rules is set forth below:

General Provisions
R 338.17101: This proposed rule lists the definitions of terms used in the proposed rules.

Prelicensure Licensed Midwifery Education
R 338.17111: Pursuant to section 16148 of the Public Health Code, MCL 333.16148, this proposed rule requires an individual seeking licensure to complete a training in identifying victims of human trafficking.

R 338.17113: This proposed rule pertains to licensed midwifery accrediting organizations. In this proposed rule the Board approves the MEAC as an accrediting organization and states that other midwifery accrediting organizations with equivalent standards and evaluative criteria to MEAC may be approved by the Board.

R 338.17115: This proposed rule pertains to licensed midwifery credentialing programs. In this proposed rule the Board, by petition, may approve a licensed midwifery credentialing program with

standards and evaluative criteria equivalent to the credential of a CPM from the NARM, meets the criteria of section 16148 of the Public Health Code, MCL 333.16148, and is accredited by the National Commission for Certifying Agencies (NCCA), or another accrediting organization approved by the Board with standards and evaluative criteria equivalent to NCCA.

Licensure

R 338.17121: This proposed rule pertains to licensure for licensed midwives. The proposed rule requires an applicant to: complete and pay for an educational program or pathway accredited by MEAC or if he or she holds a current credential of CPM before January 1, 2020, hold a midwifery bridge certificate from NARM; complete and pay for the credential of a CPM from NARM or a credential approved by the Board; pass and pay for an examination approved by the Board; pay a licensing processing fee of $450 or $75, depending on when the fee is paid; submit proof to the department of meeting the English language requirement; and pay an annual licensing fee of $200. The proposed rule will adopt the examination developed and scored by NARM and allows the Board to accept other examinations.

R 338.17122: This proposed rule will implement a nonrenewable temporary license for an applicant who holds a current CPM credential from a midwifery education program that is not MEAC accredited in order to obtain a midwifery bridge certificate from NARM to qualify for a full license.

R 338.17123: This proposed rule pertains to licensure by endorsement. The proposed rule will allow an applicant who is licensed as a midwife in another state, who has never been licensed as a midwife in Michigan, to apply for a license by: submitting an application, meeting the requirements in section 16174 of the Public Health Code, MCL 333.16174, completing an educational program or pathway accredited by MEAC or the Board, holding a CPM from NARM, passing the approved examination, submitting proof of no disciplinary proceedings, and submitting proof of meeting the English language requirement.

R 338.17125: This proposed rule pertains to lapsed licenses of licensed midwives. The proposed rule will require applicants, who have let their license lapse, to meet specific requirements depending on the length of time they have been unlicensed. The requirements include an application and fee, good moral character, a background check, 30 hours of continuing education, an examination, proof of no disciplinary action from another state, and the CPM or equivalent credential. The proposed rule will allow an applicant to submit deficient continuing education hours within 2 years of the date of the application and the application will be held and the license will not be issued until the continuing education requirements have been met. The proposed rule also addresses the requirements for applicants who have let their Michigan license lapse but who have a valid license in another state.

R 338.17127: This proposed rule requires an applicant for a license who attended a nonaccredited program, or a program outside of the United States that was not conducted in the English language, to demonstrate a working knowledge of the English language.

Practice, Conduct, and Classification of Conditions

R 338.17131: This proposed rule lists definitions for appropriate pharmacology training, consultation, emergency medical services personnel, futility, refer, transfer, and transport used in Part 4 of the rules.

R 338.17132: This proposed rule pertains to written informed disclosure by the licensed midwife and consent by the patient. The proposed rule specifies what is required for informed disclosure and informed consent and when they are required. Informed disclosure includes: 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; access to the midwife's practice guidelines; whether the licensed midwife is permitted to administer drugs and medications pursuant to R 338.17137, which medications the licensed midwife carries for potential use, and if a medication is required by law, and not available from the midwife, how and where the medications can be obtained; access to the Michigan Board of Licensed Midwifery rules; whether the licensed midwife has malpractice liability insurance coverage, and if so, the policy limitations of the coverage. The informed consent process includes: explanation of the available treatments and procedures; explanation of both the risks and expected benefits of the available treatments and procedures; discussion of alternative procedures, including delaying or declining of testing or treatment, and the risks and benefits associated with each choice; documentation of any initial refusal by the patient of any action, procedure, test, or screening that is recommended by the licensed midwife; and obtaining the patient's signature acknowledging that the patient has been informed, verbally and in writing, of the disclosures. The proposed rule also states that the licensed midwife shall provide an abbreviated informed consent appropriate to the emergent situation with documentation to follow once the situation has stabilized.

R 338.17133: This proposed rule pertains to additional informed consent requirements. Additional written informed consent is required when a patient presents to a licensed midwife under any of the following circumstances: previous cesarean birth, at the inception of care; 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; and twin or multiple gestation, at the time of discovery by the midwife. If additional written informed consent is required the licensed midwife is required to: disclose to the patient his or her practice guidelines surrounding the management of the pregnancies with these additional circumstances, which includes the licensed midwife's level of experience, type of special training, care philosophy, and outcome history relative to such circumstances; disclose 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; practice within the limits of his or her practice guidelines; and provide the patient with an informed choice document, specific to the conditions listed in the rule, which includes the potential increased risks and benefits of these additional circumstances, a birth outside a hospital setting, medical care options, and the risks of cesarean section. The licensed midwife shall provide an abbreviated informed consent appropriate to the emergent situation with documentation to follow once the situation has stabilized.

R 338.17134: This proposed rule pertains to the circumstances in the antepartum, intrapartum, and postpartum phases of labor and in regard to an infant, when the licensed midwife must consult with or refer a patient to a physician, physician's assistant, or advanced practice registered nurse. The proposed rule requires the midwife to follow up with the patient regarding the consultation or referral and allows the licensed midwife to remain in communication with the physician, physician's assistant, or advanced practice registered nurse until resolution of the concern. The proposed rule also provides that the licensed midwife may maintain care of the patient if possible, or in circumstances where the patient elects to not accept the referral or the physician's, physician's assistant's, or advanced practice registered nurse's advice, and the refusal is documented in writing.

R 338.17135: This proposed rule pertains to emergent circumstances involving the mother or infant when the licensed midwife must transfer care of a patient to a hospital. The licensed midwife is required to: initiate immediate transport according to the licensed midwife's emergency care plan; provide necessary emergency stabilization until transfer to the hospital or emergency medical services personnel is completed; provide pertinent information to the receiving provider assuming

care of the patient or patients; and is encouraged to fill out a patient transfer form provided by the department. The proposed rule allows for transport by private vehicle if it is the most expedient method for accessing medical services. A licensed midwife, if present, is allowed to provide care to a patient if: no emergency medical services personnel are available; delivery occurs during transport; the patient refuses to be transported to the hospital; or the transfer or transport entails futility, or extraordinary and unnecessary human suffering. 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.

R 338.17136: This proposed rule lists the conduct by a licensed midwife that is prohibited.

R 338.17137: This proposed rule pertains to the administration of prescription drugs and medications by a licensed midwife. The proposed rule allows a licensed midwife who has appropriate pharmacology training, as defined in the rules, and holds a standing prescription from an appropriate health professional with prescriptive authority, to administer specific listed drugs and medications. Administration of the drugs or medication must be in accordance with Table 1.

R 338.17138: This proposed rule requires a licensed midwife to report a patient's data to the statistics registry maintained by MANA's DOR, pursuant to MANA's policies and procedures, or a similar registry maintained by a successor organization approved by the Board unless the patient refuses. A licensee shall register with MANA's DOR, and must annually, by the date determined by MANA, submit patient data on all completed courses of care in the licensee's practice during the previous 12 months, plus during the first year of licensure, a licensee must submit data from the date of licensure to the date determined by MANA.

License Renewal and Continuing Education

R 338.17141: This proposed rule establishes the requirements for renewal of a license. The proposed rule requires the applicant to: hold the credential of CPM from NARM, or an equivalent credential approved by the Board; accumulate 30 hours of continuing education that is met by obtaining or maintaining, the credential of CPM from NARM, or an equivalent credential approved by the Board; accumulate one hour of continuing education in pain and symptom management; accumulate one hour of continuing education in pharmacology applicable to the practice of midwifery; and accumulate 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. The proposed rule states that submission of an application for renewal constitutes the applicant's certification of compliance with the requirements of the rule. The proposed rule will allow the Board to require an applicant for license renewal to submit evidence to demonstrate compliance with the continuing education requirements. Further, the proposed rule will require a licensee who seeks a waiver of continuing education to submit the request prior to the expiration date of the license. A CPM credential from NARM, or equivalent credential approved by the Board, may not be waived. This rule does not apply to an applicant during an initial 1-year licensure cycle.

5. List names of newspapers in which the notice of public hearing was published and publication dates (attach copies of affidavits from each newspaper as proof of publication).

Marquette Mining Journal – October 4, 2018
Flint Journal – October 11, 2018
Grand Rapids Press – October 11, 2018

6. Date of publication of rules and notice of public hearing in *Michigan Register:*

October 15, Issue No. 18

7. Time, date, location, and duration of public hearing:

October 30, 2018
9:00 a.m. – 9:14 a.m.
G. Mennen Williams Building Auditorium
525 W. Ottawa Street
Lansing, Michigan 48909

8. Provide the link the agency used to post the regulatory impact statement and cost-benefit analysis on its website*:*

http://dmbinternet.state.mi.us/DMB/ORRDocs/RIS/1812_2018-031LR_ris.pdf

9. List of the name and title of agency representative(s) attending public hearing:

Andria Ditschman, Senior Policy Analyst, Bureau of Professional Licensing
Rick Roselle, Senior Policy Analyst, Bureau of Professional Licensing
Kerry Ryan Przybylo, State Administrative Manager, Bureau of Professional Licensing

10. Persons submitting comments of support:

The following individuals submitted written support for licensing midwives and the midwifery rules as proposed: Brett Averill, Melodee Babcock, Amy Bowditch, Jason Brown, Abbey Brunner, Carolyn Cronk, Eileen Denomme, Raymond DeVries, Lisa Ellens, Vicki Ferrier, Faith Groesbeck, Elizabeth Hawver, Brooke Henning, Jennifer Holshoe, Paul Howell, Cynthia Jackson, Susan Jenkins, Rebecca LaDuca, Stephanie Mayne, Melissa, Michigan Midwives Association, Kathi Mulder, Jill Nolan, Kristen Paquin, Sandra Pera, Jennifer Phillips, Heidi Pohl, Nikki Polce, Meghan Redder, Michelle Sperlich, Helen Stockton, Michelle Thomas, Carly Van Thomme, Despina Walsworth, Nancy Ward, Amy Tracy Wells, Jason Wilson, and Sarah Wilson, and Laurie Zoyiopoulos.

11. Persons submitting comments of opposition:

Matthew Allswede, Melissa Bayne, Nicole Budrys, Emily Dove-Medows (emailed by Moira Tannenbaum), Renay Gagleard, Jennifer Gorchow, Jenn Dewaard, Katie Lavery, Robert Lorenz, Federico Mariona, Tobi Moore and Linda Taft, letter from Tobi Moore, Emily Dove-Medows, Amy Zaagman, Gretchen Schumacher, Chris Mitchell, Betty S. Chu and 55 other persons as noted in attachment to letter, and Robert J. Sokol.

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12. Identify any changes made to the proposed rules based on comments received during the public comment period:

	Name & Organization	Comments Made at Public Hearing	Written Comments	Agency Rationale for Change	Rule Number & Citation Changed
1.	Tobi Moore, Executive Director, American Nurses Association of Michigan (ANA); Emily Dove-Medows, President, Michigan ACNM; Amy Zaagman, Executive Director, Michigan Council for Maternal & Child Health (MCMCH); Gretchen Schumacher, President, Michigan Council of Nurse Practitioners (MICNP); Chris Mitchell, Senior Vice President, Michigan Health & Hospital Association (MHA); Matthew Allswede, Michigan Section Chair, American College of Obstetricians and Gynecologists (ACOG); and Betty S. Chu, 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	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 5 and 7	338.17101(1)(d)

	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, and Bryan Popp **(Moore/ANA et al.)**				
2.	Jason Brown	N/A	Email dated October 29, 2018	Public Comment Summary, 12/5/18, pg. 4 and 5	338.17101(1)(a)
3.	Katie Lavery	N/A	Email dated October 18, 2018	Public Comment Summary, 12/5/18, pg. 4 and 5	338.17101(1)(a)
4.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 5-6	338.17113(1) and (2)
5.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 6-7	338.17115
6.	Matthew Allswede, ACOG	N/A	Email dated October 30, 2018 with attached Letter dated October 2, 2018	Public Comment Summary, 12/5/18, pg. 7-11	338.17121
7.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with	Public Comment Summary, 12/5/18, pg.	338.17121

			attachments	7-11	
8.	Ida Darragh, Executive Director, North American Registry of Midwives (NARM)	N/A	Email dated October 29, 2018 with attached Letter dated October 29, 2018	Public Comment Summary, 12/5/18, pg. 7-11	338.17121
9.	Amy Tracy Wells	N/A	Email dated October 24, 2018	Public Comment Summary, 12/5/18, pg. 7-11, and 16-17	338.17121(d)
10.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg.11-13	338.17123
11.	Amy Tracy Wells	N/A	Email dated October 24, 2018	Public Comment Summary, 12/5/18, pg. 11-13	338.17123
12.	Katie Lavery	N/A	Email dated October 18, 2018	Public Comment Summary, 12/5/18, pg. 14	338.17125(1)(f)
13.	Amy Tracy Wells	N/A	Email dated October 24, 2018	Public Comment Summary, 12/5/18, pg. 14	338.17125(1)(d) and (2)(d)
14.	Amy Tracy Wells	N/A	Email dated October 24, 2018	Public Comment Summary, 12/5/18, pg. 16-17	338.17127
15.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 17-20	338.17131(a)
16.	Katie Lavery	N/A	Email dated October 18, 2018	Public Comment Summary, 12/5/18, pg. 17-20	338.17131(a)
17.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg.17-20	338.17131(c)(f)
18.	Linda Taft, President ANA- Michigan and Tobi Lyon Moore, Executive Director **(Taft and Moore/ANA)**	N/A	Email dated October 30, 2018 with Letter dated July 26, 2018	Public Comment Summary, 12/5/18, pg.17-20	338.17131(f)

19.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 20-23	338.17132(1)
20.	Ida Darragh - NARM	N/A	Email dated October 29, 2018 with attached Letter dated October 29, 2018	Public Comment Summary, 12/5/18, pg. 20-23	338.17132(1)
21.	Melissa Bayne	N/A	Email dated October 28, 2018	Public Comment Summary, 12/5/18, pg. 20-23	338.17132(4)
22.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 20-23	338.17132(4)
23.	Taft and Moore/ANA	N/A	Email dated October 30, 2018 with Letter dated July 26, 2018	Public Comment Summary, 12/5/18, pg. 23-24 and 28-33	338.17133(2), (4), and (5)
24.	Michigan Midwives Association	N/A	Email dated October 28, 2018	Public Comment Summary, 12/5/18, pg. 24 and 33	338.17133(5)
25.	Melissa Bayne	N/A	Email dated October 28, 2018	Public Comment Summary, 12/5/18, pg. 25 and 33	338.17133(6)
26.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 33-37, and 47-56	338.17134(1), (2), (3), (4), and (5)
27.	Melissa Bayne	N/A	Email dated October 28, 2018	Public Comment Summary, 12/5/18, pg. 35-37, and 47-56	338.17134(1)
28.	Taft and Moore/ANA	N/A	Email dated October 30, 2018 with Letter dated July 26, 2018	Public Comment Summary, 12/5/18, pg. 33-37, and 47-56	338.17134(1)
29.	Matthew Allswede, ACOG	N/A	Email dated October 30, 2018 with attached Letter dated October 2, 2018	Public Comment Summary, 12/5/18, pg. 33-37, 47-56	338.17134(1)

30.	Sandra Pera	N/A	Email dated October 29, 2018	Public Comment Summary, 12/5/18, pg. 33-37, and 47-56	338.17134(1)
31.	Paul Howell	N/A	Email dated October 30, 2018	Public Comment Summary, 12/5/18, pg. 37 and 52	338.17134(1)(a)
32.	Laurie Zoyiopoulos	N/A	Email dated October 30, 2018	Public Comment Summary, 12/5/18, pg. 35 and 47-56	338.17134(1)(a) and (c)
33.	Kathi Mulder	N/A	Email dated October 30, 2018	Public Comment Summary, 12/5/18, pg. 37 and 47-56	338.17134(1) and (2)
34.	Taft and Moore/ANA	N/A	Email dated October 30, 2018 with Letter dated July 26, 2018	Public Comment Summary, 12/5/18, pg. 57 and 63-66	338.17135
35.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 56-58 and 63-66	338.17135
36.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 56, 63, 66, and 69	338.17136(d) and (e)
37	Taft and Moore/ANA	N/A	Email dated October 30, 2018 with Letter dated July 26, 2018	Public Comment Summary, 12/5/18, pg. 72 and 75-77	338.17137(1)
38.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 72, 73, 75, and 76	338.17137(1)(k) and Table 1
39.	Amy Tracy Wells	N/A	Email dated October 24, 2018	Public Comment Summary, 12/5/18, pg. 79, 81, and 82	338.17141(2)
40.	Moore/ANA et al.	N/A	Letter dated October 30, 2018 with attachments	Public Comment Summary, 12/5/18, pg. 79, 81, and 82	338.17141(2) and (2)(d)

13. Date report completed:

March 27, 2019

STATE OF MICHIGAN)
County of Genesee ss Rhonda L. Walker

Being duly sworn deposes and say he/she is Principal Clerk of

THE FLINT JOURNAL
DAILY EDITION

a newspaper published and circulated in the County of Genesee and otherwise qualified according to Supreme Court Rule; and that the annexed notice, taken from said paper, has been duly published in said paper on the following day(days)

October 11 A.D. 20 18

Sworn to and subscribed before me this 11th day of October 20 18

Janice M. DeGraaf
JANICE M. DEGRAAF
NOTARY PUBLIC, STATE OF MI
COUNTY OF KENT
MY COMMISSION EXPIRES Oct 3, 2020
ACTING IN COUNTY OF Kent

RECEIVED
OCT 15 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing

NOTICE OF PUBLIC HEARING

October 30, 2018
9:00 a.m.

Location: G. Mennen Williams Building Auditorium
525 W. Ottawa Street, Lansing, Michigan

The hearing is held to receive public comments on the following administrative rules:

Acupuncture – General Rules (ORR 2017-002 LR)

Authority: MCL 333.16141; MCL 333.16145; MCL 333.16148; MCL 333.16174; MCL 333.16201; MCL 333.16287; MCL 333.16525.

Overview: The proposed changes include revising definitions; revising and organizing rules pertaining to registration, reregistration, and registration renewal; updating adopted standards, educational training requirements, and certification organizations that are approved by the board; and rescinding rules that are duplicative of statutory requirements.

Midwifery- General Rules (ORR #2018-031 LR)

Authority: MCL 333.16145, MCL 333.16148, MCL 333.16174, MCL 333.16186, MCL 333.16201, 16204, MCL 333.16205, MCL 333.17105, MCL 333.17107, MCL 333.17111, MCL 333.17112, MCL 333.17117, MCL 338.3501, MCL 445.2001, MCL 445.2011, and 445.2030

Overview: The purpose of the Board of Midwifery Rules is to regulate the prelicensure education, licensure, practice, conduct and classification of conditions, informed disclosure and consent, consultation and referral, transfer of care, prohibited conduct, administration of prescription drugs, data reporting, licensure renewal, relicensure, and continuing education for licensed midwives.

The rules will take effect immediately upon filing with the Secretary of State, unless specified otherwise in the rules. Comments on the proposed rules may be presented in person at the public hearing. Written comments will also be accepted from date of publication until 5:00 p.m. on **October 30, 2018**, at the following address or e-mail address:

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170
Attention: Policy Analyst Email: BPL-BoardSupport@michigan.gov

A copy of the proposed rules may be obtained by contacting Board Support at (517) 241-7500 or the email address noted above. Electronic copies also may be obtained at the following link:

http://w3.lara.state.mi.us/orr/AdminCode.aspx?AdminCode=Department&Dpt=LR&Level_1=Bureau+of+Professional+Licensing

The meeting site and parking are accessible to people with disabilities. Individuals attending the meeting are requested to refrain from using heavily scented personal care products, in order to enhance accessibility for everyone. People with disabilities requiring additional accommodations (such as materials in alternative format) in order to participate in the meeting should call (517) 241-7500).

8828908-01

STATE OF MICHIGAN)
County of Kent
and County of Ottawa

ss Dawn Suttorp

Being duly sworn deposes and say he/she is Principal Clerk of

RECEIVED
OCT 15 2018
LARA

THE GRAND RAPIDS PRESS
DAILY EDITION

a newspaper published and circulated in the County of Kent and the County of Ottawa and otherwise qualified according to Supreme Court Rule; and that the annexed notice, taken from said paper, has been duly published in said paper on the following day(days)

October 11 A.D. 20 18

Sworn to and subscribed before me this 11th day of October 20 18

Janice M. DeGraaf
JANICE M. DEGRAAF
NOTARY PUBLIC, STATE OF MI
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Authority: MCL 333.16141; MCL 333.16145; MCL 333.16148; MCL 333.16174; MCL 333.16201; MCL 333.16287; MCL 333.16525.

Overview: The proposed changes include revising definitions; revising and organizing rules pertaining to registration, reregistration, and registration renewal; updating adopted standards, educational training requirements, and certification organizations that are approved by the board; and rescinding rules that are duplicative of statutory requirements.

Midwifery- General Rules (ORR #2018-031 LR)

Authority: MCL 333.16145, MCL 333.16148, MCL 333.16174, MCL 333.16186, MCL 333.16201, 16204, MCL 333.16205, MCL 333.17105, MCL 333.17107, MCL 333.17111, MCL 333.17112, MCL 333.17117, MCL 338.3501, MCL 445.2001, MCL 445.2011, and 445.2030

Overview: The purpose of the Board of Midwifery Rules is to regulate the prelicensure education, licensure, practice, conduct and classification of conditions, informed disclosure and consent, consultation and referral, transfer of care, prohibited conduct, administration of prescription drugs, data reporting, licensure renewal, relicensure, and continuing education for licensed midwives.

The rules will take effect immediately upon filing with the Secretary of State, unless specified otherwise in the rules. Comments on the proposed rules may be presented in person at the public hearing. Written comments will also be accepted from date of publication until 5:00 p.m. on **October 30, 2018**, at the following address or e-mail address:

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170
Attention: Policy Analyst Email: BPL-BoardSupport@michigan.gov

A copy of the proposed rules may be obtained by contacting Board Support at (517) 241-7500 or the email address noted above. Electronic copies also may be obtained at the following link:

http://w3.lara.state.mi.us/orr/AdminCode.aspx?AdminCode=Departement&Dpt=LR&Level_1=Burea u+of+Professional+Licensing

The meeting site and parking are accessible to people with disabilities. Individuals attending the meeting are requested to refrain from using heavily scented personal care products, in order to enhance accessibility for everyone. People with disabilities requiring additional accommodations (such as materials in alternative format) in order to participate in the meeting should call (517) 241-7500.

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The Mining Journal

Upper Michigan's Largest Daily Newspaper

249 W. Washington St., P.O. Box 430, Marquette, Michigan 49855. Phone (906)228-2500. Fax (906)228-3273.

AFFIDAVIT OF PUBLICATION

STATE OF MICHIGAN

AFFIDAVIT OF PUBLICATION

For the County of **MARQUETTE**

In the matter of: Notice of Public Hearing
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Acupuncture – General Rules
Midwifery – General Rules

Size: 3 x 6

State of **MICHIGAN,** County of Marquette ss.

JAMES A. REEVS

being duly sworn, says that he is

PUBLISHER

of **THE MINING JOURNAL**

a newspaper published and circulated in said county and otherwise qualified according to Supreme Court Rule; that annexed hereto is a printed copy of a notice which was published in said newspaper on the following date, or dates, to-wit

October 4, 2018

JAMES A. REEVS

Subscribed and sworn to before me this 5th day of October, 2018

ROBYN M. KINNUNEN
Notary Public for MARQUETTE County, Michigan
Acting in the County of Marquette
My commission expires: April 27, 2020

ary Committee hearing.

I would tell him, knock it off. You're not ...ping," Trump ally Sen. Lindsey Graham,

...treated like a Faberge egg by all of us, beginning with me and the president," and said Trump was merely "pointing out factual inconsistencies."

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing

NOTICE OF PUBLIC HEARING

October 30, 2018
9:00 a.m.

Location: G. Mennen Williams Building Auditorium
525 W. Ottawa Street, Lansing, Michigan

...he hearing is held to receive public comments on the following administrative rules:

Acupuncture – General Rules (ORR 2017-002 LR)

Authority: MCL 333.16141; MCL 333.16145; MCL 333.16148; MCL 333.16174; MCL 333.16201; MCL 333.16287, MCL 333.16525.

Overview: The proposed changes include revising definitions; revising and organizing rules pertaining to registration, reregistration, and registration renewal; updating adopted standards, educational training requirements, and certification organizations that are approved by the board; and rescinding rules that are duplicative of statutory requirements.

Midwifery- General Rules (ORR #2018-031 LR)

Authority: MCL 333.16145, MCL 333.16148, MCL 333.16174, MCL 333.16186, MCL 333.16201, 16204, MCL 333.16205, MCL 333.17105, MCL 333.17107, MCL 333.17111, MCL 333.17112, MCL 333.17117, MCL 338.3501, MCL 445.2001, MCL 445.2011, and 445.2030

Overview: The purpose of the Board of Midwifery Rules is to regulate the prelicensure education, licensure, practice, conduct and classification of conditions, informed disclosure and consent, consultation and referral, transfer of care, prohibited conduct, administration of prescription drugs, data reporting, licensure renewal, relicensure, and continuing education for licensed midwives.

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Department of Licensing and Regulatory Affairs
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P.O. Box 30670
Lansing, MI 48909-8170
Attention: Policy Analyst Email: BPL-BoardSupport@michigan.gov

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... meeting site and parking are accessible to people with disabilities. Individuals attending the ...ting are requested to refrain from using heavily scented personal care products, in order to ...ance accessibility for everyone. People with disabilities requiring additional accommodations (such ...aterials in alternative format) in order to participate in the meeting should call (517) 241-7500.

1 STATE OF MICHIGAN
DEPARTMENT OF LICENSING and REGULATORY AFFAIRS
2 BUREAU OF PROFESSIONAL LICENSING

3 - - -

4 PUBLIC HEARING

5 TUESDAY, OCTOBER 30, 2018

6 9:00 A.M.

7 at

8 G. MENNEN WILLIAMS BUILDING AUDITORIUM

9 525 W. Ottawa Street

10 Lansing, Michigan

11 - - -

12 RICK ROSELLE, Presiding
ANDRIA DITSCHMAN
13 KERRY RYAN PRZYBYLO

14 - - -

15 RE: BUREAU OF PROFESSIONAL LICENSING

16 Acupuncture - General Rules
(ORR 2017-002 LR)
17
- and -
18
Midwifery - General Rules
19 (ORR 2018-031 LR)

20 - - -

21

22

23

24 REPORTED BY: Lori Anne Penn, CSR-1315
33231 Grand River Avenue
25 Farmington, Michigan 48336

I N D E X

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ROBERT LORENZ	7
RENAY GAGLEARD	10

1 Lansing, Michigan
2 Tuesday, October 30, 2018
3 At 9:00 a.m.
4 - - -
5 (Public hearing commenced pursuant to due notice.)
6 MR. ROSELLE: Okay. We're going to go
7 ahead and get started. My name is Rick Roselle, I'm an
8 analyst for the Bureau of Professional Licensing in the
9 Department of Licensing and Regulatory Affairs, and I
10 will be facilitating the hearing today.
11 This is public hearing on proposed
12 administrative rules entitled "Board of Acupuncture -
13 General Rules" and "Board of Midwifery - General Rules."
14 The hearing is being conducted under the authority of the
15 Administrative Procedures Act, Public Act 306 of 1969, on
16 behalf of the Department of Licensing and Regulatory
17 Affairs, Bureau of Professional Licensing.
18 This hearing is being called to order at
19 9:01 a.m. on October 30, 2018, at the G. Mennen Williams
20 Building Auditorium located at 525 West Ottawa Street in
21 Lansing, Michigan. The notice of public hearing was
22 published in three newspapers of general circulation, as
23 well as the Michigan Register, Issue No. 18, published on
24 October 15, 2018.
25 We are here today to receive your

1 comments on the proposed rules. If you wish to speak,
2 please make sure you have signed in and indicated your
3 willingness to speak. You may use the cards provided in
4 the lobby for this purpose. I will organize the cards by
5 rule set so that the comments for the profession will be
6 grouped together in the transcript. If you would like to
7 testify and have not signed in, please do so now. For
8 those of you who do not sign in -- who do not wish to
9 sign in with a card, you may speak at the microphone once
10 we have exhausted the stack of cards submitted to me.
11 If you have comments, please make sure
12 that they relate directly to the proposed rules. If you
13 have questions regarding the rules, please submit your
14 questions as part of your testimony for the Department's
15 review. If you have suggested changes to the proposed
16 rules, please include the specific reasons why the
17 changes would be in the public interest. And then this
18 is not a time for dialogue. Your comments will be
19 encouraged, will be continued to the rule set committee
20 and Board -- conveyed -- I'm sorry. Your comments will
21 be conveyed to the rules committee and Board.
22 For the record, when you testify, please
23 identify yourself by name and organization, if any, that
24 you may be speaking for today; this will help the
25 Department prepare the hearing record that will go before

1 the Boards. Written statements can be submitted directly
2 to me at the table. The Department will also accept
3 written statements emailed or postmarked until 5:00 p.m.
4 today.
5 The Department staff of the Bureau of
6 Professional Licensing includes myself, Rick Roselle, and
7 Andria Ditschman.
8 The first rule set that we will take
9 comments for is Acupuncture. I have no cards. Is there
10 anyone that would wish to speak?
11 Okay. Hearing none, we will go to
12 Midwifery. And the first card I have is Dr. Allswede.
13 DR. ALLSWEDE: Thank you. My name is
14 Dr. Matthew Allswede, and I come representing the
15 American College of Obstetricians and Gynecologists in
16 Michigan. I'm the chair of the advisory council
17 committee. Thank you for the opportunity to comment.
18 We have previously submitted written comments
19 electronically.
20 I'd like to take this moment to highlight
21 the need to understand risk using a personal story.
22 Thirty-nine years ago this week I got into the front
23 passenger seat of a friend's car to make the five-mile
24 trip from my home to town for a high school theater
25 rehearsal. We never made it. A drunk driver crossed the

1 road and hit our car head-on.
2 Let me back up a moment. When I got into
3 the car that afternoon, I noticed that a cover had been
4 placed over the bench front seat and the seat belts were
5 no longer available. Even before the mandatory seat belt
6 law, I had been a compulsive seat belt user. I was faced
7 with a dilemma: Do I find a different ride? I did the
8 risk calculation. My driver was a high school senior
9 with a clean driving record; it was daylight and good
10 weather; we had not been drinking or using drugs; it
11 would be a ten-minute trip, mostly on a rural two-lane
12 highway with little traffic; and I had never been in an
13 accident before. I chose to take the ride, and I am
14 fortunate to be here.
15 Despite being an unrestrained front seat
16 passenger, I was not thrown from the car. I was launched
17 head first into the windshield. I broke both legs,
18 suffered a concussion, and picked dashboard plastic out
19 of my face for weeks afterward. I was hospitalized in
20 traction for seven weeks and wore a body cast for two
21 months after that. And I was fortunate.
22 The point of sharing this experience with
23 you is not to suggest that no one should ride in a car or
24 attempt childbirth at home; the point is that there is
25 unseen risk in everything that we do, and lives and

1 futures are often at risk.

2 The rules under consideration by this

3 Board of Midwifery are like the safety features in a car;

4 they don't prevent every accident, but they can reduce

5 the likelihood of severe, permanent injury or death. On

6 behalf of the members of ACOG and Michigan families, I

7 implore the Board and LARA to heed the recommendations

8 provided by ACOG, MSMS, the Michigan Council of Maternal

9 and Child Health, and others to strengthen the

10 protections governing the practice of home birth by

11 certified professional midwives in this state. Thank

12 you.

13 MR. ROSELLE: And the next card is

14 Dr. Lorenz.

15 DR. LORENZ: Thank you for the

16 opportunity to discuss this issue. My name is Bob

17 Lorenz, I'm an obstetrician/gynecologist, and I

18 specialize in maternal-fetal medicine, which is the care

19 of high-risk pregnancy.

20 I have seen women die in pregnancy due to

21 preventible causes. I'm a member of the Michigan

22 Maternal Mortality Review Committee, and we have looked

23 at deaths of pregnant women in Michigan, the group has

24 looked at every maternal death for the last 60 years, and

25 we have learned lessons. Other states and other

1 countries have used these same lessons to reduce the
2 chance of a mother dying in pregnancy. We know for each
3 death, there are between 10 and 100 serious injuries,
4 near misses, of women in pregnancy. So the lessons are
5 important, and it can come down basically to the concept
6 of individualized obstetrical care.
7 The right care at the right time in the
8 right place. What does that mean? Well, the right care
9 means there have been deaths due to errors in management,
10 wrong decisions at the time of a delivery or during
11 pregnancy. We have obstetrical safety bundles, these are
12 evidence-based guidelines that are national that we're
13 implementing throughout the state to provide the right
14 care.
15 The right time. What does that mean?
16 Some women die because of delays in recognition or
17 treatment of their condition. We have guidelines for
18 early warning systems, and those are also being used.
19 The right place. What does that mean?
20 Women die sometimes because they're in a hospital or a
21 setting that doesn't have the resources necessary to deal
22 with a severe condition, such as heavy bleeding with an
23 abnormal placenta that was known before delivery. So we
24 need to put people, the sickest people in the centers
25 with the most resources.

1 So how does this apply to the
2 regulations? I think all are in agreement that a
3 certified professional midwife has a focus and an
4 interest in the completely normal pregnancy. Anything
5 other than a completely normal pregnancy should be
6 referred for an evaluation by those people of the OB team
7 that have experience and knowledge to take care of that
8 problem. The sickest patients, very high-risk patients,
9 should not only be a consultation, but this small group
10 of patients should be transferred to the specialists that
11 can care for those patients.
12 This Board should join with all the other
13 agencies in the Department of Health and Human Services
14 in Michigan, the insurers, the hospital systems, the
15 certified nurse midwives, and the physicians in Michigan
16 trying to provide individualized obstetrical care. The
17 right care at the right time in the right place.
18 So specifically, any abnormal condition,
19 there should be a mandate for consultation, and
20 consultation may result in care by the CPM or not, that
21 would be up to the team itself. For the highest risk
22 conditions, it should be mandated that those patients be
23 transferred. Hopefully we won't see more women die in
24 Michigan due to preventible causes.
25 Every woman in Michigan deserves the

1 right care at the right time in the right place. Thank
2 you.
3 MR. ROSELLE: And the final card I have
4 is Dr. Gagleard.
5 DR. GAGLEARD: Good morning. Thank you
6 very much for allowing me to be here this morning with
7 you. I would like to share a little bit of my background
8 with you to begin with so you understand the
9 qualifications I bring to the stand here. After 30 years
10 of being a professional nurse and doctorally prepared,
11 I've worked in multiple healthcare settings, primarily in
12 the perinatal branch of work, so my opportunities have
13 been great to develop service lines in my current place,
14 Trinity Hospital System, St. Joseph Mercy Oakland, who
15 does about 2,000 deliveries a year. Prior to that I have
16 spent time as a CNO in the DMC, and prior to that in the
17 Beaumont Health System and Hurley Medical Center. In all
18 these facilities I have been an active proponent for the
19 certified nurse midwifery and have instituted and begun
20 multiple midwifery services within these institutions, so
21 the practice of certified nurse midwifery and the care of
22 normal pregnancy and birth is very important to the
23 health systems, as well as myself personally.
24 So some things I would like to bring to
25 highlight here within these rules echo many of the things

1 my colleagues have just stated, but specifically I want
2 to talk to you about informed consent. To echo
3 Dr. Lorenz, when women are brought to us for transfer, or
4 even when they begin their care with their midwife,
5 letting the patient know exactly what will happen, how it
6 will happen, when it will happen, and the status of their
7 condition can not be under-communicated. We know in
8 healthcare that communication is the number one deficit
9 that usually gets us into some kind of issue. So letting
10 the person know what they're in for, what the
11 expectations are, and the exact care that they will
12 receive is paramount. If and when it would become
13 appropriate for a transfer to a hospital setting, having
14 the patient understand what that entails also is vastly
15 important. Communication, as I said, can not be
16 understated.
17 We have had many situations, two I bring
18 to mind in the last year, where we have received patients
19 from the community cared for by a community midwife who,
20 due to lack of communication, have resulted in a
21 hysterectomy for one patient who arrived with multiple
22 internal injuries, it was very traumatic for her and the
23 family; and most recently we've had a patient arrive at
24 our doorstep hemorrhaging, without her midwife to guide
25 us through what happened to her or any history. So some

1 of the experiences are quite dramatic and leave less to
2 be desired, scares the family, scares our colleagues in
3 the hospitals, because we really try to do the right
4 thing for the right patient at the right time, as
5 Dr. Lorenz stated. Without informed consent and proper
6 collaboration on transfer, these become exceptionally
7 challenging to deliver our care, so we advocate for that
8 paramount.
9 Also, what we would like to see, as
10 identified in the letter communicated to you, is that
11 standardized education, benchmarking for that, a standard
12 platform, equality among the states, so if one midwife is
13 in another state and comes into Michigan, they have the
14 exact same preparedness so we can understand the
15 platforms by which they are learning, educated, and
16 moving forward.
17 At this moment in time, according to what
18 we have read in the excerpts, the nurses in the hospitals
19 prepared with an associate degree most likely have more
20 experience as a first-year RN than what these Board rules
21 promulgate for the new professional midwives, so that
22 would be something to consider. As far as education for
23 medications, 8 hours is identified to be directed; I
24 strongly advocate for the increase to 16, because that
25 still is not enough, but it's better than 8 hours.

1 So that being said, I think we need to
2 continue to be collaborative, because we do know women
3 have a choice to make, we want them to make the best
4 choice to be in the right place at the right time for the
5 care that they receive. Thank you.
6 MR. ROSELLE: Are there any other
7 comments for midwifery? Okay.
8 Is there anyone, are there any other
9 comments for acupuncture? Okay.
10 If there are no further comments at this
11 time, I hereby declare the hearing closed. The record
12 will remain open until today at 5:00 p.m. for any
13 additional comments you may wish to share regarding the
14 proposed rules.
15 Thank you for coming.
16 (The public hearing closed at 9:14 a.m.)
17 - - -
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25

1 STATE OF MICHIGAN)
)
2 COUNTY OF MACOMB)

3 I, Lori Anne Penn, certify that this
4 transcript consisting of 14 pages is a complete, true,
5 and correct record of the public hearing held on Tuesday,
6 October 30, 2018.
7 I further certify that I am not
8 responsible for any copies of this transcript not made
9 under my direction or control and bearing my original
10 signature.
11 I also certify that I am not a relative
12 or employee of or an attorney for a party; or a relative
13 or employee of an attorney for a party; or financially
14 interested in the action.
15
16
17 ______________________ ______________________________________
Date Lori Anne Penn, CSR-1315
18 Notary Public, Macomb County, Michigan
My Commission Expires June 15, 2019
19
20
21
22
23
24
25

Allswede

Ditschman, Andria (LARA)

From:	BPL-BoardSupport
Sent:	Tuesday, October 30, 2018 1:19 PM
To:	Ditschman, Andria (LARA)
Subject:	FW: Comments on Board of Midwifery rules 2018-031 LR
Attachments:	Comments on Board of Midwifery General Rules.pdf

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From: Allswede, Matthew <Matthew.Allswede@sparrow.org>
Sent: Tuesday, October 30, 2018 1:17 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Ditschman, Andria (LARA) <DitschmanA@michigan.gov>
Subject: Comments on Board of Midwifery rules 2018-031 LR

Please accept the following recommendations from the American College of Obstetricians and Gynecologists regarding the rules proposed for the recently formed Board of Midwifery.

I am available to address any questions.

Thank you.

Matthew Allswede, MD, FACOG
Michigan Section Chair

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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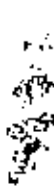
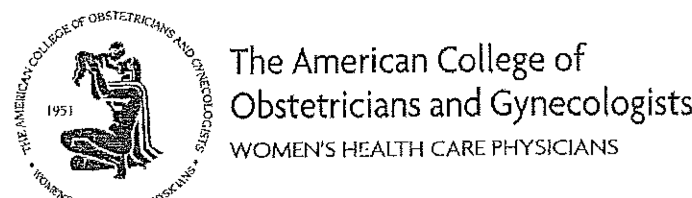
Allsucde I





October 2, 2018

Thank you for providing the American College of Obstetricians and Gynecologists (ACOG) the opportunity to comment on the proposed rules promulgated for the Michigan Board of Licensed Midwifery (ORR #2018-031 LR).

On behalf of the Michigan Section of ACOG, I am providing the following input, organized as follows:

1. **Scope of care including informed consent and consult, referral & transfer requirements**
2. **Outcomes reporting** (pages 3-4)
3. **State oversight & peer review** (pages 5-6)

Scope of care, informed consent, consult, referral & transfer requirements

- **Definition of "appropriate health professional"** (beginning on page 6, part 4).
  Recommendation: Specify appropriate obstetric expertise, holds a current Michigan license, and has admitting and obstetric privileges at a nearby hospital with labor and delivery services.

- **Additional informed consent (rule 133)**
  Comment: Additional informed consent does not replace adequate training to assess and manage these complications

- **Consultation and referral (rule 134)** (beginning on page 8)
  Recommendation: Delete the clause "...that in the judgment of the licensed midwife warrant consultation or referral..."
  - ✓ Particularly important for immediate referral, not addressed elsewhere, are
    (xxxi) Symptoms of ectopic pregnancy and
    (xxxiii) Symptoms or evidence of hydatidiform mole

- **Midwife transfer of care plan & patient transfer form** (page 6 section 17132; and page 11):
  Comment: The new law requires the midwifery 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"*.
  We recommend that the regulations specify the following:
  - ✓ A licensed midwife's client care plan must incorporate the conditions under which consultation, including transfer of care or transport of the client, may be implemented.
  - ✓ A licensed midwife's transfer of care plan shall include procedures and processes to be undertaken in the event of an emergency for the mother, newborn or both; identify the

409 12th Street SW • Washington, DC 20024-2188 • Mailing Address: PO Box 96920 • Washington, DC 20090-6920
202.638.5577 • www.acog.org

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 Midwifery 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.

- **Prohibited conduct** (page 11, section 17136)
  We recommend that the following be added as absolute contraindications:
  - ✓ *Pharmacological induction or augmentation of labor or artificial rupture of membranes prior to onset of labor*
  - ✓ *previous uterine surgery*
  - ✓ *cesarean section (VBAC) or myomectomy*

- **Postpartum prohibitions**
  We recommend including the following:
  - ✓ *uncontrolled postpartum hemorrhage; preeclampsia; thromboembolism*
  - ✓ *uterine infection*
  - ✓ *postpartum mental health disorder*

- **Informed consent for a client with a previous c-section:**
  Comments: Adequate informed consent for VBAC at home should include reference to current outcome statistics with consideration of the reliability of the data. Please see the attached ACOG Committee Opinion on Planned Home Birth for details.
  - ✓ We recommend requiring a specific, additional consent for VBAC

- **2nd assistant at home birth:**
  Comment: A difficult delivery at home may demand simultaneous attention for both the mother and newborn by appropriately trained providers.
  - ✓ We recommend requiring 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 two years and possesses the skills and equipment necessary to perform a full resuscitation of the newborn in accordance with the principles of NRP.

Outcomes reporting

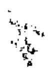
Comment: There is insufficient reporting and monitoring requirements in the current set of rules to ensure that appropriate care is being provided by licensees. The MANA registry does not provide sufficient access to individual practitioner outcomes data to ensure quality of care oversight. Outcome information should be available to LARA and the Board to inform license renewal applications. This is a public accountability issue.

Recommendations:

- **A patient transfer form** is to be provided by LARA.
  ACOG would like to review and comment on any draft form before implementation.

- **Outcomes reporting for specific conditions/outcomes should be a requirement** for license renewal, with penalties for failure to report.
  Mandatory outcomes reporting by midwives should include:
  - *The midwife's name and license number.*
  - *The calendar year being reported.*
  - *The following information with regard to cases in which the midwife, or someone supervised by the midwife, assisted in the previous year:*
    - ✓ *The total number of clients served as primary care giver*
    - ✓ *The total number of clients served with collaborative care by, or backup from, a physician and surgeon*
    - ✓ *The number and county of live births attended as primary care giver*
    - ✓ *The number and county of stillbirths attended as primary care giver*
    - ✓ *The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer*
    - ✓ *The number, reason, and outcome for each elective hospital transfer*
    - ✓ *The number, reason, and outcome for each urgent or emergency transport of an expectant mother prior to labor*
    - ✓ *The number, reason, and outcome for each urgent or emergency transport of an infant or mother during or after labor or birth*
    - ✓ *The number of planned out-of-hospital births at onset of labor and number completed in an out-of-hospital setting*
    - ✓ *Brief description of complications resulting in morbidity or mortality of mother or neonate*
    - ✓ *Any other information prescribed by the board in regulations*

- The regulations should specify the duties of the new midwifery board and LARA to collect, review and report (make publicly available) outcomes.
  - ✓ specify that LARA maintain the confidentiality of the information submitted
  - ✓ specify that LARA report to the midwifery board annually those midwife licensees who have met the reporting requirements
  - ✓ specify that LARA submit the aggregate information collected to the midwifery board by a certain date each year



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- **Require midwives to report to LARA and MDCH specific adverse incidents** in all attempted and/or completed planned out-of-hospital births, including the following:
  - ✓ Maternal death that occurs during delivery or within 42 days after delivery
  - ✓ Transfer of a maternal patient to a hospital intensive care unit
  - ✓ A maternal patient experiencing hemorrhagic shock or requiring a transfusion of more than 4 units of blood or blood products
  - ✓ A fetal or newborn death, including a stillbirth, associated with an obstetrical delivery
  - ✓ A transfer of a newborn to a neonatal intensive care unit due to a traumatic physical or neurological birth injury, including any degree of a brachial plexus injury
  - ✓ A transfer of a newborn to a neonatal intensive care unit within the first 72 hours after birth if the newborn remains in such unit for more than 72 hours
  - ✓ Any other injury as determined by department rule

- Require hospitals that receive an emergency transfer of mother/newborn, to report these transfers and the outcomes to the midwifery board, LARA and the Boards 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.

State Oversight & Peer Review

- **The roles and responsibilities** of the state licensing agency (LARA) and midwifery board should be specified in the regulations and include:
  - ✓ Verify that all licensed midwives meet annual reporting requirements
  - ✓ Collect & report safety measures and outcomes; aggregate this information and report annually to the midwifery board and to the Legislature
  - ✓ Monitor consumer complaints, conduct investigations and oversee the disciplinary process

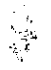
  Comment: *Does LARA have* <u>*subpoena power*</u> *that would allow it to pursue and investigate consumer complaints about a midwife? Several states have this, e.g. Colorado.*

- **The regulations include a definition of peer review** in the first section on page 1 but nothing else. Peer review should be mandatory and ideally, it should be tied to outcomes reporting and license renewal.
  - ✓ Maryland's law requires 4 hours of peer review every two years consistent with the NARM standards.
  - ✓ California's Standard of Care for Licensed Midwives Consensus Document includes the following:

    > *"The California licensed midwife is accountable to peers, the regulatory body and to the public for safe, competent, ethical practice, including formal or informal sources of community input. This includes but is not limited to the licensed midwife's participation in the peer review process and any required mortality and morbidity reporting. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice."*

  - ✓ Vermont has very detailed requirements:

    > *"A licensed midwife shall, within 30 days of a birth or sentinel event, complete any peer review that is both required by rules governing licensed midwives and which is generated due to a death, significant morbidity to client or child, transfer to hospital, or to practice performed outside the standards for midwives as set forth in the rules governing licensed midwives. This peer review report shall be submitted to the office of professional regulation within 30 days of its completion. Peer review reports in cases where care is transferred shall be provided to facilities and professionals involved in the case who may submit a supporting or dissenting addendum to the peer review report. Any peer review report or addendum identifying areas for improvement shall be reviewed by the three OPR advisors for licensed midwives who shall design a peer review plan for improvement and follow up in appropriate cases. Facilities and professionals who have submitted information or addenda through the peer review process may review and comment on the peer review report and follow up plan."*



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- **The Midwifery Bridge Certificate** is not specified in the regulations
  The bridge certificate should be specified in each of the licensure sections, beginning on page 3: initial licensure, licensure by endorsement, and re-licensure. The regulations should track language in the law.

- **Additional licensure requirements:** The law gives the new midwifery board the authority to *"promulgate rules to supplement the requirements for licensure"* (see law, top of page 5, section 17117 (2).
  We recommend the following additional requirements:
  - ✓ <u>**Initial license:**</u> current CPR certification; completion of the AAP & American Heart Association *Neonatal Resuscitation Program* in last 2 years.
  - ✓ <u>**License renewal:**</u> specify accredited CEUs; 4 hours of peer review; submission of required annual outcomes reports (as discussed above).
  - ✓ <u>**Continuing education requirements**</u> (pages 4 and 5 in the chart): should specify **accredited** courses.

- **Midwifery Formulary, Equipment and Medical Devices:** The regulations specify only drugs and medications. The use or prohibition of medical devices (e.g. laminaria, uterine hemorrhage balloons, urinary catheters, etc.) should be specifically addressed.

Respectfully submitted,

Matthew Allswede, MD, FACOG
Chair, Michigan Section of ACOG

Averill

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 7:41 AM
To: Ditschman, Andria (LARA)
Subject: FW: Comments on Licensed Midwifery Rules.
Attachments: Response to Midwifery Rules.pdf

From: Brit Averill <nmhomebirth@gmail.com>
Sent: Monday, October 29, 2018 5:37 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Comments on Licensed Midwifery Rules.

Please see attached PDF.

Thank you!

Brit Averill, CPM, LM
www.nmhomebirth.com

Averill

Northern Michigan Home Birth
314 Howard St. Suite 4
Petoskey, MI 49770
760.889.2857
brit@nmhomebirth.com
www.nmhomebirth.com

10/29/2018

To whom it may concern,

I am writing this letter in response to the requested amendments to the proposed Licensed Midwifery rules & regulations.

I am a CPM who has just moved into Michigan in September of 2018. I am currently licensed in both Maryland and Virginia, and attended a MEAC accredited program for 4 years. Midwifery education and licensure is important to me; important to me for some of the same reasons it's important to you and your organizations. Additionally, I am not just a midwife, but a home birth parent.

I have been involved in the law and rule writing processes in Maryland, Maine, and Washington D.C. This process can be difficult. From what I have seen in my short time here, both midwives and other health providers and professional organizations in the state of Michigan are together working hard to come ensure a safe law while also maintaining autonomy for practitioners of direct entry midwifery.

After reading ACOG's proposed amendments, I have the following feedback;

The majority of the proposed changes of the rules from ACOG and other professional organizations, such as language changes & definitions, are helpful for ensuring our clients have continuity of care, and that all clients of a licensed midwife have consistent options for consultation, transfer of care referrals, and midwifery skills & education requirements.

Some of the proposed rules changes, such as prohibiting gestation beyond 42 0/7 weeks and transfer of care for non-cephalic presentation at or beyond 38 weeks are restrictive and unnecessary. They should be listed under required consultation. Unresolved non-cephalic presentation at the time of delivery is already listed as a contraindication to home birth.

A proposed recommendation that I, and all of the midwives of Michigan & their clients, cannot support is VBAC/prior uterine surgery as an absolute contraindication to home birth. This contraindication does not protect or offer greater safety for birthing people in Michigan. Over half the state by geographical location is experiencing a VBAC "ban" at local hospitals. Not

Averill

only is this practice unethical, it is also illegal. The recommendation to prohibit midwives from attending VBAC at home does not produce better outcomes for birthing people, and it violates patient autonomy. Among legal and ethical concerns, I ask that the committee consider religious and cultural groups, as well as a harm reduction perspective; unassisted deliveries and VBAC deliveries with non-licensed midwives will still continue to happen in Michigan given the complete absence of choice for patients with a history of prior uterine surgery.

Local hospitals in the northern areas of Michigan have a higher than national average cesarean delivery rate, as well as lower than average VBAC success rates. (or 0%, for those hospitals who have a VBAC ban). 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, and there is a responsibility for all providers to improve our statistics. This certainly will not happen by completely eliminating access to VBAC friendly care providers in rural areas, and areas with physicians altogether refusing to attend TOLAC.

The overuse of cesarean delivery effects patients for their entire reproductive lives, and beyond. The morbidities and mortalities associated with repeat cesarean delivery, along with a ban on VBAC birth at both hospital 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. Not only are there no local hospital providers attending vaginal deliveries for primary VBAC, there are also no providers willing to perform 10th cesareans on women whose religion and culture include non-use of birth control. Purposefully restricting options for birthing bodies and the people who own them is degrading, unethical, harmful, and misogynistic.

The midwives of Michigan will support reasonable and collaborative change to our rules and regulations, as well as specific risk criteria (such as VBAC being contraindicated in patients with a history of other than low transverse incision, placenta overlying prior incision, etc.) but we will not support the erasure of client choice for over a third, sometimes closer to half, of the birthing people in our communities.

Midwives and physicians have a lot that we can learn from one another. We, midwives, desire collaborative relationships, smooth and articulate hospital transports, and respectful hospital options for clients who can no longer, or no longer desire, to have home births. We are not only midwives, but people who give birth in the hospital and at home. We are the people who have cesareans and VBAC, abortions and term pregnancies. When we press for rights and autonomy, it is for both our own bodies as well as the preservation of our profession and a woman's legal right to choose.

Thank you for considering these comments.

Brit Averill

Brit Averill, CPM, LM

Bayne 4

Ditschman, Andria (LARA)

From:	BPL-BoardSupport
Sent:	Monday, October 29, 2018 7:49 AM
To:	Ditschman, Andria (LARA)
Subject:	FW: Concerns and comments about board of mifeway rules
Attachments:	Board of Midwifery rules.pdf

Thank you,
Stephanie Wysack
Departmental Technician
Boards and Committees Section
Bureau of Professional Licensing
Michigan Department of Licensing and Regulatory Affairs
Phone: 517-241-7500
Email: BPL-BoardSupport@michigan.gov

From: Melissa.Bayne@spectrumhealth.org <Melissa.Bayne@spectrumhealth.org>
Sent: Sunday, October 28, 2018 10:35 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Concerns and comments about board of mifeway rules

To whom it may concern,

I would like to start off by saying that I support this initiative, the board and the work that has gone into making these rules. I strongly support a women's autonomy to decide to deliver with a licensed midwife in her home or a birth center. I have worked over my last 12 years of practice to help break down any unnecessary barriers to care for women who are interested in or who are choosing this care model. Nevertheless after reading these rules today, I am concerned that appropriate general obstetrical, high risk obstetrical and legal representation were not adequately a part of bringing this draft of rules to hearing – especially as it relates to delivery planning for women who have had a cesarean section, women with multiple gestations, and women with non-vertex presentation.

I am grateful for the opportunity for comment.

Here are my specific concerns/comments :

1. R338.17132…. R(4)

Current language is not set to legal standard of care. No health professional is exempt from the informed consent process when a women is in active labor or in an emergent situation. Please see legal precedent as it relates to cesarean section, operative vaginal delivery or episiotomies being done without informed consent. If immediate action is needed - informed consent is done in a verbal fashion and then later documented in the medical record. The only time that informed consent would be implied is if a patient is non responsive with there is absence of a do not resuscitate order to proceed with resuscitation or emergent surgical services (even then informed consent is many times obtained from next of kin).

(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

Bayne

change in the condition of a patient requires immediate action on the part of the licensed midwife.

(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 of 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.

2. R3338.17133 (6)

Again I am concerned about these rules holding exempt the need for informed consent in active labor and emergency situations.... Especially as it relates to risks that go a long with the high risk situations of previous cesarean, multiple gestation, and breech delivery. This is unsafe language that does not respect a women's autonomy for informed choice and does not protect women and the unborn children from harm.

(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.

R 338.17133 Additional informed consent requirements.

Rule 133. (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, specific to the patient's situation, 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

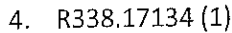
pregnancies.

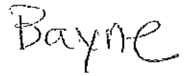
Bayne

3. R338.171334

From this paragraph it seems that the future licensed home birth community is planning to counsel women into planning vaginal birth after cesareans, multiple births, and breech births in the home. These are all risk factors that ACOG has identified as being high risk deliveries that are best managed at a hospital where there are readily to immediately available high risk obstetrical, anesthetic and pediatric services. It is confusing how a state licensure could allow a committee to go against such recommendations. This is very concerning. These three situations at a minimum should require consultation with an OBGYN so that the patient is adequately counseled to the risks of these situations and for appropriate delivery planning. From a licensure standpoint, I feel strongly that licensure should not allow for these deliveries to be planned in an homebirth setting. In the last two years of practice in rural Michigan – I have been on the receiving end of the following. A breech delivery with a newborn requiring resuscitation in the home and then brain cooling, hemorrhage after each of these situations that were not able to be managed in the home setting with subsequent serious morbidity to the mother (with two resulting hysterectomies and loss of future fertility), two uterine ruptures from trial of labors in the home. I have unfortunately been to the funeral of a baby born at a birth center in Owosso who the midwives felt that vaginal breech delivery outside of the hospital setting was a good idea. I am a strong supporter of a women's choice to desire to deliver in the home or at a birth center. Nevertheless, with each of these situations the mothers and fathers all said that they would have not made the decision to deliver in the home or at a birth center if they would have understood the risks fully of these situations.

R 338.17133 Additional informed consent requirements.
Rule 133. (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, specific to the patient's situation, 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.





4. R338.17134 (1)

This language is not safe. The rules should clearly state that these high risk situations should warrant consultation... Not " that in the judgement of the midwife."
Vaginal birth after cesarean, multiple gestation and breech presentation at term and in labor should each be on this list.

Other conditions that should be included in the antepartum list that are not currently: chronic hypertension, pre-gestational diabetes, prior history of preeclampsia or eclampsia, advanced maternal age (especially if 40 and above), history of prior shoulder dystocia, history of prior obstetrical hemorrhage, 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, maternal seizure disorder, prior history fetal growth restriction, uncontrolled asthma, uncontrolled hypothyroidism, hyperthyroidism, morbid obesity,

Rule 134. (1) A licensed midwife shall consult with or refer a patient to an appropriate health professional if the patient presents with any of the following conditions that in the judgment of the licensed midwife warrant consultation or referral:

5. R338.17134 (1. Viii)

There is no medical basis of this statement to wait 24 hours on obtaining further medical care if a mother has a fever. This is especially concerning going into influenza season. If a pregnant patient has a fever of 100.4 or greater and signs or symptoms of Influenza she should be started on antiviral therapy as soon as possible with close medical follow up.

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

6. R338.17134 (1. Xxi)

It would be prudent to better define this. As an OBGYN I have no idea what "marked abnormal fetal heart tones" means. It should be better defined as fetal bradycardia, fetal tachycardia, absence of fetal variability (or beat to beat variance by Doppler), and or persistent fetal decelerations.

(xxi) Marked abnormal fetal heart tones.

7. R338.17134 b

The following indications should be listed.

1. Fetal heart rate abnormalities of persistent fetal bradycardia, tachycardia, decelerations, or absence of beat to beat variability.
2. 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 and continuous monitoring of the neonate. Patients with mild elevation of blood pressure are still at elevated risk of maternal and neonatal morbidity and mortality. Hypertension related diagnosis is the number one cause of maternal mortality in the US. It is odd that these 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.

Bayne

3. It is concerning that a mother would have rupture of membranes for up to 72 hours without assessment in the hospital (especially NST) and possible intervention. This is especially true for patients who are group b strep positive or unknown. Standard of care from the Center for Disease Control is that patients who are group b strep unknown receive antibiotics after 18 hours of rupture of membranes (which many patients who choose homebirth decline GBS testing and are GBS unknown).
4. Signs of symptoms of maternal infection (this is not defined as it relates to GBS status) – If appropriate IV antibiotics are not available in the home setting - it should include that 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 that 18 hours.
5. Prolonged second stage of labor without ongoing progress
6. Vaginal bleeding not consistent with bloody show
7. 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), vaginal bleeding not consistent with bloody show (I see some of these are listed later in the document under immediate transfer)

(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) 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.

8. R338.17134 c

Postpartum hemorrhage not controlled with initial maneuvers and medications should be included in this list.

9. R338.17134 d

The following should be included:

1. 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).

10. R 338.17135

1. This should be better defined to stating signs or symptoms of preeclampsia/eclampsia: 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 great than twice normal, serum creatinine 1.1 or double baseline, thrombocytopenia less than 100,000, cerbral/visual disturbances, right upper quadrant or mid epigastric pain.

(xi) Symptoms of preeclampsia or eclampsia.

11. R 338.17136

HIV should be included in this list – not just AIDS.

Thank you and best regards.

Bayne

Melissa S. Bayne, DO. FACOOG.
Spectrum Health Gerber Memorial: OBGYN Department Chief
Spectrum Health Medical Group: Section Chief OBGYN - Gerber Memorial
Obstetrics and Gynecology
Office: 231.924.1212
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J. Brown

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Monday, October 29, 2018 3:11 PM
To: Ditschman, Andria (LARA)
Subject: FW: Attention: Policy Analyst

Thank you,
Stephanie Wysack
Departmental Technician
Boards and Committees Section
Bureau of Professional Licensing
Michigan Department of Licensing and Regulatory Affairs
Phone: 517-241-7500
Email: BPL-BoardSupport@michigan.gov

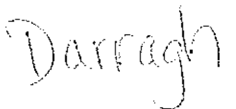
From: Jason Brown <jasonbrowndc@gmail.com>
Sent: Monday, October 29, 2018 3:01 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Attention: Policy Analyst

To Whom it May Concern:

My name is Jason Brown and I am a chiropractor in Muskegon, MI. I have a specialized certification in prenatal, postpartum, and pediatric care from the Academy Council of Chiropractic Pediatrics (C.A.C.C.P.). I would like to be included as "an appropriate Health Care Provider" as someone Licensed Midwives can refer patients with structural related conditions. I have enjoyed working with midwives in the care of pregnant women and babies in a variety of chiropractic related conditions. It is not my desire to see patients of midwives that require specialized medical care that is outside my scope of practice.

It is my hope that it will be decided that the client (patient) will retain the right to receive care from whichever practitioner they desire all while not restricting the scope of practice of midwives. It has been my experience as a practitioner as well as a user of midwives that patients receive better care when there are fewer "hoops" to jump through.

--
Jason Brown, D.C.
2045 Holton Rd.
Muskegon, MI 49445
231.744.3332



Ditschman, Andria (LARA)

From:	BPL-BoardSupport
Sent:	Monday, October 29, 2018 4:53 PM
To:	Ditschman, Andria (LARA)
Subject:	FW: NARM support of midwifery rules for licensure
Attachments:	NARM support of midwifery regulations.pdf

From: Ida <testing@narm.org>
Sent: Monday, October 29, 2018 4:50 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: NARM support of midwifery rules for licensure

Please find attached a letter in support of the proposed midwifery regulations in Michigan.

Ida Darragh, Executive Director
North American Registry of Midwives
1-501-296-9769

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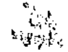

North American
Registry of Midwives
Providing Certification Standards
For Certified Professional Midwives

Ida Darragh, CPM, LM
Executive Director
Credentialing Specialist
Ida@narm.org

Board of Directors

Miriam Khalsa, CPM, LM
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Technology & Research

Test Department
Phone: 501-296-9789
testing@narm.org
www.narm.org

October 29, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing-- Boards and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170

Attention: Policy Analyst

NARM's comments in support of the proposed Rules and Regulations

The North American Registry of Midwives writes in support of the proposed Rules and Regulations for Licensed Midwives in Michigan. In requiring that all licensees have obtained the Certified Professional Midwife credential, the state may be assured that all CPMs have a credential accredited by the National Commission on Certifying Agencies, 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 hands-on classes (online programs are not acceptable), and have taken at least one course in cultural awareness.

All CPMs must also have a care plan for transport to a hospital and must 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.

All CPMs must recertify every three years and must obtain 25 hours of continuing education and 5 hours of peer review, Recertification also requires that CPR and NRP certifications are up to date.

Requiring the CPM credential for initial licensure and for periodic renewal of the license will assure the state that these requirements are being verified by NARM, and may not require additional verification by the state, thus eliminating staff time and record keeping.

Sincerely,

Ida Darragh

Ida Darragh
Executive Director, North American Registry of Midwives

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 7:45 AM
To: Ditschman, Andria (LARA)
Subject: FW: Midwifery – General Rules (ORR#2018-031 LR)
Attachments: MI ACNM Ltr to LARA Policy Analyst 10-29-2018 .docx

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From: Moira Tannenbaum <moiratan@hotmail.com>
Sent: Monday, October 29, 2018 11:44 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Cc: Monika Wierzbicki Miner <monika@wayne.edu>
Subject: Midwifery – General Rules (ORR#2018-031 LR)

Dear LARA BPL Policy Analyst:

Please find attached a letter from Emily Dove-Medows, president of the Michigan Affiliate of the American College of Nurse-Midwives (ACNM).

Best regards,

Moira Tannenbaum, MSN, CNM, IBCLC

Legislative Co-Chair, Michigan Affiliate, American College of Nurse-Midwives

Dove-Medows

MICHIGAN AFFILIATE *of the*
AMERICAN COLLEGE
of NURSE-MIDWIVES
With women, for a lifetime®

By email to: BPL-BoardSupport@michigan.gov

October 29, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing – Boards and Committees Section
Attention: Policy Analyst
P.O. Box 30670
Lansing, MI 48909-8170

Re: Midwifery – General Rules (ORR#2018-031 LR)

Dear Policy Analyst:

We are writing as the Michigan Affiliate of the American College of Nurse-Midwives. We previously contributed to a letter, with attachments (referenced herein as Letter, Attachment A, and Grid), written jointly with several other maternal-child health organizations, e.g., the Michigan Section of ACOG and the Michigan State Medical Society.

However, we wanted you to have our thoughts separately as well, as we represent midwives who are also licensed under the Department of Licensing and Regulatory Affairs who are CNMs, and we see some parallels and differences we wanted to highlight as you consider the regulations for the new licensure of CPM/LMs. For example, there remain some items in the previously submitted documents that we had asked not to have included, either because they make no sense given what is required to have the CPM credential, or because the parallel is not required for CNMs.

Below you will find our feedback on each of the three documents submitted. Following that feedback is additional commentary on the draft regulations.

LETTER

2nd paragraph (p. 1)

"Included in that shared decision-making is the need to assess a variety of factors including the favorable prognosis for a healthy labor, birth, and postpartum outcome; clinical practice guidelines; and the availability and timeliness of transport to a nearby hospital should that become necessary."

> The Michigan ACNM Affiliate would like to point out that not just outcome, but also experience and satisfaction, are important. Particularly as increasing emphasis is placed

Dove-Medows

nationally on maternal mental health, a woman's experience of childbearing is critically important, and satisfaction with experience is a hallmark of midwifery care. So, while we support the need to focus on outcomes, we also advocate that outcomes be combined with a positive experience, as they should be complementary, not exclusive of one another.

"Licensure" section of Letter (p. 2)

"Additional licensure criteria [are] proposed to ensure that licensed midwives show proof of current CPR and neonatal resuscitation certifications; obstetric emergency skills training; high school graduation or GED; minimal prenatal, birth and postpartum experience; proof of current credential as CPM; and proof of passing the required examination."

The Michigan ACNM Affiliate does not find the addition of the two statements highlighted above as necessary because they are subsumed under the requirements for certification as a CPM and similar requirements are not a component of licensure for other health professionals beyond their certification:

- For the request for proof of minimal prenatal, birth, and postpartum experience, there are no parameters given, and substantial practice experience is already folded into the CPM credential itself as a requirement.
- Re required reporting of the score on the exam: this is not required for any other health profession that we know of – if a licensee passes the exam, they are certified.

We do not want to distract with items that are redundant, as these weaken the other items that are relevant. These same points apply to the Grid, which includes the request for minimal practice experience and passing score in the "R 338.17121 – Licensure" section (Grid p. 1) and the "R 338.17123 - Licensure by Endorsement" section (Grid p. 2).

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"Administration of Medication" section of Letter (p. 3)

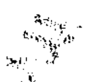
"In the interest of patient safety, this rule should be amended to limit those who may issue the standing prescriptions to a physician or certified nurse-midwife with current experience in obstetrics."

The Michigan ACNM Affiliate advocates having both a physician or certified nurse-midwife issue standing prescriptions, *and additionally* having the CPM/LM to be able to access appropriate emergency medications – as designated by the Board – for dispensing without the extra burden and barrier of this extra step. We view this as a safety measure designed to ensure that the CPM/LM has the necessary emergency medications for practice, such as those used to avert a postpartum hemorrhage (e.g., Pitocin). Through the use of a standardized list of emergency medications, the CPM/LM has access to emergency resources if necessary. The addition of standing prescriptions then is in addition to the emergency medications and should be promulgated as outlined in the letter. The standing orders for non-emergency medications can be refined, updated, and reviewed, consistent with local needs and practice skills.

"Administration of Medication" section of Letter (p. 3)

"Finally, there are some medications that are given to newborns within hours of birth. If the licensed midwife is not qualified to administer that medication or the family refuses, the licensed midwife should minimally make the recommendation that the family see an appropriate health professional to obtain that medication."

The Michigan ACNM Affiliate objects to the statement highlighted above, as a midwife holding a current CPM credential is – by definition – qualified to administer the routine



Dave Medows

newborn medications. We do appreciate and endorse the sentiment behind the recommendation to assure that all Michigan newborns have access to the recommended medications, regardless of the birth setting.

GRID
"R 338.17121 – Licensure" section (p. 1)
Regarding the following items in the Grid:

- "Documentation verifying the applicant has at least minimal practice experience"
- "Proof of a passing score on the Board-approved examination"

The Michigan ACNM Affiliate has the same objections in the Grid as we do in the Letter pertaining to the above two items. As before, we do not want to distract with items that are not congruent with other providers' requirements and/or that are redundant, as it weakens the relevance of the other items.

Commented [M1]: "Practice experience" is part of the CPM's education, which includes didactic and clinical components.

Commented [M2]: Having the CPM credential means the midwife has already passed the NARM exam. I do not know of a mechanism for providing a score separately from the CPM credential.

Commented [LLK3]: I think we have already addressed these so don't think we need to go line by line unless you think we risk not getting the point across.

ATTACHMENT A
"R 338.17134 Required Consultation and Referral" (p. 1)

(vii) Hemoglobin level less than 9 *[g/dL]* and resistant to supplemental therapy.

(xiv) Fetus with diagnosed congenital abnormalities that will require immediate medical intervention at birth.

Both items are also listed (in R338.17135 – as "q" and "kk," respectively) as a required *transfer*. If the concept of an exhaustive list of conditions is maintained, these items will need to be clarified.

The units (g/dL) in which hemoglobin is typically measured need to be added, as inserted above.

"R 338.17135 Required transfer of care to an appropriate health professional" (p. 3)

(nn) Marked or severe hydramnios or oligohydramnios

This is a typographical error and needs to be changed to "marked or severe polyhydramnios or oligohydramnios."

***

While the Michigan Affiliate of ACNM has worked with the other organizations using the current framework of the proposed rules to offer our response, we also offer some additional considerations for approaching the criteria for consultation, collaboration, and/or transfer. There will always be an ongoing challenge to maintain an exhaustive list of criteria for consideration that can be affected by changing evidence, resources, and access to hospital settings and health care providers.

Instead, we refer to ACNM's 2015 Clinical Bulletin "Midwifery Provision of Home Birth Services" as a key resource for a reduced list approach, but a resource that highlights higher risk criteria for certain conditions. We acknowledge that the approach taken thus far by the Board of Midwifery has been to promote the use of an exhaustive list.

Dove Medows

In addition to our comments above, we remain very concerned about the lack of access to quality care for families who desire access to health care providers and a hospital setting which will support their choice to pursue a vaginal birth after a prior cesarean birth (VBAC). National data support that women who desire a VBAC disproportionately choose to have a home birth due to a lack of access to health systems that will support them in their choice to have a VBAC and not have an elective repeat cesarean birth.

While national data confirm there is a higher risk for women having a first VBAC compared to women who have a vaginal birth at home, there is also a risk to initiating a "VBAC ban" for home birth, unless there is a corollary response to opening access in the hospital setting for individuals to pursue the choice of VBAC. Putting a "ban" on care for women who desire a VBAC at home risks women either pursuing unattended births or accessing unlicensed providers to attend their birth at home. We strongly advocate expanding options for women who have had a prior cesarean to have evidence-based, informed choices for their care.

Finally, we recommend the inclusion of 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 family needs to transition from a planned homebirth to a hospital setting.

Thank you for your consideration of our viewpoints and suggestions. Please let us know if you have questions.

Sincerely yours,

Emily Dove-Medows, CNM, President
Michigan Affiliate of the American College of Nurse-Midwives
emilydovemedows@gmail.com

Howell

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 2:43 PM
To: Ditschman, Andria (LARA)
Subject: FW: amend rule 134 for midwives

From: Paul Howell <paul.d.howell@gmail.com>
Sent: Tuesday, October 30, 2018 2:41 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: amend rule 134 for midwives

Hello, I am writing as a concerned consumer. I have been studying the proposed rules for the Board of Midwifery and I take particular issue with one of them.

Please amend rule 134 (1)(a)(xxv) Gestation beyond 42 weeks.

I request that this be changed to 43 weeks, or else remove any reference to gestation beyond 40 weeks.

Preferable to my mind would be eliminating the reference altogether. My own child was more than 42 weeks in gestation with no problems at all, and at that time my wife and I did considerable reading on this issue and discussed it with both midwives and doctors, and we could find no substantive scientific basis that should require this rule.

Please amend this rule. Thank you.

Paul Howell
Clinton Michigan

Lavery

Ditschman, Andria (LARA)

From:	Katie Lavery <katiecnm@aol.com>
Sent:	Thursday, October 18, 2018 9:27 PM
To:	Ditschman, Andria (LARA); ORR; katiecnm@aol.com
Subject:	CPM request for rulemaking, Board of Midwifery
Attachments:	CPM rules comment by Katie Lavery CNM.pdf

Hello Ms Ditschman
I am submitting comment regarding the Request for Rulemaking for the Board of Midwifery. I have attached a word document with my comments, which related to length of licensure (too long); strict adherance to the licensure requirements in the law (MEAC and NARM specifically, not other petitioning for others to be accepted); other state licensure only accepted if it is equivalent or higher than our standards for licensure; minor revisions to the medication table; the definition of 'appropriate health professional'; and informed consent being required at all junctures of care, and not exempted due to active labor or emergencies.
I am an actively practicing CNM in the state, and have 8 years of experience on the Board of Nursing. I supported the establishment of this Board and licensure of CPMs in order to improve the homebirth landscape and increase birth safety in our state. I look forward to working with my sister midwives as the licensing process moves forward.
If you have any questions, please email me. I will be out of the country until after the hearing at the end of the month, but I will try to return emails.
Thank you so much for your time.

Katie Lavery

Katie Lavery, CNM
Everyday Blessings Midwifery
Women's Health Care
500 South Jackson
Jackson, MI 49203 517-796-1398

Lavery

October 18, 2018

To Ms Andria Ditschman, Bureau of Professional Licensing, Lansing MI

DitschmanA@michigan.gov

Re the Request for Rulemaking for the Board of Midwifery, rules R 338.17101 – R 338.17151, 2018

I am a Certified Nurse Midwife in Michigan. I served on the Michigan Board of Nursing for 8 years, and as the Chair of that body for 3 years. I am very familiar with Administrative Rules, and their impact on the boards ability and purpose – regulating the profession to protect the public. I am approaching my comments here both as a 'regulator' and a 'clinician', as I am actively engaged in women's health care and birth in this state. In general, I supported the push for licensure and regulation, as I believe it will make the homebirth community in our state safer. I believe we need a seamless process of care in addition to competent providers, and I hope the legislation, and these rules, move us towards that.

I have concerns about the rules as written, and have suggestions for modifications for these rules.

1. The length of the licensure period is too long and out of step with other health care providers in the state. With a 4 year license period, requiring only minimal continuing education and no exams or recertification, a CPM could be practicing with no oversight (not being in a hospital system) and no verification of safety or mandatory skills/education improvement for a very long time. In addition, the re-licensure requirements after a lapse are minimal ... So, a new CPM could be licensed for 4 years, allow her license to lapse for up to 7 years, so a total of nearly 11 YEARS from initial licensure (which is the only time she would have been required to demonstrate competence via her exam and licensure requirements) ... and all she needs to do to get her license back is pay the fees, have 30 hours of CE, and remain credentialed with NARM. If a Registered Nurse, with a college education, goes that long, she is required to do a refresher course with a skills certification and her exams over. **I recommend shortening the licensure period to 2 years, and requiring examination or recertification at the 3-7 year lapse time.** (as an aside, I found it confusing to note in the first table 338.17125 which is specifically for CPMs who do NOT hold a CPM license in another state ... in section 1(f) t requests proof of license from another state ... this is better placed in the following section, dealing specifically with CPMs who are licensed elsewhere also)
2. I would like the rules to reflect the intent of the original legislation in their requirements for licensure. I recognize that credentialing and accrediting organizations change, and that you do not want to revise the rules when a new organization evolves. However, the legislation was specifically written to be compliant with the national licensure standards of the US-MERA group, a stakeholder group who hashed out the bare minimum preparation and standards needed to be considered adequately educated and trained to be a safe provider. These standards are critical to our women's safety. They are also the minimum standards for a midwife according to the International Confederation of Midwives. So I **recommend deleting the segments throughout the rules (338.17121 (2), (3), (5), (6)) which allow applicants to 'petition the board' to review and accept their pathway to midwifery which is not MEAC accredited or NARM**

Lavery

credentialed, or to develop "equivalent" status for different programs or exams. A possible solution would be to use 'successive organization' language, indicating that if MEAC or NARM change to something else, that their next iteration of organization would be recognized. To say that there is a way to 'petition' to get some other preparation approved is in direct opposition to the intent of the law.

3. Similarly, I would point out that there are strikingly different criteria for CPM or Licensed Midwife licensure in other states. **I request that it be made clear that we only license by endorsement, or accept licensure from other states when the state in question has equivalent or higher standards for licensure than we do in Michigan. (338.17125 (1 f) and (2 intro and e).**
4. We need to recognize that not all consults and transfers are for women during childbirth; some are neonatal, some are for medical problems, etc. In 338.17131 (a) it references "Certified Midwife" instead of Certified Nurse-Midwife. This needs correction since we do not license the distinct group Certified Midwife (CM) in Michigan. But more importantly, there will be times when the CPM needs to consult with pediatrics, emergency medicine, or family practice, and these could include PAs and NPs. However, there needs to be some guidance so as not to be too loose with provider type when we have required consults or referrals. **I recommend amending this section to define "appropriate health professional" to mean any appropriately qualified MD, DO, NP, PA or CNM licensed under article 15.**
5. A minor concern is the Medication tables; **I would simply recommend changing them to two separate tables, one for maternal medications and the other for newborn medications.** Some of the medications are the same but in dramatically different dosages. It is critical to keep them separate when administering them, and a separate table might clarify that.
6. I have a question which is not addressed in the rules, and was not addressed specifically in the law, but I will raise it here for consideration. I do not believe CPMs are mandatory reporters for child abuse or for vulnerable adult abuse. I believe they should be, as they will have direct access and visualization into the homes and experiences of their clients.
7. And now we come to my biggest concern, Consent issues. I am a midwife too. I believe that women should be educated well, given options, given recommendations when indicated, and that then those women should be able to make their own choices about their birth experiences, just like they do for the care of their children once they are born. This is a philosophy that most midwives share. However, these rules EXEMPT the CPM from needing to obtain consent in the situation when the woman is laboring or if it's an emergency. Specifically, rule 338.17132 (4) states that a licensed midwife is exempt from the requirements of {informed consent} if the need 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". I strongly object to this.
   a. In the case of active labor, and discovering a problem, the CPM absolutely needs to engage the woman and her support people, explain (sometimes VERY quickly) the situation, and offer options, which the woman gets to choose from. This woman (unless she is seizing or unconscious) deserves the same standards of consent which we are held to in the same situations in the hospital. Sometimes it is simply "your baby is in trouble and we need to do a cesarean" but if that woman says NO, STOP, we must stop

Lavery

even if I means losing a baby. The reverse is often true in a homebirth situation – the woman is known to be declining interventions, so the CPM sees trouble late in labor and doesn't provide informed consent because she believes the woman will refuse a transfer, leading to a poor outcome and a woman left in the dark. Women deserve information and consent in all circumstances where they are conscious.

b. In the case of a woman refusing the recommended care, it is critical that informed consent be obtained (education, options, warnings, questions answered) and WELL documented. Consider a case of a late diagnosed breech, near birth. The woman needs to be informed, between contractions, given education about the risks, and her options, and to make her own choices. Her partner and support people should be involved. It should be documented and there should be indication that the woman understands and accepts potential consequences.

c. Yes, this is difficult. But we manage to do it with every emergency we have in the hospital. And we discuss difficult topics and options with women actively laboring all the time. You use compassion, and tailor the information to what she can handle between contractions. Women do not lose their brains, nor their right to parent this child how they wish, simply because they are working hard in labor. It is critical that informed consent happen at all junctures in care.

d. **My recommendation is to remove this section entirely, and not to have exemptions for anything other than an incompetent woman.** Of course, if the woman is incompetent, then the CPM needs to provide care based solely on her own judgement and any consultation she is doing. An incompetent woman can not consent nor refuse transport, and clearly would require the most conservative safe care possible.

Thank you for your time and consideration of my concerns. I look forward to working with my sister midwives as the licensing process moves forward, and hope that you can modify the rules for clarity, high standards, and protecting the public.

Katie Lavery, MS, CNM
Everyday Blessings Health Care for Women
500 South Jackson Street
Jackson, MI 49203
517-474-6100

Mi Midwives Assoc

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 3:06 PM
To: Ditschman, Andria (LARA)
Subject: FW: Attn: Policy Analyst -- comments on rules for Licensed Midwifery

From: Michigan Midwives Association <mimidwives@gmail.com>
Sent: Tuesday, October 30, 2018 2:54 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Attn: Policy Analyst -- comments on rules for Licensed Midwifery

---------- Forwarded message ----------

Subject: Attn: Policy Analyst -- comments on rules for Licensed Midwifery
To: Mimidwives@gmail.com

Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing– Boards and Committees Section

P.O. Box 30670

Lansing, MI 48909-8170

Attention: Policy Analyst

October 28, 2018

Dear Policy Analyst:

The Michigan Midwives' Association is grateful to the Board of Licensed Midwifery for their hard work in constructing a rules set that will govern the practice of midwifery and facilitate the best possible care for Michigan families. We appreciate the work that the board has done with establishing rules that fulfill the mandate of the midwifery licensing statute and also appreciate the collaboration that has occurred between the CPM, CNM, consumer, and physician members of the board. We understand that this is very important work and that the rules will help set the stage for safe and effective midwifery practice in the state of Michigan in the future. We acknowledge that midwives are experts in normal, physiologic birth and that midwifery training prepares midwives to utilize professional judgement as independent providers to determine when the condition of a pregnant, birthing, or postpartum patient and/or her baby are deviating from normal and require care or consultation from another provider or transport to another facility. We believe these rules strike a balance between ensuring patient safety and allowing midwives to be fully empowered to work within the scope of their training and experience.

We submit the following comments for consideration on the rules set:

MI Midwives Assoc.

R 338.17133, Rule 133

Question: If a midwife is providing the client with an informed choice document that is specific to that client's situation, wouldn't it be necessary to have time to prepare that document? Suggest changing wording so that it is clear that midwives will have time to prepare customized informed consent.

Comment: The Michigan Midwives Association commends the Board of Licensed Midwifery for including extra informed consent around breech, twin, and vbac birth. A thorough informed consent process helps empower patients to guide their own care while maintaining clear communication and optimizing safety.

R 338.17134

Comment:

(a) (i) We suggest defining gestational hypertension as systolic blood pressure >140mmHg and diastolic blood pressure>90mmHg measured on two separate occasions more than four hours apart with the absence of proteinuria.

Source: ACOG Task Force and Work Group Reports, Hypertension in Pregnancy and https://www.ncbi.nlm.nih.gov/m/pubmed/26158653/Comment:

(a) (xxv) We suggest amending "gestation beyond 42 weeks" to "gestation beyond 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 this consultation and referral list describe disease processes or concerning symptoms. This item is different.

Drug table, regarding 0.5% erythromycin ointment. Suggest change to within 1 hour of birth so that the recommended treatment is given in accordance with Michigan law.

Drug table, consider adding valtrex/valacyclovir for HSV prophylaxis during the antepartum period for previously diagnosed non-primary HSV outbreak prophylaxis. This 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.

Drug table, consider modifying epinephrine to allow for generic epinephrine autoinjecting devices and for multi-dose vial of epinephrine for use in severe maternal allergic reactions.

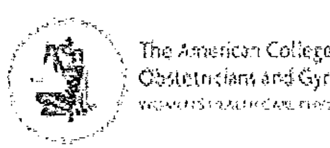
Thank you for your consideration,

Board of Directors

Michigan Midwives Association

michiganmidwives.org

Moore/ANA et al.



October 30, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing-- Boards and Committees Section
Attention: Policy Analyst
P.O. Box 30670
Lansing, MI 48909-8170

Re: Midwifery – General Rules (ORR#2018-031 LR)

Dear Policy Analyst:

Thank you for the opportunity to provide input on the proposed Board of Midwifery rules, which will implement provisions of Public Act 417 of 2016. The signatories of this letter represent health care professionals and maternal and child health advocates who believe that patient safety and well-being must be our highest priority.

The American Academy of Pediatrics, American College of Nurse-Midwives, and American College of Obstetrics and Gynecology have all created thoughtful policy statements pertaining to planned home births. Each recognizes that there are women and their families who desire and will choose to have home births. They also recognize the need for informed choice and consent utilizing evidence-based protocols and counsel regarding standards of care. Included in that shared decision-making is the need to assess a variety of factors including the favorable prognosis for a healthy labor, birth, and postpartum experience, clinical practice guidelines, and the availability and timeliness of transport to a nearby hospital should that become necessary.

Our respective organizations urge the Michigan Department of Licensing and Regulatory Affairs (LARA) to take these standards into consideration when finalizing the Board of Midwifery rules. We believe that it is in the best interest of Michigan's women and children to support licensed midwives in the safe practice of caring for women during childbirth. Inclusive in this practice is respectful inter-professional collaboration, transparency, and ongoing communication.

On behalf of our respective members, we have several concerns with the proposed regulations as currently drafted. To ensure that the licensing of midwives will make the public safer and to ensure those seeking to be licensed as midwives are qualified to provide care, we would urge LARA to consider incorporating our joint recommendations prior to finalizing these rules. Our organizations believe they are consistent with the Legislature's directive to LARA in MCL 333.17117(c) to promulgate rules that "describe and regulate, limit, or prohibit the performance of acts, tasks, or functions by midwives" and, to "include rules that recognize and incorporate the requirements under section 17107 regarding the referral to and consultation with appropriate health professionals and ensure that those rules conform to national standards for the practice of midwifery..."

Attached is a grid and related attachment detailing these recommend changes, as well as a summary of those recommendations below.

Moore/ANA et al, 32

Licensure

The goal of licensure and regulation is to assure appropriate minimum standards of education and preparation. Public Act 417 of 2016 gives the new midwifery board the authority to "promulgate rules to supplement the requirements for licensure."

Language is proposed to establish a benchmark for accrediting and credentialing program equivalency standards and recognition of successor organizations. Additional licensure criterion proposed to ensure that licensed midwives show proof of current CPR and neonatal resuscitation certifications, obstetric emergency skills training, high school graduation or GED, minimal prenatal, birth and postpartum experience, proof of current credential as Certified Professional Midwife, and proof of passing the required examination.

Regarding licensure by endorsement, we propose to require out-of-state licensed midwives to meet the same criteria as Michigan licensed midwives as directed by MCL 333.17119. This is critical since there is no assurance of equivalency among states or consistent criteria, especially when applicants may be reviewed for exceptions in education or certification in their licensing states.

The current proposal of a four-year licensure cycle is too long. Our organizations recommend that it be two-years, which is consistent with Board of Nursing requirements. As currently written, there is essentially no consequence to not renewing license over a period of nearly seven years given that the licensing cycle is proposed to be four years, and a midwife could allow his or her license to lapse for two years and 364 days. Additionally, we recommend some adjustments to the relicensure requirements.

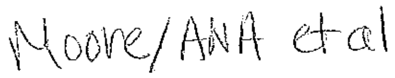
Definitions

As currently written in the proposed rule, the definition of "appropriate health professional" would include every health professional licensed under the Public Health Code, even those with no obstetrical training or training in the practice of medicine or nursing such as dentists, veterinarians, physical therapists, social workers, etc. Our organizations propose the definition be scaled back to include physicians, physician's assistants, certified nurse practitioners, and certified nurse midwives with experience in the practice of obstetrics, pediatrics, or emergency medicine. These are the professionals that will be expected to consult with licensed midwives or take over the care of their patients when risk factors present. It is imperative that licensed midwives are collaborating with health professionals that have the appropriate training and experience.

The required hours of training under the definition of "appropriate pharmacology training" is proposed to be increased from eight hours to minimally 16. Eight hours is not sufficient training for the administration of medications to pregnant women and infants.

The definition of 'transfer" is modified to provide a stronger legal basis to assure transfer with the least risk of delay due to clear, previously agreed upon responsibility and adherence to national standards as required by MCL 333.17117(1)(e).

Based on suggested changes from our organizations later in the document, we are proposing to add the definition of "emergency medical services personnel". These front-line professionals will be assisting in emergency situations. To ensure a transparent transfer of care, they need to be recognized in the rules.



Informed Consent

The current proposed rules only require informed disclosure of certain information where the statute (MCL 333.17109) clearly requires informed consent at inception and continuation of care. We recommend that the statute be followed, and written informed consent be required. We are also suggesting that additional information be provided during the process to ensure transparency to the patients regarding expectations around consultation, transfer of care, the care team, and any collaborative relationships.

Consultation, Referral and Transfer of Care

We collectively recommend that the issues of consultation/referral and transfer of care/transport to hospital be addressed in two separate rules to ensure clarity. Therefore, Attachment A reflects the suggested restructure of current proposed rule 333. The rationale for items under our proposed "required transfer of care" is that these conditions move the pregnancy from a low or normal risk pregnancy into higher risk categories which are more likely to result in complications and the need for medical intervention by an appropriate health professional.

Additionally, language changes are proposed regarding action to be taken by the licensed midwife when the mother and/or infant require transportation to a hospital to ensure the patients' safety and a smooth care transition. In emergency situations, at a minimum, we would request that a licensed midwife be required to remain with the patient and continue to provide care until an appropriate health care provider has assumed care of the patient. Additionally, consistent with standards of practice, the licensed midwife should be expected to communicate with appropriate health professionals on the mother's and/or infant's condition and, when possible, present their medical records.

Finally, the addition of a new rule is proposed to establish minimum criteria and expected protocols for the transfer of care plan.

Administration of Medication

In the interest of patient safety, this rule should be amended to limit those who may issue the standing prescriptions to a physician or certified nurse midwife with current experience in obstetrics. If any additional medications need to be added to the list, they should be added through the rules promulgation process to ensure the opportunity for adequate public review and input. Finally, there are some medications that are given to newborns within hours of birth. If the licensed midwife is not qualified to administer that medication or the family refuses, the licensed midwife should minimally make the recommendation that the family see an appropriate health professional to obtain that medication.

Continuing Education

We are proposing a slight modification to make the continuing education more consistent to that of nurses by requiring at least 25 credits every two years. Additionally, the recommendation is that at least 20 hours come from activities to maintain their credential, one hour in pain and symptom, two hours in cultural awareness and one hour in pharmacology.

As noted previously, our goal is to increase the likelihood of safe deliveries and post-partum care for mothers and infants. These rules must signify a level of regulation and safe practice that all stakeholders, especially the public, can trust. We believe our suggestions assist in achieving that outcome.

Thank you for your consideration of our recommended changes. Significant effort has been made in the last few years within state government and in communities, in partnership with the undersigned to lower Michigan's rate of infant and maternal mortality, we need midwifery rules that reflect this priority. If you have any questions or need any additional information, please do not hesitate to reach out to any or all of our organizations.

Respectfully submitted,

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Attachments (3)
- List of additional individuals and organizations in support of this joint statement
- Grid of recommended changes and Attachment A

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PROPOSED MIDWIFERY RULE	PROPOSED REVISIONS TO BOARD OF MIDWIFERY RULES	COMMENTS/RATIONALE
R338.17113 – Licensed Midwifery Accrediting Organizations	Amend (1) and (2) to read as follows: (1) The board approves the midwifery accreditation council (MEAC), **or its successor entity,** as an accrediting organization. (2) A petition may be filed with the board for approval of a midwifery accrediting organization. **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 the MEAC.**	Clinical standards are not subjective and should not be decided upon a case-by-case basis. There needs to be a mechanism for future organizations, but they need to be equivalent to meet the standards established in the original act.
R338.17115 – Licensed Midwifery Accrediting Organizations	Amend to read as follows: Rule 115. The board may approve a licensed midwifery credentialing program **only** if **its standards and evaluative criteria** are equivalent to the credential of certified professional midwife (CPM) from the North American registry of midwives (NARM), meets the criteria of section 16148 of the code, MCL 333.16148, and is accredited by the national commission for certifying agencies (NCCA) **or an accrediting organization approved pursuant to Rule 113**.	As noted above, any mechanism intended to recognize future organizations must ensure equivalency to meet the standards established in the original act.
R 338.17121 - Licensure	Amend (1) to require all of the following be submitted with the completed application and requisite fee: • Proof of current CPR and neonatal resuscitation certification from courses that include a hands-on skill component • Proof of competition of obstetric emergency skills training • A photocopy of a high school diploma or a GED certificate • Documentation verifying the applicant has at least minimal practice experience • Proof of current credential as CPM or another credential as permitted by MCL 333.17115 • Proof of a passing score on the Board approved examination Regarding (2) and (3), establish a process and criteria for determining "equivalency."	Additional licensure requirements are included to ensure completion of basic competencies to ensure the safety of both the mother and child. Variation in how equivalence is determined deters from the ability to assure public health and safety, as well as consistent expectations related to the practice of a midwife. It is critical that the criteria remain equivalent to meet the standards in the act for the protection of the public. MEAC accredited programs should be the bare minimum preparation for practice. This is critical to the safety of our families.

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R 338.17123 - Licensure by Endorsement	Amend Rule 123 to read as follows: Rule 123. To be eligible for licensure by endorsement, an applicant must meet the requirements of sections 16174 and 17119 of the code, MCL 333.16174 and MCL 333.17119, and must submit all of the following: (1) A completed application, on a form provided by the department; (2) The requisite fee; (3) Proof of current CPR and neonatal resuscitation certification from courses that include a hands-on skills component. Approved CPR courses include the American Heart Association and the Red Cross. Neonatal resuscitation courses must be approved by the American Academy of Pediatrics, the Canadian Paediatric Society, or pre-approved by the Board; (4) Proof of completion of obstetric emergency skills training such as Birth Emergency Skills Training (BEST) or an Advanced Life Saving in Obstetrics (ALSO) course; (5) A photocopy of a high school diploma or a GED certificate; (6) Documentation verifying the applicant has at least minimal practical experience in the provision of prenatal examinations and supervised participation in births, newborn examinations, and postpartum examinations; (7) Proof of current credential as CPM or other credential as permitted by section 17115 of the code, MCL 333.17115; and (8) Proof of passing the national examination required of licensed midwives in this state.	There is no assurance of equivalency among states, especially when applicants may be reviewed for exceptions in education or certification in states without the assurance that equivalency was determined by consistent criteria. Public health and safety may be jeopardized by inconsistent application of equivalency criteria. Consistent with the recommendation for modification to Rule 121, the proposed language for Rule 123 includes additional licensure requirements to ensure completion of basic competencies to ensure the safety of both the mother and child.
R 338.17125 – Relicensure	Include inducements to maintain current licensure. Amend (1)(e) in the table to require completion of the examination if the license has lapsed more than 3 years but less than 7 years. Amend (2) to read as follows: (2) For a midwife who has let his or her Michigan license lapse, but who holds **<u>an equivalent</u>**, current, and valid licensed midwife license in another state:	There is essentially no consequence to not renewing license over a period of nearly 7 years given that the licensing cycle is proposed to be 4 years, and a midwife could allow his or her license to lapse for 2 years and 364 days. In this scenario, the licensee would only need to get fingerprinted, and have 30 hours of continuing education sometime in the last three years prior to applying for relicensure. As a result, a licensee could feasibly go nearly 11 years after initial

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		licensure prior to paying the fee and relicensing, with only 30 hours of continuing education. CPM licensure criteria varies state to state; any licensure in a different state must be equivalent to MI criteria if it is to be considered a basis for licensure in Michigan.
R338.17131 – Definitions	Amend the following definitions to read as follows: "Appropriate health professional" means any 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. "Appropriate pharmacology training" means a minimum of 16 hours of training related to pharmacology applicable to midwifery practice, approved by MEAC or the board. "Transfer" 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). Add the following definition: "Emergency medical services personnel" means an individual licensed as an "emergency medical services personnel" under article 17 of the public health code.	The definition of "appropriate health professional" as proposed in the current draft rule would include every health professional licensed under the Public Health Code, even those with no obstetrical training or training in the practice of medicine or nursing such as dentists, veterinarians, physical therapists, social workers, etc. This definition needs to be narrowed to include physicians, physician's assistants and certified nurse midwives and NPs with experience in the active practice of obstetrics, pediatrics, or emergency medicine as these are the professionals that will be expected to consult with licensed midwives or take over the care of their patients when risk factors present. It is imperative that licensed midwives are collaborating with health professionals that have the appropriate training and experience. The eight hours of training proposed in the definition of "appropriate pharmacology training" in the current draft is not is not sufficient training for the administration of medications to pregnant women and infants. The drugs and medications listed have the potential

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		for severe side effects, highly sensitive responses to reactions, dosages, etc. Neonates and infants have a very small margin of error for overdosing of medication. They are especially vulnerable to severe damage from reactions, dosing. The proposed definition of 'transfer" is intended to provide a stronger legal basis to assure transfer with the least risk of delay due to clear prior agreed upon responsibility. Makes a clear connection and easy reference for the provider. The definition of "emergency medical services personnel" is proposed to be added since forthcoming recommendations include references to emergency medical services personnel.
R338.17132 – Informed Disclosure and Consent	Require the licensee to provide the patient with an informed disclosure and consent process at the inception of care. Require informed consent to be provided in writing. Include the following in the list of items to be disclosed: • Conditions under which consultation, transfer of care, or transport of the patient must be initiated. • Information regarding the midwife's care team. • Whether the licensed midwife has entered into a collaborative relationship with an appropriate health professional and, if so, the names and contact information of those health professionals. Strike 338.17132(4).	This is the standard of care for freestanding birth centers, including their plans for transport, their limits of care and the options for a patient if the patient falls outside of their scope. These are provided to patients in order to facilitate communication and make clear the limits of the location in which they are birthing in addition to the providers scope and the subsequent parental responsibilities. In the case of an emergency, the woman and her family deserve to be communicated with, informed of their options and offered an explanation of the issues.

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338.17133 – Additional informed consent requirements	Amend (1)(b) to read as follows: (b) Fetus in a breech presentation **at the time of discovery if after 34 weeks**. Amend (2) to read as follows: (2) A licensed midwife shall disclose to the patient **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. Amend (4) to read as follows: (4) The licensed 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**. Amend (5) to read as follows: (5) The licensed midwife shall provide the patient with an informed choice document, specific to the patient's situation, which includes the following: (a) **Evidence-based information regarding** the **potential increased risks and benefits associated with the** circumstances listed in subrule (1) of this rule. (b) **Evidence-based information regarding** the **potential increased risks and benefits associated with the** birth outside a hospital setting **when** the circumstances listed in subrule (1) of this rule **are present**. (c) **Evidence-based information regarding medical care** options associated with the circumstances listed in subrule (1) of this rule **together with referral to an appropriate health professional for further discussion** about medical care options, including the risks of cesarean section, both in the current pregnancy and any future pregnancies.	Breech prior to this gestational age is normal and does not require any different care or consult/transfer. References to "personal practice guidelines" are deleted. Guidelines are professional standards of care not personal. Referring to "personal guidelines" implies the capacity for variation which is undesirable in assuring public health and safety. The patient needs to understand the scope of practice attributable to the licensed midwife should the patient's or her baby's condition change to the extent that the licensed midwife would be needing to transfer care. When providing information to assist with shared decision-making and informed consent, it must be balanced and based on evidence not personal philosophy. Medical issues that fall outside of their scope of practice should be addressed by appropriate health professionals.
338.17134 - Consultation and Referral Rule	Retitle to read: "**Required** Consultation and Referral" Suggest that R 338.17134 and R 338.17135 be restructured to better clarify the situations in which consultations, referrals and transfers or care are required and the process for doing so; add a new (2) to separate out conditions related to newborns that may require	The listed symptoms and conditions require clinical judgement and diagnosis and management that are outside the scope of practice of the licensed midwife.

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	consultation or referral; add a (4) to provide further specificity as to action to be taken if the patient refuses referral or advice – See Attachment A. Amend (1) to read as follows: "(1) A licensed midwife shall consult with or refer a patient to an appropriate health professional, and 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:" Amend blood pressure to 140/90 and include an additional parameter of blood pressure to be increased by 30mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure. Under "Antepartum": Add - "hyperreflexia", "new onset pitting edema", "clonus", "rheumatoid arthritis", and "chronic pulmonary disease". Under "Intrapartum": Amend – "Confirmed ruptured membranes without onset of labor after **24** hours." Add – "Fetal heart rate anomalies."	The proposed Rules, as currently written, are unclear as to whether and when a licensed midwife is required to seek a consultation or make a referral. The proposed modification adds specificity to the actions to be taken to avoid delays in care to that may be detrimental to the health of the mother and/or infant. Need to ensure that licensed midwives are following standard guidelines for intermittent auscultation of the fetus.
R 338.17135 - Emergent Transfer of Care	See above suggestion to restructure R 338.17134 and R 338.17135 – See Attachment A. Amend title to read: "Required transfer of care".	The rationale for items under the proposed "required transfer of care" is that these conditions move the pregnancy from a low or normal risk pregnancy into higher risk categories which are more likely to result in complications and the need for medical intervention by an appropriate health professional. Language is proposed to require action to be taken by the licensed midwife when the patient needs to be transported to a hospital to ensure the patient's safety and the expectation that the midwife ensures a smooth transition of care.

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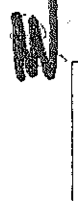
R 338.17136 – Prohibited Conduct	Add the following to the list of prohibitions under Rule 136: (e)(xi) Previous uterine surgery. (f)Pharmacological induction or augmentation of labor or artificial rupture of membranes prior to onset of labor. Previous (g)Cesarean section (VBAC) or myomectomy.	To ensure the safety of the mother and fetus, it needs to be clear that these items are absolute contraindications.
Proposed: R 338.17135A – Transfer of Care Plan	Add a new Rule, R 338.17135A, to identify what is required of a transfer of care plan. A licensed midwife shall create a transfer of care plan that minimally includes the following: (a) Conditions under which the midwife will transfer of 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.	Minimum criteria and expected protocols for the transfer of care plan should be identified in rules. According to the Best Practice Guidelines: Transfer from Planned Home Birth to Hospital, "Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital." It is standard of care for a homebirth to have a second provider for the baby, but protocols should be developed to assure that there is an appropriate level of care for both patients if one needs transport for additional care, especially in emergent situations.
R 338.17136- Prohibited Conduct	Amend (d) by striking "frenulum revisions".	This is not standard within NARM skill set or within NACPM. It requires additional education not addressed in the licensing criteria.



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R 338.17137 – Administration of Prescription Drugs or Medications	Amend (1) to read as follows: (1) A licensed midwife who has appropriate pharmacology training and holds a standing prescription from **<u>a physician or certified nurse-midwife with experience in the active practice of obstetrics</u>**, may, but is not required to, administer the following prescription drugs and medications." Require that any other drugs or medications authorized by the board be added by Rule. Divide Table 1, which is referenced in (2), into two segments - - administration to mother and administration to infant. Add a new (3) to read as follows: (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.	In the interest of patient safety, the physician or certified nurse midwife who issues a standing order needs to have current experience and training in obstetrics. If any additional medications need to be added to the list, they should be added through the rules promulgation process to ensure the opportunity for adequate public review and input. It is important that the medical community be able to publicly comment on the addition of medications to ensure that such additions are appropriate and take into consideration patient safety. Subsection (2) directs licensed midwives to utilize Table 1 for "indications, dose, route of administration, duration of treatment, and contraindications" when administering medications. To reduce confusion and potential for errors with medications which are used for both patients in critically different dosages.
R338.17141 – License renewals; Requirements; Applicability	Require a licensure period of 2 years. Require 25 hours of continuing education prior to renewal that are approved by the board pursuant to those rules during the 2 years preceding an application for renewal and that is inclusive of all of the following: • At least 20 hours - obtaining and maintaining, the credential of CPM from NARM, or an equivalent credential approved. • One hour - pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2). • Two hours - cultural awareness. • One hour - pharmacology applicable to midwifery practice.	Compared with other health professional licensees, 4 years is too lengthy for a licensure period. The purpose is to protect the public. This continuing education proposal is more consistent to that of nurses by requiring at least 25 credits every two years.

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Table 1	Identify the source for this document. As proposed under R 338.17137, divide Table 1, which is referenced in (2), into two segments - - administration to mother and administration to infant. Identify party responsible for ensuring the currency of the Table, as well as timeline for review and updating.	The source for this document is not identified. Only sources that are evidence based should be utilized. Additionally, it is not clear who is responsible for maintaining the document's currency in relation to evolving national standards.
R 338.17141	Establish a 2-year license cycle. Require a minimum of 25 credit hours of continuing education every licensure cycle. Of the 25 hours, 20 be met by obtaining and maintaining, the credential of CPM from NARM, or an equivalent credential approved by theboard by Rule; 1 hour must be related to pain and symptom management pursuant to section 16204(2) of the code, MCL 333.16204(2); Two hours on cultural awareness; and, one hour of continuing education in pharmacology applicable to midwifery practice.	Make the continuing education more consistent to that of nurses by requiring at least 25 credits every two years.

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ATTACHMENT A

R 338.17134 **Required** Consultation and Referral.

Rule 134. (1) A licensed midwife shall consult with or refer to an appropriate health professional, 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:

(a) Antepartum:

(i) Gestational hypertension.

(ii) Blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure.

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

(iv) Persistent symptoms of urinary tract infection.

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

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

(xii) Symptoms of deep vein thrombosis.

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

(xiv) Fetus with diagnosed congenital abnormalities that will require immediate medical intervention at birth.

(xv) Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations.

(xvi) Marked abnormal fetal heart tones.

(xvii) Abnormal non-stress test or abnormal biophysical profile.

(xviii) Suspected intrauterine growth restriction.

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

(xx) Suspected active alcohol use disorder.

(xxi) Suspected active substance use disorder.

(xxii) Sexually transmitted infection.

(xxiii) Symptoms of ectopic pregnancy

(xxiv) Symptoms or evidence of hydatidiform mole.

(xxv) Thrombocytopenia with a count less than 100,000 platelets per microliter.

(xxvi) Vaginal infection unresponsive to treatment.

(xxvii) Symptoms of hepatitis.

(xxviii) Significant hematological disorders or coagulopathies, or pulmonary embolism.

(xxix) Gestation beyond 42 weeks.

(xxx) Hyperreflexia.

(xxxi) New onset pitting edema.

(xxxii) Clonus.

(xxxiii) Rheumatoid arthritis.

(xxxiv) Chronic pulmonary disease.

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(xxxv) Abnormal liver or metabolic panel.
(xxvi) Abnormal PAP test results.
(xxxvii) Chronic pulmonary disease.
(xxxviii) Gestation beyond 42 weeks.
(xxxvii) 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 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over the usual blood pressure.
(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 **24** hours.
(vi) Excessive vomiting, dehydration, acidosis, or exhaustion unresponsive to treatment.
(vii) Uncontrolled current serious psychiatric illness.
(viii) **Fetal heart rate anomalies.**
(viii) 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.
(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.

(2) **A licensed midwife shall consult with or refer to an appropriate health professional, and document the consultation or referral, if the newborn demonstrates any of the following conditions**:

a. **Weight less than 2500 grams or 5 pounds, 8 ounces**.
b. Abnormal metabolic infant screening.
c. Failed hearing screening.
d. Jaundice occurring outside of normal range.
e. Failure to urinate within 24 hours of birth.
f. Failure to pass meconium within 48 hours of birth.
g. Medically significant nonlethal congenital anomalies.
h. Suspected birth injury.
i. Signs of clinically significant dehydration.
j. Signs and symptoms of neonatal abstinence syndrome.
k. **Lethargy.**
l. **Irritability.**
m. **Abnormal crying.**
n. **Poor feeding.**
o. 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.

(3) When a referral to an appropriate health professional is made, after referral the licensed midwife may, if possible, remain in communication with the appropriate health professional until resolution of the concern.

(4) If the patient elects not to accept a referral or an appropriate health professional'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 and whether the licensed midwife will continue or discontinue care of the patient.
(c) If birth is imminent, call 9-1-1 and remain with the patient until emergency services personnel arrive, transfer care, and give a verbal report of the care provided to the emergency medical services providers.

(5) Neither consultation nor referral precludes 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.

R 338.17135 Required transfer of care to an appropriate health professional.
Rule 135. (1) A licensed midwife shall arrange for the orderly transfer of care of a patient to an appropriate health professional if any of the following disorders or situations exit:
(a) Diabetes mellitus, including uncontrolled gestational diabetes;
(b) Hyperthyroidism treated with medication;
(c) Uncontrolled hypothyroidism;
(d) Epilepsy with seizures or antiepileptic drug use during the previous 12 months;
(e) Coagulation disorders;
(f) Heart disease in which there are arrhythmias or murmurs except when, after evaluation, it is the opinion of a physician or certified nurse mid-wife or certified nurse practitioner that midwifery care may proceed;
(g) Hypertension, including pregnancy-induced hypertension (PHI);
(h) Renal disease;
(i) Rh Sensitization with positive antibody titer;
(j) Previous uterine surgery, including a cesarean section or myomectomy;
(k) Indications that the fetus has died in utero;
(i) Premature labor (gestation less than 37 weeks);
(m) Multiple gestation;
(n) Noncephalic presentation at or after 38 weeks;
(o) Placenta previa or abruption;
(p) Preeclampsia;
(q) Severe anemia, defined as hemoglobin less than 9g/dL;
(r) Addison's disease;
(s) Cushing's disease;
(t) Systemic lupus erythematosus;
(u) Antiphospholipid syndrome;
(v) Scleroderma;
(w) Cancer;
(x) Periarteritis nodosa;
(y) Marfan's syndrome;
(z) AIDS/HIV;

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(aa) Hepatitis A through G and non-A through G;
(bb) Acute toxoplasmosis infection, if the patient is symptomatic;
(cc) Acute Rubella infection during pregnancy;
(dd) Acute cytomegalovirus infection, if the patient is symptomatic;
(ee) Acute Parvovirus infection, if the patient is symptomatic;
(ff) Alcohol abuse, substance abuse, or prescription abuse during pregnancy;
(gg) Continued daily tobacco use into the second trimester;
(hh) Thrombosis;
(ii) Inflammatory bowel disease that is not in remission;
(jj) Primary herpes simplex virus, genital infection during pregnancy, or any active genital lesions at the time of delivery;
(kk) Significant fetal congenital anomaly;
(ll) Ectopic pregnancy;
(mm) Rupture of membranes prior to the 36.6 weeks of gestation without active labor.
(nn) Marked or severe hydramnios or oligohydramnios.
(oo) Other diseases and disorders, as determined by the Department;
(pp) 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; or
(qq) The patient requests transfer.

(2) When a transfer of care to an appropriate health professional is made, the licensed midwife may, if possible, remain in communication with the appropriate health professional until resolution of the concern.

(3) A licensed midwife shall arrange immediate transfer of care and transport to a hospital for the following conditions:

(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.

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(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.
(viii) Lacerations requiring repair beyond the scope of practice of the licensed midwife.
(ix) Any other condition or symptom that could threaten the health of the mother as assessed by a licensed midwife exercising reasonable skill and judgment.

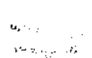
(b) Infant:
(i) Persistent cardiac irregularities.
(ii) Persistent central cyanosis, pallor, or abnormal perfusion.
(iii) Persistent lethargy or poor muscle tone.
(iv) Seizures.
(v) Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.
(vi) Non-transient respiratory distress.
(vii) Significant signs or symptoms of infection.
(viii) Evidence of unresolved hypoglycemia.
(ix) Abnormal, bulging, or depressed fontanel.
(x) Persistent breathing at a rate of more than 60 breaths per minute.
(xi) Temperature persistently over 99.0 degrees Fahrenheit or less than 97.6 degrees Fahrenheit.
(xii) Abnormal crying.
(xiii) Significant evidence of prematurity.
(xiv) Clinically significant abnormalities in vital signs, muscle tone, or behavior.
(xv) Failed critical congenital heart defect screening.
(xvi) Persistent inability to suck.
(xvii) Clinically significant abdominal distension.
(xviii) Clinically significant projectile vomiting.

(4) As required under Rule 3 of this Section, the 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 emergency medical services personnel or an appropriate health professional is completed; provide pertinent information to emergency medical services personnel or an appropriate health professional; and is encouraged to fill out a patient transfer form provided by the department.

(5) Transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services **and the licensed midwife, an appropriate health care professional or emergency medical services personnel accompanies the patient**.

(6) A licensed midwife shall continue to provide care to a patient with any of the complications or conditions set forth in this rule under any of the following circumstances **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):**

a. If no appropriate health professional or other equivalent medical services are available.
b. If delivery occurs during transport.
c. If the patient refuses to be transported to the hospital.
d. If the transfer or transport entails futility, or extraordinary and unnecessary human suffering.



Moore/AWA et al

(7) The licensed midwife may remain in consultation with the appropriate health professional after a transfer is made.

(8) 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.

Moore/ANA et al

Additional Individuals in Support of Joint Letter from American Nurses Association Michigan, Michigan Affiliate of the American College of Nurse Midwives, Michigan Council for Maternal and Child Health, Michigan Council of Nurse Practitioners, Michigan Health & Hospital Association, Michigan Section-ACOG and Michigan State Medical Society

Katherine Gold	MD
Kathleen Johnston-Calati	Program Manager, MPA, MA
Jennifer Schaible	RN, MSN
Elizabeth Leary	MD
Sara Cramton	MD
Chelsea Carver	MD Student
Brendan Conboy	MD
Michelle Konieczny	MD
Christine Matoian	MD
Elizabeth Cousineau	MD
Kelly Wiersema	MD
Lauren Smith	
Kristina VanderMark	MD
Fatemeh Parsian	MD
Christopher Niehues	DO
Christine Pipitone	MD
Angelica Lorenzo	DO
Whitney Nieland	DO
Joseph Rutz	MD, ABOG
Daphne Tumaneng	DO
Sarah Pearl	DO, MBA
Sara Garmel	MD
Ann Gillett-Elrington	MD, PhD, MPH, FACOG
Dawn Robinson	MD
Despina Walsworth	MD, MHSA
Robert P. Lorenz	M.D.
Paige Paladino	DO
James A. Hall	M.D.
Jenny Stimac	CNM
Robert P Roberts, Jr	MD
Laurence Burns	DO
Lynda Grosjean	RNC, PPSN
Samuel Bauer	MD, FACOG
Paul Nehra	MD
Jennifer Veltman	MD
Heidi Grabemeyer-Layman	MD

Moore/AWA et al

Anne Ronk	Associate Chief Nursing Officer
Atinuke Akinpeloye	MD, FACOG
Melanie Beth Schweir	OMS4
Thomas Edward McCurdy	DO
Mehmet O. Bayram	MD FACOG
Sharon O'Leary	MD
Robert F. Flora	MD, MBA, MPH
Michael Swirtz	MD
Penny Cox	WHNP-BC; Maternity APRN
Lena Weinman	DO
Anwar Jackson	MD
Rachel Ford	MD
Andrea Pacheco Arias	MD
Mey Yip	MD
Anushka Magal	MD, MS
Stephanie Menon	MD
Lisa Peacock	MSN, WHNP-BC
Mark G. Lewis	D.O., M.S.
Bryan Popp	MD, Department Chair of St. Joesph Mercy Hospital Ann Arbor

Mulder

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 7:46 AM
To: Ditschman, Andria (LARA)
Subject: FW: Midwifery General Rules (ORR #2018-031LR)
Attachments: Letter to LARA.doc

From: Kathi Mulder <kathi@tcmidwife.com>
Sent: Tuesday, October 30, 2018 7:39 AM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Midwifery General Rules (ORR #2018-031LR)

Mulder

Dance of Life Midwifery,LLC

October 30th, 2018

Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing Boards and Committees Section
PO Box 30670
Lansing, MI 48909-8170

Midwifery-General Rules (ORR #2018-031LR)

Attention: Policy Analyst

I have been a practicing Certified Professional Midwife in the state of Michigan for 28 years. In regards to Public Act 417 of 2016, I support the rules as currently proposed with the following exception: I think the Board of Midwifery needs to revise the list of conditions under rule 134 that a Licensed Midwife should seek consultation from an appropriate health professional.

Respectfully submitted,
Kathi Mulder, CPM
Director and Owner of Dance of Life Midwifery, LLC

134 State Street, Traverse City, MI 49684
(231) 929-3563
tcmidwife.com

Pera

Ditschman, Andria (LARA)

From: BPL-BoardSupport
Sent: Tuesday, October 30, 2018 7:44 AM
To: Ditschman, Andria (LARA)
Subject: FW: Policy Analyst

From: Sandra Pera <sandrapera@att.net>
Sent: Monday, October 29, 2018 10:27 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Policy Analyst

Department of Licensing and Regulatory Affairs

After reviewing the Rules and Regulations, Rule 134.(1) sounds mandatory until the last part of the sentence " in the judgment of the licensed midwife warrant consultation or referral. ", sounds like it is not mandatory. Leaving out the last part of sentence from "conditions" on would alleviate that confusion. Also, wording that the consult is mandatory but the referral only has to be suggested is important.

Practicing in the Upper Penninsula has been very challenging due to lack of health care professionals sympathetic to choices in childbirth including homebirth. I have been practicing 29 years and a couple hospitals are so hostile that it negatively affects the families when trying to obtain needed tests, referrals and/or being transported there. It would be helpful to have a team come with me to address this as well as open doors for services when tests are needed or referrals, as in the Rules and Regulations 134.(1).
Being licensed in Wi since 2008, families have better experiences and I am able to work with the hospitals for those tests and referrals which means better health care for them. I am looking forward to seeing that in the U.P.!

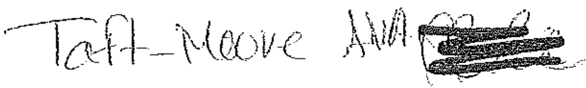
Rule 135.(1) The wording implies mandatory and optional. " ...midwife may transfer care...".and then, "...conditions require immediate.." " May" should be" shall" if it is mandatory.

There could be other phrases to check that I may have overlooked where "shall" could be "may" or visa-versa for clear understanding of the rules.

Thank you for reviewing these suggestions.

Sincerely,

Sandra Pera CPM,LM



Ditschman, Andria (LARA)

From:	Tobi L. Moore <tobi@ana-michigan.org>
Sent:	Tuesday, October 30, 2018 3:25 PM
To:	Ditschman, Andria (LARA)
Subject:	Comments regarding Board of Midwifery
Attachments:	ANA-MI Comments to Part 171.pdf
Importance:	High

Andria, ANA-MI comments.

Respectfully,

Tobi L. Moore, MBA
Executive Director | ANA-Michigan
tobi@ana-michigan.org | www.ana-michigan.org
P: (517) 325-5306

Taft / Moore ANA
~~Moore / Taft ANA~~

July 26, 2018

Andria M. Ditschman, JD
Senior Analyst
Boards and Committees Section
Bureau of Professional Licensing
Michigan Department of Licensing and Regulatory Affairs
P.O. Box 30004
Lansing, Michigan 48909

RE: Comments Part 171 of the Public Health Code, MCL 333.17101 through MCL 333.17123

The American Nurses Association-Michigan (ANA-MI) has review the proposed rules regarding the formation of the Board of Midwifery. We have attached a document that highlights a summary of our editorial comments and suggested recommendations

Respectfully,

Linda Taft, RN

Linda Taft, RN
President, ANA-Michigan

Tobi Lyon Moore

Tobi Lyon Moore, MBA, CAE, CFRE
Executive Director, ANA-Michigan

2501 Jolly Road
Suite 110
Okemos, Michigan 48864
517.325.5306
www.ana-michigan.org

Taft/Moore ~~Moore/Taft~~ ANA

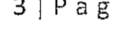
PROPOSED MIDWIFERY RULE	PROPOSED REVISIONS TO BOARD OF MIDWIFERY RULES	RATIONALE, COMMENTS/SUGGESTED CHANGES
p. 3 R 338.17121 Licensees **Rule 121 (3), (6)**	A process determining "equivalency" should be established.	Variation in how equivalence is determined deters from assuring public health and safety in the expectation of practice of a midwife.
p.3 R 338.17123 **Rule 123 (1)**	Remove licensure by "endorsement" when applicant is licensed in another state; "may have been licensed with credential or "equivalent" in another state.	There is no assurance of equivalency among states, especially when applicants may be reviewed for exceptions in education or certification in states without the assurance that equivalency was determined by consistent criteria (see above rationale). Public health and safety may be jeopardized by inconsistent application of equivalency criteria.
p.6 R338.17131 **Rule 131 (b)**	"Appropriate pharmacologic training". What is the evidence that 8 hours is a safe, sufficient amount of training, particularly in consideration of the powerful drugs listed in the table: Administration of Prescription Drugs and Medications.	The drugs and medications listed have potential for severe side effects, highly sensitive responses to reactions, dosages, etc. Neonates and infants have a very small margin of error for overdosing of medication. They are especially vulnerable to severe damage from reactions, dosing. There is need for a provision for updating and credible reference in the Rule for the table. No reference or attribution is provided.

p.6 R338.17131 **Rule 131 (f.)** **"Transfer"**	Clarify definition to include "convey by mutual, written consent, the responsibility for care…. Suggest referencing here "in accordance with national guidelines for safe transfer as indicated in P.A. 417 of 2016 (Section 17117 (1)(e)".	Health and safety of two highly vulnerable populations is the rationale' for this comment. Provides a stronger legal basis to assure transfer with the least risk of delay due to clear prior agreed upon responsibility. Makes a clear connection and easy reference for the provider.
p.7 338.17133 **Rule 133** **(2), (4)**	…..shall practice within the limits of…. Personal practice guidelines. **Recommend change to "professional practice guidelines".** These items are not "practice **guidelines**", but rather qualifications and experiential outcomes.	"Guidelines" are professional not personal. This speaks to the capacity for variation which is undesirable in assuring public health and safety. This is a scope of practice statement under the construct of "that in which the midwife is educated and experienced".
p.8 338.17134 **Rule 134 (1)**	Recommend removal of "in the judgement of the licensed midwife warrant consultation or referral.	The listed symptoms, conditions require clinical judgement and diagnosis and management that are outside the scope of practice of the licensed midwife.
p.10 **Rule 135 (1)**	Clarify "….require immediate notification of _____?" Whom? Is there a transfer plan with a written agreement by the "appropriate health professional" to accept the transfer? The Rule is unclear. "…..may, but is not required to administer the following drugs and medicines";	Specific clear identification avoids delays in care to the detriment of the mother and/or infant.

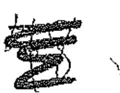
Taft-Moore ~~Moore/Taft~~ ANA

p.10 **Rule 137 (1) (a-g) (2)**	but must assure that they are provided by another appropriate health professional.	Is the licensed midwife required to assure that the needed drugs and medications are **administered**? Lack of clarity and responsibility could lead to missed care and endanger the mother and infant.
Table 1	There is not source for this document. Is it evidence based? Who is responsible to maintaining the currency to meet national standards, updating?	Rules with this amount of specificity for items which are subject to clinical updates, drug recalls, etc. are problematic in that the changes make the Rule obsolete and in need of revision (a lengthy process). Rather, can a document be adopted by reference so that it can be continuously updated and still in alignment with the Rule.

Taft/Moore ~~Moore/Taft~~ ANA



Wells



Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing– Boards and Committees Section
P.O. Box 30670
Lansing, MI 48909-8170

Wednesday, October 24, 2018

Re: Board of Licensed Midwifery proposed rules

To the Board:

I would like the Board to consider these questions and suggestions.

R 338.17125 - Change the references from 3 years to 4 years for consistency in the document. Clarify what continuing education is needed in (d) in the table. Is cultural awareness required? Clarify what happens if the continuing education is determined to not be complete after an application has been submitted.

R 338.17123 – Clarify when someone needs to have a license in another state. Does the license need to be current? In (3) and (4), delete the reference to 17119(2), as that section is not about the CPM credential from NARM or about examinations.

R 338.17127 – Clarify when the English language test requirement is required. Is it only needed once, or each time an application is made? In (ii), clarify "where English is an official language," as that is not always clear.

R 338.17141 – Clarify the time frame when the continuing education must be completed and submitted.

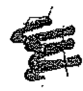
A rule regarding how an applicant gets a temporary license should be added.

I appreciate the opportunity to submit this public comment on the proposed rules for the practice of Licensed Midwifery in Michigan.

Sincerely,

Amy Tracy Wells

Amy Tracy Wells
1941 Cambridge Rd
Ann Arbor, MI 48104

Zoyiopoulos 

Ditschman, Andria (LARA)

From:	BPL-BoardSupport
Sent:	Tuesday, October 30, 2018 1:31 PM
To:	Ditschman, Andria (LARA)
Subject:	FW: Board of Midwifery Rules Comments/Questions

From: Laurie Zoyiopoulos <faithgms@gmail.com>
Sent: Tuesday, October 30, 2018 1:30 PM
To: BPL-BoardSupport <BPL-BoardSupport@michigan.gov>
Subject: Board of Midwifery Rules Comments/Questions

First, I would like to thank the Board of Licensed Midwifery for all they have done to bring us to this point in our licensing process. As I read over the proposed rules I can see all of the hard work and attention to crucial details that have taken place.

I would like to say that I strongly agree with the majority of the proposed rules and feel that these rules closely reflect how I have practiced, as a midwife, for nearly 25 years. I currently consult with many health care professionals, when needed, and this system works very well.

I have recently taken a Pharmacology for Midwives seminar (8 hours/MEAC accredited) and feel quite confident that it was thorough in information and skills needed in my profession.

Since public opinion is encouraged I would like to share my opinion here. I submit the following comments for consideration on the rules set:

R 338.17134, Rule 134, Item 1 (a) (i)
Comment: I would suggest giving the definition of Gestational Hypertension as BP readings of 140/90, or higher, taken 4 hours apart.

R 338.17134, Rule 134, Item 1 (a) (xxv)
Question: Could 42 weeks be defined as 42 completed weeks?

R 338.17134, Rule 134, Item 1 (a) (xxxv)
Question: Would this be better defined as Bacterial Vaginal infection unresponsive to treatment?

R 338.17134, Rule 134, Item 1 (c) (i)
Question: Could this be defined as "Failure to void bladder within six hours of birth or catheterization"?
Comment: The need for the midwife to use a straight catheter in the immediate postpartum period is not rare and thus the mother may not void on her own until a few hours after this procedure, which could then be beyond 6 hours postpartum.

R 338.17135, Rule 135, Item 6
Comment: I am happy to see this addressed because all too often a midwife has been treated as only a support person to the patient and when those are limited a patient has had to decide between her partner, family member, and/or her midwife. A midwife should be counted as part of the care team and allowed to be present if the patient desires it.

Thank you for your consideration on these comments and questions.

Sincerely,

Zoyiopoulos

Laurie Zoyiopoulos, CPM

8295 18 Mile Road
Marion, MI 49665
231-388-0981

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

MEMORANDUM

TO:	**Cheryl Pezon, BPL Director**
FROM:	**Kim Gaedeke, LARA Chief Deputy**
CC:	**Orlene Hawks, LARA Director**
	Adam Sandoval, LARA Deputy Director
	Courtney Pendleton, LARA Exec. Assistant Director/Transparency Officer
DATE:	**March 26, 2019**
RE:	**Midwifery DRAFT Rules**

In follow-up to the transmittal of the Board of Midwifery rules that were passed and adopted by the Board on March 7, 2019 and given to me for Director Hawks to consider and approve, please find the final draft version with the inclusion of two more edits.

Below is an explanation of the two additional edits that the Director has approved of for inclusion to be part of the final draft rule set to be moved to the next phase of the rule promulgation process for JCAR consideration:

<u>R. 338.17134 Consultation and Referral (pages 10-11)</u>

Page 10 – Replace 43 weeks with 42 weeks so it reads as follows:

- (xxvi) Gestation beyond **42** weeks.
    a. When the draft rules were considered during the public hearing and public comment period, the original draft established the gestation period of 42 weeks and not 43. During the public comment period, there were written comments expressing concern about the 42 weeks and it was expressed that the gestation period should be reduced to 41 weeks. Despite this recommended change, the Board decided to amend the rules to 43 weeks which is arguably a significant of a change from the original 42 weeks as previously proposed.
    b. Additionally, in looking over what other state's have in place for rules or statute, most go with 42 weeks. The health care providers while advocating for 41 weeks as ideal during the public comment period are okay with the 42 weeks (versus 43 weeks) as previously proposed in the draft rules prior to the public hearing.

Page 12 – Replace 72 hours with 24 hours so it reads as follows:

- (iv) Confirmed ruptured membranes without onset of labor after **24** hours.

These recommendations are based on best practices and medical evidence for protecting the health, safety and welfare of the baby and the mother. The intent of the legislature for licensing

the practice of Midwifery was to have processes in place that protects the health and safety of the patients and gives LARA the ability to take appropriate action if a licensed Midwife is found to be in violation of the statute and/or administrative rules.

Specifically, based on a 2014 article from the American Academy of Family Physicians written by Mary Wang, MD from the University of California and Patricia Fontaine, MD, MS with the HealthPartners Institute for Education and Research, they note the following:

> "*Pregnancy is considered late term from 41 weeks, 0 days' to 41 weeks, 6 days' gestation, and postterm at 42 weeks' gestation.*

The same article also referenced:

> "*A 2012 Cochrane review of 22 trials with a total of more than 9,000 women compared induction of labor at 41 weeks' gestation with expectant management. It showed that induction at 41 weeks was associated with fewer perinatal deaths*."

In general, there are higher risks with going to postterm or late-term at 42 weeks and beyond without having further consultation or understanding of those risks to the patient. When a patient is willing to go beyond the 41 weeks, it is important to manage appropriately.

During the discussion that occurred with the Board Rules Committee on February 15, 2019, one of the board members tried to explain the rationale for having the consultation and referral to occur at 43 weeks, but when one of the medical doctors from the University of Michigan asked if this was based on medical evidence, an answer could not be provided.

The second recommended change to the current draft rules where the licensed midwife would be required to consult or make a referral to the appropriate medical clinician is related to when the membrane has broken. Currently the draft rules suggest waiting until 72 hours, based on the input and feedback from the health care providers along with medical standard of care, the consultation and/or referral should be made at least 24 hours after it is confirmed the membrane has broken.

Monitoring the fluids once this has occurred is critical to prevent harm to the baby and mother. Additionally, states that license midwives, on average require consultation between 12 or 24 hours after the membrane breaks. In an article written by The American College of Obstetricians and Gynecologists, dated February 2017, it references consultation and management at 12-24 hours after pre-labor rupture of membranes and risks associated with exceeding this timeframe, primarily infection.

Again, for both of these changes, it is only requiring the licensed midwife to seek consultation and/or refer the patient based on medical best practices and to minimize the risks to the mother and baby. It was stated during the February 15, 2019 stakeholder meeting with the Board Rules Committee that a midwife would not have the appropriate equipment or technology to monitor certain medical situations which is why obtaining proper consultation or referring the patient to the hospital is important in certain situations.

The attached draft rules with the recommended changes made by the Board on March 7, 2019 along with the two additional items, highlighted in blue for quick reference, are approved by Director Hawks. These changes are in line with the legislative intent of the law to provide for a licensing and regulatory program of this profession to help safeguard and protect the health, safety and welfare of our Michigan residents. The authority granted to the Department Director to approve the draft proposed rules during the rule promulgation process is based on MCL 333.17112, 333.17117, 333.16145 and 333.16175.

Please let me know if you have any questions and/or need additional information.