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.

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,

Tobi L. Moore, Executive Director
American Nurses Association Michigan

Emily Dove-Medows, CNM, President
Michigan Affiliate of the American College of Nurse Midwives

Amy U. Zaagman, Executive Director
Michigan Council for Maternal and Child Health

Gretchen Schumacher, PhD, GNP-BC, FNP, NP-C, President
Michigan Council of Nurse Practitioners

Chris Mitchell, Senior Vice President, Advocacy
Michigan Health & Hospital Association

Matthew Allswede, MD, FACOG, Chair
Michigan Section - American College of Obstetricians and Gynecologists

Betty S. Chu, MD, MBA, President
Michigan State Medical Society

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