

Summary of Information and Recommendations

Midwifery Scope of Practice Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The Washington State Legislature's intent, as stated in Chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act (RCW 18.120.010) says a health care profession should be regulated, or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public can't be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered, as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.¹ A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

¹ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistants – certified, home care aides, and pharmacy technicians.

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PREFACE

For easy reference, these acronyms are used in this document:

AMCB	American Midwifery Certification Board
ARNP	Advanced registered nurse practitioner
AWHP	Association of Washington Healthcare Plans
CNM	Certified Nurse-Midwife [®]
ICM	International Confederation of Midwives
LBC	Legislative Budget Committee (now Joint Legislative Audit and Review Committee, or JLARC)
LM	Licensed midwife
MANA	Midwives Alliance of North America
MAWS	Midwives' Association of Washington State
NARM	North American Registry of Midwives
RCW	Revised Code of Washington
UW	University of Washington
WAC	Washington Administrative Code
WHO	World Health Organization

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EXECUTIVE SUMMARY

Background and Proposal

The Midwives' Association of Washington State describes a midwife as “a health professional who provides holistic health care to a childbearing woman and newborn. Licensed midwives work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. Licensed midwives are required by law in Washington state (RCW 18.50.010) to consult with a physician regarding the client’s care,” when there are significant deviations from normal during the pregnancy, labor, or postpartum period.

Licensed midwives are regulated under chapter RCW 18.50 and chapter WAC 246-834. In addition, student midwives are permitted under WAC 246-834-160. This sunrise review doesn't address certified nurse-midwives regulated under RCW 18.79 and WAC 246-840.

On May 23, 2013, the House Health Care and Wellness Committee asked the Department of Health (department) to review a proposal that would *change* the statutory scope of practice for licensed midwives. The modification would include the provision of medical aid to an infant up to two weeks of age, and assess whether the proposal meets the sunrise criteria for a scope of practice *expansion*. The legislative request included draft bill H-2588.1/13, which proposed the following amendment to RCW 18.50.010:

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her infant up to two weeks of age or who shall advertise as a midwife by signs, printed cards, or otherwise...”

Recommendation

The department has determined that the proposal meets the sunrise criteria and is in the public interest. We recommend the legislature enact the proposal with the following changes:

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her newborn infant up to two weeks of age, or who shall advertise as a midwife by signs, printed cards, or otherwise. The care to be included within “medical aid” shall be defined by the secretary in rule. Nothing shall be construed in this chapter to prohibit gratuitous services [or to require licensure under this chapter of other regulated professionals whose scope of practice includes such services]. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the ~~infant~~ newborn.”

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SUMMARY OF INFORMATION

Background

The Midwives' Association of Washington State describes a midwife as “a health professional who provides holistic health care to the childbearing woman and newborn. Licensed midwives work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.”

Washington began regulating midwives in 1917 under RCW 18.50. The statute was revised in 1981 to incorporate standards for midwifery education and other amendments. Vagueness and lack of scope definition in chapter 18.50 were cited in a 1980 review by the University of Washington's (UW) School of Public Health and Community Medicine and again in a 1986 sunset review of midwifery regulations.

There are three types of regulated midwives in Washington:

- Licensed midwives regulated under chapter 18.50 RCW and chapter 246-834 WAC;
- CNMs regulated as a subset of advanced practice registered nurses (ARNPs) under chapter 18.79 RCW (generally) and chapter 246-840 WAC;
- Student midwives, who can function under either licensed midwives or CNMs per WAC 246-834-160.

Licensed midwives are sometimes referred to as “direct-entry” midwives² in the sense that they have entered the field directly and not via the nursing profession. Certified nurse-midwives have a different scope of practice than licensed midwives. They can provide a broader scope of care and have broad prescriptive authority. However, certified nurse-midwives often work in hospital settings where care of the newborn is provided by a neonatal nursery.³ This review examines the scope of practice for licensed midwives, not certified nurse-midwives, while recognizing there is a relationship between the two. As of July 1, 2013, there were 124 direct-entry midwives licensed in Washington.

Proposal for Sunrise Review

On May 23, 2013, the House Health Care and Wellness Committee asked that the department do two things: (1) consider a sunrise review application for a proposal that would *change* the scope of practice for licensed midwives to include the provision of medical aid to an infant up to two weeks of age; and (2) assess whether the proposal meets the sunrise criteria for a scope-of-practice *expansion*. (See Appendix B). The legislative request included draft bill H-2588.1/13, which proposed the following amendment to RCW 18.50.010:

² Not to be confused with doulas, who are unregulated. A doula's functions in respect to newborn care may intersect with some aspects of midwifery care; however, those functions are non-medical. They do not include clinical or medical tasks such as examining the mother or baby or other postpartum clinical care.

³ Testimony by MAWS at the public hearing.

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her infant up to two weeks of age or who shall advertise as a midwife by signs, printed cards, or otherwise...”

The applicant has stated that the proposal is a *clarification* to the scope of practice for licensed midwives’ care of infants. Also, during the public hearing, it was noted that the verbiage of the amendment included in the the Midwives’ Association of Washington State presentation differed from the draft legislation, H-2588.2/13. The two-week time period was not included and “newborn” was substituted for “infant” in the proposed addition to RCW 18.50.010:

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages and to her newborn or who shall advertise as a midwife by signs, printed cards, or otherwise. ...”

The Midwives’ Association of Washington State application itself doesn’t specify proposed language to define “newborn” but refers to a two- to six-week time period and asks that the scope of practice be explicitly addressed. (See Appendix A). The Midwives’ Association of Washington State hearing presentation asked that the scope be addressed in rule, “rather than delineated in statute.” At the hearing, the applicants were informed that the department must respond to the proposal as it was referred by the House Health Care and Wellness Committee.

Public Participation

The department shared the proposal with interested parties and began accepting written comments in June 2013. A public hearing was held on Aug. 9, 2013, in Tumwater. Written comments were accepted through Aug. 9, and there was an additional comment period after the hearing through Aug. 19. (See Appendix D for public hearing transcript and Appendix E for written comments).

In Support

We received comments from representatives of the Washington State Midwifery and Birthing Center Joint Underwriting Association, which provides liability insurance for midwives. The group provides resources for developing midwifery practice documentation, including practice guidelines with indications for consult and transfer clearly called out.

We heard from a medical billing provider who bills for midwives that all third-party payers have been paying for newborn care. Typically, she doesn’t bill for care to newborns over two weeks of age except for special circumstances.

We received comments from 37 parents who shared positive experiences working with midwives, both in terms of delivery and postpartum care. Many emphasized the value of home visits in resolving issues like sleep and feeding problems. Some stories told of licensed

midwives catching problems that may have gone undetected, or detected much later, if their child hadn't been cared for by a licensed midwife.

The Advanced Registered Nurse Practitioners' United of Washington State, the professional association representing certified nurse-midwives, nurse practitioners, and nurse anesthetists, supports "explicitly including the care of newborns in the licensed midwives scope of practice." The organization stated that licensed midwives are trained to assess and manage newborn care and that rigorous licensure requirements assure high standards. It also stated that licensed midwives have a history of providing newborn care and know when to consult or refer.

We heard from 18 licensed midwives and other licensed health care professionals in support of the proposal, affirming that licensed midwives have the education and training to care for newborns. Many shared the value of home birth for the mother and baby.

In Opposition

We received one letter in opposition to the proposal. The officials from the Association of Washington Healthcare Plans wrote that they have significant concerns with the proposal, stating the change is an expansion of midwives' current scope, not a clarification. The Association of Washington Healthcare Plans cited patient safety and quality of care issues, because infants are at the highest risk of complications such as newborn infections, metabolic disorders, jaundice, etc. The association officials wrote that newborns should be cared for in this high-risk period by a trained medical doctor. They indicated concerns that the expansion is not consistent with midwifery training and licensure. The organization also stated that there may be an increase in the number of complications and associated costs.

Audrey Levine, a practicing LM in Olympia and former president of the Midwives' Association of Washington State, called the association's concerns unfounded.

Education and Training

To be licensed as a direct-entry midwife today, an applicant must:

- Complete high school or a GED (RCW 18.50.040(1) and WAC 246-834-060(2));
- Attain a certificate or diploma in midwifery from an approved school (RCW 18.50.040(1) and WAC 246-834-060(2));
- Complete a minimum period of midwifery training for at least three years, including basic nursing skills (RCW 18.50.040(2)(a) and WAC 246-834-140(1)). Under certain circumstances, this period may be reduced to two years;
- Have studied obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule (RCW 18.50.040(2)(b) and WAC 246-834-140);

- Acquire clinical practice as a student in midwifery, including care of at least 50 women in prenatal, intrapartum, and early postpartum periods (RCW 18.50.040(2)(c) and WAC 246-834-140);
- Observe an additional 50 women in the intrapartum period (RCW 18.50.040(2)(d));
- Submit the application materials specified in RCW 18.50.040(1) and WAC 246-834-060; and
- Pass both the midwifery examination offered by the North American Registry of Midwives and the Washington state-specific component examination no more than two years prior to applying for a Washington license (WAC 246-834-050).

There are also provisions for alternate licensure tracks, such as those transferring from another state with substantially equivalent standards, and a permit for student midwives.

The original 1917 statute required testing on the following aspects of newborn care:

“hygiene of...infant; asphyxiation, convulsions, malformation and infectious diseases of the new-born; causes and effects of ophthalmia neonatorum; abnormal conditions requiring attention of a physician; and requirements of the...rules of the state board of health relative to ophthalmia neonatorum or other infectious diseases of the new-born.”

State-administered testing has been replaced by the North American Registry of Midwives exam. The registry’s requirements to qualify for the examination include “didactic and clinical experience. ... The clinical experience includes...newborn care by a student midwife under supervision.” Candidates must have attended and functioned in the role of primary midwife under supervision for a specified number of births, including newborn exams. Candidates must possess an infant or neonatal resuscitation certification. Thirty-five percent of the exam content is comprised of labor, birth and immediate postpartum questions (123); 15 percent, postpartum questions (54); and five percent, well baby care (16 questions). The bulk of newborn care knowledge is covered by these sections, but other portions of the test (midwifery counseling, education and communication and general healthcare skills) also address aspects of newborn care. A skills assessment test accompanies each of these topical areas.

Seattle’s Bastyr University, a state-accredited midwifery program under RCW 18.50.045, includes courses in newborn care – such as identifying jaundice and other diseases, genetic screening, and neonatal eye prophylaxis. The school’s practicum also includes a variety of clinical settings and participation in numerous births and newborn examinations.

In addition to state licensure, the American Midwifery Certification Board may also grant the Certified Midwife® or Certified Professional Midwife® certifications, but these are not required for licensure in Washington, nor do they eliminate the need for state licensure.

Current Regulation

There are two separate paths one might take to practice legally as a midwife in Washington, either as a licensed midwife or as a certified nurse-midwife.⁴ However, this review only focuses on licensed midwives.

Direct-entry midwives are regulated under chapter 18.50 RCW and chapter 246-834 WAC. A clear scope of practice is not set in statute or rule for licensed midwives. The department interprets the scope as being inferred from the entirety of the RCW and WAC, with various aspects of the scope stated or implied throughout.

Under current laws and rules, licensed midwives are authorized to provide limited newborn care services:

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant.” (RCW 18.50.010)

“Every licensed midwife shall develop a written plan for ... transport of an infant to a newborn nursery or neonatal intensive care nursery...” (RCW 18.50.108)

“A midwife licensed under this chapter may obtain and administer prophylactic ophthalmic medication [and] vitamin K...” (RCW 18.50.115)

“Licensed midwives may purchase and use legend drugs and devices as follows:...neonatal... resuscitation equipment... . In addition to prophylactic ophthalmic medication...vitamin K...licensed midwives may obtain and administer the following medications: ...HBIG and HBV for neonates born to hepatitis B+ mothers...” (WAC 246-834-250)

Additionally, the laws and rules require that midwifery schools provide instruction and that midwives be schooled in newborn care:

“Each school must ensure that the students receive instructions in the following instruction area: (a) Instruction in ... neonatology...” (WAC 246-834-140)

“[Midwifery] candidate[s] shall meet the following conditions: ...Meeting minimum educational requirements which shall include studying...neonatal pediatrics...[and] neonatology...” (RCW 18.50.040)

⁴ The 1986 sunset review recognizes a third pathway of lay midwives who do not receive compensation, and the 1980 UW study acknowledges five pathways (including nurses and physicians). Although accurate, they are not included here as they are outside the definition of “practice of midwifery” included in state law, and the scope question does not apply to them.

This demonstrates that a degree of care to newborns already exists within Washington midwives' scope of practice. However, the existing licensed midwife scope is vague. The midwife is required to consult about "significant deviations from normal." This would require a newborn assessment to determine normalcy. However, "significant deviations from normal" is not defined. It's also unclear whether the assessment for normalcy means merely upon birth, or if it also applies to assessments at subsequent check-ups; and what actual tasks are involved in the assessment.

The law is silent on whether the midwife is authorized to carry out direction from the physician when consultation is required. It's logical to assume that the midwife would carry out neonatal resuscitation, if necessary, and activate the required written plan for newborn transport as appropriate to the situation. The administration of prophylactic eye drops or ointment, vitamin K, and a specific inoculation by the midwife is permissive but not mandatory.

Standard of Care and Current Practice

NARM espouses the Midwives Alliance of North America *Core Competencies for Care During Labor, Birth and Immediately Thereafter*. As related to newborn care, Midwives Alliance of North America competency areas include:

- Provision of health care to the newborn during the postpartum period and support and information to parents regarding newborn care;
- Determination of the need for consultation of referral as appropriate; and
- Functioning from a foundation of knowledge and/or skill which includes:
 - Anatomy, physiology and support of the newborn's adjustment during the first days and weeks of life;
 - Parameters and methods for evaluating newborn wellness, including relevant historical data and gestational age;
 - Nutritional needs of the newborn;
 - Community standards and state laws regarding indications for, administration of and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period; and
 - Causes of, assessment of, appropriate treatment and emergency measures for newborn problems and abnormalities.

In addition, the department reviewed principles, guidelines, position statements, standards, and other resources to determine regulatory intent and breadth of scope. These included the World Health Organization (WHO), International Confederation of Midwives, Citizens for Midwifery, and the National Association of Certified Professional Midwives. Our review revealed that most of these organizations promote a highly flexible, individualized model in which scope might vary not only from practitioner to practitioner, but also depending on each client's particular needs and desires. Some specifically call out newborn care, while others are more inferential. The International Confederation of Midwives recognizes the scope of midwifery practice to include "support, care and advice during pregnancy, labour and the

postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant.”⁵

The Midwives' Association of Washington State has provided its position statement, *Statement Regarding the Provision of Care to Newborns by Licensed Midwives*, as its customary standard of care in relation to newborns born with midwives in Washington. Some functions “float” between being maternal and newborn in nature, reflecting on hearing testimony about the “mother-baby dyad.” For example, bonding and breastfeeding initiation tasks involve both mother and baby.⁶

Depending on whether these interdependent mother-baby functions are characterized as newborn services or services to the mother, they may or may not be viewed as being within scope. Almost every source references these functions as a cornerstone of midwifery services, and they clearly serve the mother as well as the baby. Acknowledging newborn care tasks like these within the midwifery scope would extend the reach and value of the breastfeeding campaign and other health promotion efforts.

The state requires newborn screening tests for phenylketonuria (PKU) and certain other metabolic diseases for babies born in hospitals.⁷ (Chapter 70.83 RCW) Metabolic testing is accomplished using what is commonly called a “heel stick,” where the baby's heel is pricked and several drops of blood collected. After performing the heel stick, the practitioner sends the dried blood specimen to the Washington State Newborn Screening Laboratory for analysis. The lab results are conveyed to the practitioner, who would then refer appropriately if result(s) are out of range. Currently, there are 29 disorders that are included in the newborn screening.

Though screening is not mandated for midwife-assisted births, staff in the department's Newborn Screening Program indicated that their efforts are guided by RCW 70.83.010, which states:

“It is hereby declared to be the policy of the state of Washington to make every effort to detect as early as feasible and to prevent where possible phenylketonuria and other preventable heritable disorders leading to developmental disabilities or physical defects.”

Midwives' education and training includes heel sticks, and “newborn metabolic screening” is among the items they are tested on. The Newborn Screening Program maintains that performing this screening has historically been within midwives' practice. The program said that it's *critical* that it remain so, because a key characteristic of the screened conditions is that there is often no clinical indication that a child is affected until it's too late, possibly

⁵ <<http://www.internationalmidwives.org/assets/uploads/documents/Definition%20of%20the%20Midwife%20-%202011.pdf>>

⁶ Breastfeeding initiation relates to current public health priorities. The department, together with WithinReach and the Breastfeeding Coalition of Washington, is engaged in the “Baby-Friendly Ten Steps to Successful Breastfeeding” campaign in every hospital in Washington that provides maternity services.

⁷ The “hospital” language was inserted into law in 1976 (1975-76 2nd ex.s. c 27 § 1) at a time when interest in home birthing was just beginning to spur and when most or all births did occur in hospitals.

resulting in permanent disability or death. The program actively encourages screening by midwives through actions such as working with Medicaid to ensure midwives perform the screening for their clients and including midwives in its provider directory.⁸

Midwives also conduct newborn hearing screenings. This isn't a life-or-death issue as with metabolic screening, but it illustrates how the standard of care has evolved⁹ since the early 1900s when state regulations of midwifery came into being. In 2008, the department's Early Hearing-Loss Detection, Diagnosis, and Intervention Program observed that most infants delivered by midwives at home or in free-standing birth centers weren't receiving newborn hearing screenings. The program conducted a pilot project to extend hearing screenings to midwife-assisted births and concluded that newborn hearing screening by licensed midwives was successful. In 2011, the Board of Hearing and Speech submitted a statement of support for the efforts to include licensed midwives in these screenings, and the Midwifery Advisory Committee¹⁰ found no conflict with the LM scope of practice.

Regulation in Other States

Regulations of selected other states were reviewed to determine if they define the practice of midwifery and, if so, what it says about newborn care. Our review included statutes and administrative rules or codes for Alaska, Arizona, Florida, Idaho, Minnesota, Montana, New Mexico, New York, Oregon, South Carolina, and Wyoming. (See Appendix F.) These regulations related to direct-entry midwives, not CNMs, with one exception. New York's regulations apply equally to both licensed midwives and CNMs (noting that one must still have ARNP licensure for the latter category).

Oregon originally began regulating midwives in 1993, long after Washington. Even then, licensure was not mandatory. Its regulations are currently in flux, as its statute was just modified during the 2013 legislative session (House Bill 2997-C) with rulemaking still to come. In addition to other changes unrelated to this review, the bill changes the terms of ORS 687.405 to add "providing the following services *for compensation*" and includes "newborn assessments" in its definition of "direct entry midwifery (emphasis added)."

The majority of the other states reviewed use a practice definition that's similar to Washington's statutes. Most of the definitions of midwifery practice incorporate newborn care, some more clearly than others. Numerous states have taken the approach of organizing midwifery scopes of practice by periods of time in the spectrum of pregnancy care (i.e., antepartum, intrapartum, postpartum, and newborn care – perhaps using slightly different

⁸<<http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/NewbornScreening/NBSProviderDirectories.aspx>>

⁹ The National Institute on Deafness and Other Communication Disorders of the National Institutes of Health offers a good retrospective on the evolution of newborn hearing screening as a care standard at <<http://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=104>>, and the U.S. Preventive Services Task Force's recommendation that it become a standard may be viewed at <<http://www.uspreventiveservicestaskforce.org/uspstf08/newbornhear/newbhearrs.htm>>.

¹⁰ The Midwifery Advisory Committee is authorized by chapter 18.50 RCW to provide advice and recommendations to the secretary but is not the regulatory authority for licensing or disciplining LMs.

terms, but typically broken down along these lines). States that have the most encompassing scopes for newborn care also incorporate more detailed scopes for these other gestational periods, but that information is not included for this purpose.

Additional Issues to Consider

Medical aid

The term “medical aid” in RCW 18.50.010 has never been defined. Lacking definition, this term may be construed broadly and could imply a wide scope of functions. The Midwives’ Association of Washington State has indicated that it interprets “medical aid” to include the activities shown in its “customary care” list.¹¹

Use of “infant” rather than “newborn”

WHO defines a newborn as a child less than 28 days of age, adding that “during these first 28 days of life, the child is at highest risk of dying. It is thus crucial that appropriate feeding and care are provided during this period, both to improve the child’s chances of survival and to lay the foundations for a healthy life.” The “infants” that would be addressed under the proposed bill language are newborns. The department recommends the use of “newborn” rather than “infant” for this proposal, but limiting midwife care to newborns up to two weeks of age.

Defining “significant deviation from normal”

In the statutory definition of midwifery (RCW 18.50.010), midwives are directed to consult with a physician whenever there are “significant deviations from normal” in either the mother or the infant. However, this term isn’t defined, leaving when an LM is required to consult and/or authorized to provide care to the mother and newborn open to interpretation by the individual midwife. The Midwives’ Association of Washington State provides guidelines for when to consult and transfer, but it’s just the association’s interpretation; not all Washington licensed midwives are members of the association.

¹¹ <<http://www.washingtonmidwives.org/documents/MAWS-position-statement-Newborn-Care-by-LMs.pdf>>

Defining practice of midwifery in terms of “for a fee or compensation”

Pursuant to RCW 18.50.010, midwives must be licensed if they “provide medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages...”

Because the clause references services to the birthing mother *only*, the question has been raised of whether licensed midwives are currently authorized to charge for newborn care otherwise allowed within the scope. The Midwives’ Association of Washington State raises this as an issue in relation to third-party payors, referencing an example in which Premera reportedly audited a midwife’s billing and sought a refund for newborn care.

It seems likely this language stems from the times in which legislation was originally adopted, in an effort to differentiate between “commercial” midwives and birthing assistance rendered by family members, neighbors, or religious practitioners (the latter specifically exempted by RCW 18.50.030). In the early 1900s, there was a much greater likelihood of lay persons attending to births, particularly in rural parts of the state. RCW 18.50.010 still includes the original 1917 statement that “Nothing shall be construed in this chapter to prohibit gratuitous services.” The 1986 sunset review of midwifery regulations considered this specific language and similarly related it to lay midwives and rural service availability.¹²

¹² The scope of this review does not include evaluating the wisdom of a continued exemption for lay midwives.

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act (chapter 18.120 RCW) doesn't specifically address a proposal to modify or expand a profession's scope of practice. RCW 18.120.010(2) states that when considering regulating health professions for the first time, the profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First criterion: Unregulated practice can harm or endanger health or safety.

This criterion doesn't apply.

Midwifery is already a regulated profession, and the proposal would clarify the existing scope of practice in response to ambiguities. This proposal would offer midwives increased clarity as to what is and isn't. Without this clarification/scope change, the ability of licensed midwives to provide continuity of care to the mother and newborn may be jeopardized.

Second criterion: Public needs will benefit from assurance of professional ability.

This criterion is satisfied.

The level of education and training required of midwives in order to attain licensure already requires them to be knowledgeable about newborn care. Their licensure examination tests their proficiency in this care. The exact nature of the newborn care could be further defined in rule.

Third criterion: Public protection cannot be met by other means in a more cost-beneficial manner.

This criterion is satisfied.

Public protection is already in place with current midwifery regulations. Given that the question of newborn care appears to be spurred by insurance concerns, clarifying the existing scope could aid the public by addressing an issue that could otherwise enable third-party payers to decline payment for specific services rendered by midwives. Clarifying what newborn care tasks midwives are authorized to perform in rule will alleviate confusion and inconsistency in midwifery practice in Washington.

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DETAILED RECOMMENDATION TO LEGISLATURE

The department recommends that the legislature enact the proposal with the following changes to the draft bill:

“Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her newborn infant up to two weeks of age, or who shall advertise as a midwife by signs, printed cards, or otherwise. The care to be included within “medical aid” shall be defined by the secretary in rule. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or ~~the infant~~ newborn.”

Rationale:

- *There is no clearly defined scope of practice for Washington licensed midwives. Strict interpretation of existing statute and rules could negatively impact the availability of timely, crucial care that would not otherwise be provided outside the hospital setting, such as newborn metabolic and hearing screenings.*
- *Some newborn care tasks by midwives are already authorized. Although limited and subject to interpretation, certain newborn services are currently allowed.*
- *The proposal codifies the standard of care already being provided, and for which licensed midwives are trained through classroom and clinical hours and tested on in the North American Registry of Midwives examination.*
- *The interdependent nature of the mother/baby relationship creates an expectation for the midwife to provide continuity of care for both mother and baby in the period immediately after birth.*
- *In a home birth, the licensed midwife is often the only health care provider caring for the newborn prior to the infant’s first pediatric appointment.*
- *The term “newborn” is more appropriate for the first two weeks of life.*
- *Defining the tasks in rule will allow broad stakeholder participation and flexibility as the standards continue to evolve.*

In recommending language regarding rulemaking to clarify the definition of “medical aid,” the department recognizes the importance of working collaboratively with both the Midwives’ Association of Washington State and the Midwifery Advisory Committee. The association has already provided its statement on provision of care to newborns which sets out a framework for what may be considered during the rulemaking process.¹³ However, the department can’t rely on the existence of this association document alone for two reasons. First, standards and definitions must be in rule to be enforceable. Second, not all licensed midwives in Washington are members of the Midwives’ Association of Washington State or embrace the association’s resources, guidelines or standards. It’s vitally important that all midwives in the state are held to the same scope of practice and standard of care.

¹³ <<http://www.washingtonmidwives.org/documents/MAWS-position-statement-Newborn-Care-by-LMs.pdf>>

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REBUTTALS TO DRAFT REPORT

The department shared draft recommendations with interested parties and invited comments before finalizing the report. We received three letters of comment, which are included in their entirety below.

Valerie Sasson, The Midwives' Association of Washington State President; Elias Kass, The Midwives' Association of Washington State Treasurer; Audrey Levine, The Midwives' Association of Washington State Legislative Chair; Sunrise Review Applicants

“The Midwives' Association of Washington State celebrates the Department of Health's draft sunrise review report regarding the provision of newborn care by licensed midwives. We are grateful that we will be able to continue the care we have been safely providing to newborns for 35 years. For the most part, we agree with the Department's recommendations with the following exceptions:

With regard to the recommendation that the medical aid rendered to newborns by licensed midwives be defined in rule, we support the inclusion of general clinical expectations, but do not support putting specific clinical requirements in rule. Evidence changes frequently and clinical guidelines must be able to adapt accordingly and revisions should be within the purview of the professional association. Presumably this is one of the reasons that other health professions do not consistently have their clinical guidelines spelled out in rule. Appropriate general clinical guidelines might include the expectation of assurance that the baby is feeding and gaining well and is not experiencing pathologic jaundice, as well as references to requirements that already in law, such as newborn screening.

The Midwives' Association of Washington State appreciates the Department of Health's thoughtful work in synthesizing all of the input that the department received during the sunrise review.”

Department Response

The department did not make any changes in response to this rebuttal. This sunrise review was initiated in response to the lack of a clearly defined scope of practice for licensed midwives. Defining the tasks in rule will ensure all midwives in Washington are held to the same scope of practice and standard of care. It will also allow broad stakeholder participation and flexibility to update the scope of practice as standards continue to evolve.

R.W. Crothers, Rph, PharmD

I would advise that this category not be allowed to prescribe medicines (prescriptions).

Department Response

The department did not make any changes in response to this rebuttal. Licensed midwives have a very limited authority to administer drugs, and that authority was not the subject of this review.

Sydney Smith Zvara, Executive Director, AWHP

“On behalf of Association of Washington Healthcare Plans (AWHP) member healthcare plans, thank you for the opportunity to comment on the Department of Health’s (DOH) draft sunrise review report of a proposal to change the scope of practice for midwives to include the provision of medical aid to an infant up to two weeks of age.

Healthcare Plans recognize and respect the dedication of Licensed Midwives and value the care they provide expectant and new mothers. We also appreciate that pleased clients of Licensed Midwives anecdotally shared with DOH about their positive experiences. But, we respectfully submit that the majority of comments that were shared are anecdotal in nature and not based on any scientific review of experiences.

Given the number of states that some of our Member Plans operate in, we have conducted a high level review of state laws in this area. We have not been able to identify another state where licensed midwives can provide newborn care beyond two hours of birth or “for care immediately following the delivery only” (Arkansas).

Our primary concern centers on the safety and well-being of our state’s infants. We are concerned to see that the draft report recommendations so directly reflect the proponent’s desired expansion of its scope of practice, as well as anecdotal input provided by supporters. The first few weeks of an infant’s life are highly critical to his or her health. We think any decisions regarding infant care, and who is qualified to provide that care, should be based on robust evidence. Accordingly, we strongly urge against expanding the scope for midwives to perform newborn care. Given these concerns, we request that not only the “medical aid” to be provided is clarified in rulemaking, but also that the additional education and training requirements specific to newborn care be specified.”

Department Response

The department did not make any changes in response to this rebuttal for the following reasons.

- Licensed midwives are already safely providing certain aspects of newborn care.
- Clarifying what newborn care tasks midwives are authorized to perform in rule will enhance the safety and wellbeing of our state’s infants because:
 - It will alleviate confusion and inconsistency in midwifery practice.
 - In a home birth, the LM is often the only health care provider caring for the newborn prior to the infant’s first pediatric appointment. Without a clear scope of practice, this continuity of care is jeopardized.

The department identified a number of states where licensed midwives can provide newborn care beyond two hours of birth. These were discussed briefly in the report and are more fully detailed in Appendix F. Many of these states allow midwives to provide care during the first 28 days of birth or up to six weeks following birth. Idaho, for example, includes postpartum care of newborns and defines the postpartum period as not exceeding six weeks from the date of delivery. Montana also allows care of the newborn during the postpartum period, which it defines as up to six weeks following birth.

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DONA International <<http://www.dona.org/>>

Initiative on the Future of Nursing <<http://thefutureofnursing.org/>>

International Confederation of Midwives <<http://www.internationalmidwives.org>>

Midwives Alliance of North America <<http://mana.org>>

Midwives' Association of Washington State <<http://www.washingtonmidwives.org>>

North American Registry of Midwives <<http://narm.org>>

Units of government: United States, Washington & other states

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Appendix A

Applicant Report

Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

- Legislative proposal being reviewed under the sunrise process (include bill number if available):

The Midwives' Association of Washington State proposes clarifying Licensed Midwives' scope of practice for care of newborns.

The Association, with Rep. Morrell and Sen. Kline attempted to address this with HB 1773/SB 5626 (2013) but the provision was stripped from the original bills.

- Name and title of profession the applicant seeks to credential/institute change in scope of practice:

Licensed Midwives (LMs)

- Applicant's organization: Midwives' Association of Washington State (MAWS)

Contact person: Valerie Sasson, LM, CPM – President, MAWS

Address: 13128 Totem Lake Boulevard NE

Kirkland, WA 98034

Telephone number: (206) 406-8787

Email address: val@birthcenter.com

- Number of members in the organization: 95 (77 LMs; 18 CNMs)

Approximate number of individuals practicing in Washington: same as above

Name(s) and address(es) of national organization(s) with which the state organization is affiliated: N/A

- Name(s) of other state organizations representing the profession: N/A

OUTLINE OF FACTORS TO BE ADDRESSED

Please refer to RCW 18.120.030 (attached) for more detail. Concise, narrative answers are encouraged. Please explain the following:

(1) Define the problem and why regulation is necessary:

Since RCW 18.50 was established in 1978, regulating the practice of licensed midwives (LMs) in Washington State, it has been customary for LMs to provide newborn care for two to six weeks postpartum. LMs are autonomous health care providers whose training includes assessment and care of the normal newborn and MAWS, as the professional association for LMs, has clear guidelines regarding newborn conditions that require discussion, consultation, and referral to a pediatric provider.

We believe it is essential at this time to explicitly address scope of practice in order to 1) protect and educate the public about the range of newborn services that LMs are trained to provide; 2) to educate third-party payors about these services; and 3) to protect LMs from unwarranted disciplinary actions caused by lack of clarity in rule or statute.

(2) The efforts made to address the problem:

- HB 1773/SB 5626 (2013)
- MAWS *Indications for Discussion, Consultation, and Transfer of Care in an Out-of-Hospital Midwifery Practice* (currently under revision)
- MAWS *Statement Regarding the Provision of Care to Newborns by Licensed Midwives*
- MAWS Quality Management Program (Incident and Peer Review)
- MANA Core Competencies Document (Midwives Assn of North America)
- NARM Essential Knowledge and Skills (North American Registry of Midwives, a midwifery school accreditation entity as recognized by the U.S. Secretary of Education.)

(3) The alternatives considered:

LMs are currently licensed, independent providers.

HB 1773 (Original Bill) – The provision regarding newborn care was removed from the bill in response to political pressure from a third-party payor. This health carrier expressed concern about this provision expanding LM scope of practice. However, the purpose of the proposed provision was *not* meant to expand LM scope of practice but merely to clarify and make explicit what constitutes current midwifery practice around newborn care.

Both training and licensing for LMs include newborn care parameters, but not addressing the issue in statute forces LMs and the public to rely on implicit language.

(4) The benefit to the public if regulation is granted:

The public would receive assurance that care for normal newborns is within the scope of practice for LMs, allowing for continuity of care by their chosen care provider. Articulating which

newborn services LMs provide will facilitate the coordination of care between midwives and pediatric providers.

Adequate training for LMs in the care of normal newborns is already required in RCW 18.50.040. The public will be assured of maintained competency by the requirement for annual license renewal. In addition, MAWS is seeking to establish mandatory peer review, data collection, and continuing education in rule—issues also addressed in HB 1773.

(5) The extent to which regulation might harm the public:

Adopting rules that clarify LM scope of practice around newborn care will not create any barriers for practitioners because these services are already established components of midwifery education and training in all jurisdictions.

(6) The maintenance of standards:

Sufficient standards already exist under RCW 18.50 and MAWS guidelines provide parameters around professional practice.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Licensed Midwives are governed by RCW 18.50. This group has been a profession regulated by the state of Washington since 1917, with modernization in 1978.

The Midwives Association of Washington State is the sole state association for the midwifery profession. The group represents Licensed Midwives as well as Certified Nurse Midwives who choose to join:

- Number of members in the organization: 95 (77 LMs; 18 CNMs)
- Approximate number of individuals practicing in Washington: same as above.

(8) The expected costs of regulation:

As a profession already regulated by the Department, minimal changes are expected. Some rules-writing would likely be necessary in response to legislation, about \$5000.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

An average client has 15 prenatal visits (30-60 minutes each, 45% of total time); a labor and delivery at which a midwife might spend an average of 10 hours (with a range of 4-72 hours, 30% of total time), 3-4 hours of which is postpartum and includes immediate stabilization and

care of the newborn; and 4-5 postpartum home and office visits which cover care of both the newborn and the mother (15% of total time). An average client also generates 2-5 hours of administrative and consultation time (10% of total time).

Licensed midwives in Washington work in many locales and carry varying caseloads, but this general proportion of work per client is roughly consistent.

RCW 18.120.030

Applicants for regulation -- Information.

After July 24, 1983, if appropriate, applicant groups shall explain each of the following factors to the extent requested by the legislative committees of reference:

- (1) A definition of the problem and why regulation is necessary:
 - (a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety;
 - (b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession; and
 - (c) The extent of autonomy a practitioner has, as indicated by:
 - (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and
 - (ii) The extent to which practitioners are supervised;
- (2) The efforts made to address the problem:
 - (a) Voluntary efforts, if any, by members of the health profession to:
 - (i) Establish a code of ethics; or
 - (ii) Help resolve disputes between health practitioners and consumers; and
 - (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem;
- (3) The alternatives considered:
 - (a) Regulation of business employers or practitioners rather than employee practitioners;
 - (b) Regulation of the program or service rather than the individual practitioners;
 - (c) Registration of all practitioners;
 - (d) Certification of all practitioners;
 - (e) Other alternatives;
 - (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and
 - (g) Why licensing would serve to protect the public interest;

(4) The benefit to the public if regulation is granted:

(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation;

(b) Whether the public can identify qualified practitioners;

(c) The extent to which the public can be confident that qualified practitioners are competent:

(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system;

(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date;

(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions;

(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions;

(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met; and

(vi) What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected work force, including reentry workers, minorities, placebound students, and others;

(d) Assurance of the public that practitioners have maintained their competence:

(i) Whether the registration, certification, or licensure will carry an expiration date; and

(ii) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;

(5) The extent to which regulation might harm the public:

(a) The extent to which regulation will restrict entry into the health profession:

(i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance; and

(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification, and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification, or licensure as those in this state; and

(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation;

(6) The maintenance of standards:

(a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics; and

(b) How the proposed legislation will assure quality:

(i) The extent to which a code of ethics, if any, will be adopted; and

(ii) The grounds for suspension or revocation of registration, certification, or licensure;

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice; and

(8) The expected costs of regulation:

(a) The impact registration, certification, or licensure will have on the costs of the services to the public;

(b) The cost to the state and to the general public of implementing the proposed legislation; and

(c) The cost to the state and the members of the group proposed for regulation for the required education, including projected tuition and expenses and expected increases in training programs, staffing, and enrollments at state training institutions.

Appendix B

Request from Legislature And Proposed Bill

State of
Washington
House of
Representatives



May 23, 2013

John Wiesman, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would change the scope of practice for midwives to include the provision of medical aid to an infant up to two weeks of age.

A copy of the proposal (H-2588.1/13) is attached and my office can provide you with an electronic copy. The House Health Care and Wellness Committee would be interested in an assessment of whether the proposal meets the sunrise criteria for expanding the scope of practice for a regulated health profession in Washington.

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Karen Jensen, Washington State Department of Health
Amber Ulvenes, Midwives' Association of Washington State
Jim Morishima, Office of Program Research

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-2588.1/13

ATTY/TYPIST: AL:eab

BRIEF DESCRIPTION: Concerning the scope of practice for midwives.

1 AN ACT Relating to the practice of midwifery; and amending RCW
2 18.50.010.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 **Sec. 1.** RCW 18.50.010 and 1991 c 3 s 103 are each amended to read
5 as follows:

6 Any person shall be regarded as practicing midwifery within the
7 meaning of this chapter who shall render medical aid for a fee or
8 compensation to a woman during prenatal, intrapartum, and postpartum
9 stages or to her infant up to two weeks of age or who shall advertise
10 as a midwife by signs, printed cards, or otherwise. Nothing shall be
11 construed in this chapter to prohibit gratuitous services. It shall be
12 the duty of a midwife to consult with a physician whenever there are
13 significant deviations from normal in either the mother or the infant.

--- END ---

Appendix C

Applicant Follow Up

Midwifery Scope of Practice Sunrise
Follow Up Questions to Applicant
July 1, 2013

1. The term “medical aid” is very broad. You state in the applicant report that this proposal is not intended to increase the midwife scope of practice, but rather to explicitly address the newborn care that is already being provided. Is it your intent for medical aid of a newborn to include the care described in the Midwives’ Association of Washington State’s position statement, *Statement Regarding the Provision of care to Newborns by Licensed Midwives?*¹

Yes. The care articulated in the statement reflects what Licensed Midwives provide, and what the state Medicaid plan and most insurance carriers have covered. (See [First Steps Database](#), WA State Department of Social and Health Services, Dr. Laurie Cawthon.)

The statement is also consistent with RCW 18.50.010, where consultation with a physician is required whenever there are significant deviations from normal in the infant, (See also [Indications for Discussion, Consultation and Transfer of Care in an Out-of-Hospital Midwifery Practice](#), and RCW 18.50.115 and WAC 246-834-250, regarding Legend Drugs and Devices, which lists medications solely for newborn use.

Care routinely provided by Licensed Midwives is also documented on the following Midwives Association of Washington State (MAWS) forms: Post-partum Follow-up Form, Immediate Post-partum Form, and Newborn Form (attached.) Midwives must also participate in the Department of Health Neonatal Resuscitation Program (NRP), including pulse oximetry, according to the updated NRP guidelines. All Licensed Midwives have NRP registration numbers.

2. Please provide information on the training that qualifies midwives to perform this type of infant care.

Accredited midwifery schools in the United States must incorporate the Core Competencies adopted by the Midwives Alliance of North America (MANA; see Part V, Newborn Care, <http://www.mana.org/about-us/core-competencies>) and the clinical experience requirements and essential knowledge and skills identified by the North American Registry of Midwives (NARM, <http://narm.org/>). NARM sets the standards for the competency-based national certification of midwives, whose credential is “Certified Professional Midwife” or “CPM.” In Washington State, the state-specific credential is “Licensed Midwife,” the requirements of which exceed the CPM. Many state licensees carry both the LM and CPM.

The NARM general education requirements include newborn exams both immediately post-partum and follow-up. See the [NARM Candidate Information Booklet](#), Sections V,

¹ <http://www.washingtonmidwives.org/documents/MAWS-position-statement-Newborn-Care-by-LMs.pdf>

V1, and VII, pages 43-50. There are also international standards for midwives, created by the International Confederation of Midwives. The [ICM Competencies](#) detail Newborn Care in Section 6.

Specifically relevant to midwifery education in Washington State, attached are syllabi from Bastyr University's Department of Midwifery for classes related to newborn care: Midwifery Care 5, Clinical Skills 4, Breastfeeding and Lactation Education. Also attached are the Practicum handbook that outlines the clinical requirements in all categories, and letter from the Chair of the Department of Midwifery regarding education relating to newborn care. In the Practicum handbook, newborn care is specifically addressed on pages 13 and 34.

Also attached are syllabi from the Midwifery College of Utah, Postpartum Care (MDWF 246) and Pediatrics (HLTH 332), as evidence that normal newborn care is within the scope of midwives in the U.S. and internationally.

3. Is there a specific reason for choosing two weeks as the window of time for providing medical aid to infants? Please explain.

It took discussion for the Midwives Association to arrive at the two week time period. Midwives treat the mother and baby as a unit, which is unique to this model of care. This comprehensive model is also responsible for the hallmark successes of midwifery care, such as high breastfeeding rates², following the emotional health of the family, and providing culturally sensitive care. Midwives are trained to provide this care to the mother/baby dyad until six to eight weeks postpartum. International standards for midwives, created by the International Confederation of Midwives detail Newborn Care in Section 6 ([ICM Competencies](#),) utilize two months as the time frame. However, the importance of the family developing a relationship with a pediatric care provider is recognized, as well, and two weeks has become a standard recommended time period for checking in with the provider. In the MAWS [Indications for Discussion, Consultation and Transfer of Care in an Out-of Hospital Midwifery Practice](#), also mentioned in question number one above, section 3.5, "Newborn Conditions," begins:

It is strongly recommended that all parents be advised to establish care with a pediatric provider by 2 weeks of age. It is recommended that parents establish a relationship with a pediatric provider before the baby is born. The following conditions warrant contact sooner. . . .

After review of the specificity found in various health professions' scope in Title 18 RCW, the recommendation of MAWS would be to have the two week time period appear in rule rather than statute. ARNP scope, RCW 18.79.050 provides a good example of the depth of specificity that would be appropriate in this case. MAWS' preference would be for RCW 18.50 to include "care of a newborn," but, "the scope of which is defined in rule by the secretary."

² In 2012, among members of MAWS, 96.7% clients were breastfeeding as of last postpartum visit, typically at six weeks post-partum.

POSTPARTUM FOLLOW-UP

Puget Sound Birth Center
 13128 Totem Lake Blvd NE, Ste 101, Kirkland, Wa 98034
 P: 425-823-1919 / F: 425-823-7037

Mother's Name _____
 Client ID# _____ Allergies _____
 Mother's Blood type _____ RhIG, Rubella _____ Lot/exp _____
 Birth Comments/Summary _____

Infant's Name _____ Blood Type _____
 Date of Birth _____ Time _____ Weight _____
 Newborn Screening #1 _____ #2 _____
 Birth Certificate Filed _____
 Circumcision No Yes NA Feeding Plan _____

Date _____ Day/Wk _____ Midwife _____ <p style="text-align: center;">Mother</p> <input type="checkbox"/> General/Emotional _____ <input type="checkbox"/> Vitals _____ <input type="checkbox"/> Meds/Herbs _____ <input type="checkbox"/> BM/Void _____ <input type="checkbox"/> Breasts _____ <input type="checkbox"/> Lochia/Fundus/Perineum _____ <input type="checkbox"/> Rest/Nutrition _____ Notes _____ _____	<input type="checkbox"/> Phone <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Hosp <p style="text-align: center;">Infant</p> <input type="checkbox"/> Weight/Vitals _____ <input type="checkbox"/> Stool/Void _____ <input type="checkbox"/> Color _____ <input type="checkbox"/> Cord _____ <input type="checkbox"/> Sleeping/Feeding _____ Notes _____ _____
Date _____ Day/Wk _____ Midwife _____ <p style="text-align: center;">Mother</p> <input type="checkbox"/> General/Emotional _____ <input type="checkbox"/> Vitals _____ <input type="checkbox"/> Meds/Herbs _____ <input type="checkbox"/> BM/Void _____ <input type="checkbox"/> Breasts _____ <input type="checkbox"/> Lochia/Fundus/Perineum _____ <input type="checkbox"/> Rest/Nutrition _____ Notes _____ _____	<input type="checkbox"/> Phone <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Hosp <p style="text-align: center;">Infant</p> <input type="checkbox"/> Weight/Vitals _____ <input type="checkbox"/> Stool/Void _____ <input type="checkbox"/> Color _____ <input type="checkbox"/> Cord _____ <input type="checkbox"/> Sleeping/Feeding _____ Notes _____ _____
Date _____ Day/Wk _____ Midwife _____ <p style="text-align: center;">Mother</p> <input type="checkbox"/> General/Emotional _____ <input type="checkbox"/> Vitals _____ <input type="checkbox"/> Meds/Herbs _____ <input type="checkbox"/> BM/Void _____ <input type="checkbox"/> Breasts _____ <input type="checkbox"/> Lochia/Fundus/Perineum _____ <input type="checkbox"/> Rest/Nutrition _____ Notes _____ _____	<input type="checkbox"/> Phone <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Hosp <p style="text-align: center;">Infant</p> <input type="checkbox"/> Weight/Vitals _____ <input type="checkbox"/> Stool/Void _____ <input type="checkbox"/> Color _____ <input type="checkbox"/> Cord _____ <input type="checkbox"/> Sleeping/Feeding _____ Notes _____ _____

Telephone Calls

Date _____ Midwife _____
 Notes _____

Postpartum Follow-Up Pg 2

Puget Sound Birth Center
13128 Totem Lake Blvd NE, Ste 101, Kirkland, Wa 98034
P: 425-823-1919 / F: 425-823-7037

Date MANA Stats sent _____

Client ID# _____ Allergies _____
Name _____ Infant's Name _____ Date of Birth _____ Birth Weight _____

Date _____ Day/Wk _____ Midwife _____ Phone Home Office Hosp

<p style="text-align: center;">Mother</p> <input type="checkbox"/> General/Emotional _____ <input type="checkbox"/> Vitals _____ <input type="checkbox"/> Meds/Herbs _____ <input type="checkbox"/> BM/Void _____ <input type="checkbox"/> Breasts _____ <input type="checkbox"/> Lochia/Fundus/Perineum _____ <input type="checkbox"/> Rest/Nutrition _____ Notes _____ _____	<p style="text-align: center;">Infant</p> <input type="checkbox"/> Weight/Vitals _____ <input type="checkbox"/> Stool/Void _____ <input type="checkbox"/> Color _____ <input type="checkbox"/> Cord _____ <input type="checkbox"/> Sleeping/Feeding _____ Notes _____ _____
---	--

Date _____ Day/Wk _____ Midwife _____ Phone Home Office Hosp

<p style="text-align: center;">Mother</p> <input type="checkbox"/> General/Emotional _____ <input type="checkbox"/> Vitals _____ <input type="checkbox"/> Meds/Herbs _____ <input type="checkbox"/> BM/Void _____ <input type="checkbox"/> Breasts _____ <input type="checkbox"/> Lochia/Fundus/Perineum _____ <input type="checkbox"/> Rest/Nutrition _____ Notes _____ _____	<p style="text-align: center;">Infant</p> <input type="checkbox"/> Weight/Vitals _____ <input type="checkbox"/> Stool/Void _____ <input type="checkbox"/> Color _____ <input type="checkbox"/> Cord _____ <input type="checkbox"/> Sleeping/Feeding _____ Notes _____ _____
---	--

Telephone Calls

Date _____ Midwife _____	Date _____ Midwife _____
Notes _____	Notes _____
_____	_____
_____	_____

Final Postpartum Visit

Date _____ Weeks PP _____ Baby's Weight _____

S: Lochia _____ Sexuality _____
 Physical Problems _____
 Nutrition/Exercise/Activity _____
 Emotional Status/ Partner's Involvement _____
 Breastfeeding _____
 Family Planning _____
 Notes _____

O: Weight _____ Wt at delivery _____ Bp _____ Pap smear done? Yes No, date of last Pap _____
 Breasts lactating, non-tender, no masses or abnormal discharge _____ BSE reviewed
 Abdomen soft, non-tender, no masses _____ Diastasis _____
 External genitalia no redness, lesions, exudates _____ Laceration healed well _____
 Vagina pink, rugated _____ Muscle tone _____ Kegels Reviewed
 Cervix pink, non-friable _____ Uterus NSSC, non-tender, mobile _____ position _____
 Adnexa no masses or tenderness _____

A: _____

P: _____

Birth control method: _____ Midwife: _____

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Puget Sound Birth Center
 13128 Totem Lake Blvd NE, Ste 101
 Kirkland, Wa 98034
 P: 425-823-1919
 F: 425-823-7037

Parents Names _____

NEWBORN

Client ID# _____

Infant's name: First _____ Middle _____ Last _____

Sex: Female Male Date of Birth _____ Time of birth _____ Birth Weight _____

Midwife _____ Location Birth Center Home Hospital

Birth Summary: _____

Cord Blood? Yes No

Blood type _____

Suction None

Bulb

DeLee

Resuscitation

None Stimulation

Free O2 Bag & Mask for _____ minutes, or _____ puffs

Intubation CPR

Notes _____

Feeding Plan Breast Bottle Mixed First feed @ _____ minutes/age

NEWBORN EXAM

Date/time _____ Performed by _____

Estimated Gestational Age _____

Weight _____ Length _____ in _____ cm

Head Circumference _____ in _____ cm Chest _____

General Appearance/Color _____

HEENT _____

Heart No murmur heard _____

Lungs, RR _____

Abdomen _____

Temperature _____

Notes _____

APGAR SCORE	Minute	
	1	5
HEART RATE		
Absent	0	0
Below 100	1	1
Above 100	2	2
RESPIRATORY EFFORT		
Absent	0	0
Weak Cry / Gasp	1	1
Strong Cry / Breathing	2	2
REFLEX STIMULATION		
No Response	0	0
Grimace	1	1
Cough / Sneeze	2	2
MUSCLE TONE		
Limp	0	0
Some Flexion	1	1
Well Flexed	2	2
COLOR		
Pale	0	0
Body Pink / Extremities Blue	1	1
All Pink	2	2
TOTAL		

Cord 3 vessels _____

Hips Full ROM No clicks _____

Genitalia _____

Anus Terminal mec presumed patent _____

Extremities _____

Back/spine _____

Skin _____

Tone _____

Reflexes suck moro plantar palmar babinski

ADMINISTERED AT BIRTH BY MIDWIFE

- Vitamin K IM injection in R L thigh Oral Declined by Parents
(Circle one)
- Prophylactic Erythromycin Ointment to both eyes Declined by Parents
- Other _____

FOLLOW-UP PROVIDED BY MIDWIFE

- Home Visit on day _____ Includes: 1st PKU Weight Check Jaundice Check Exam Feeding evaluation
- 2nd PKU and weight check on day 7-14
- Other _____

NOT PROVIDED BY MIDWIFE

- Hearing Test
- Immunizations
- Other _____

Ongoing Pediatric Care Provider _____

Midwife Signature _____

Practicum Handbook 2013

**BASTYR
UNIVERSITY**

DEPARTMENT
OF MIDWIFERY

*educating and
inspiring leaders
in midwifery*

Revised March 2013

Practicum Handbook 2013

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PRACTICUM OVERVIEW

PRACTICUM DESCRIPTION

The Department of Midwifery theoretical coursework is balanced with clinical practice in a course called Practicum. Practicum is a 50 credit course that usually spans quarters 3-11. It includes an Introduction to Practicum course in fall and winter quarters of year 1 and clinical rotations with preceptors who provide midwifery and related women's health care. Practicum work is facilitated and overseen in the Department of Midwifery by the Practicum Coordinator.

Students are encouraged to participate in a variety of clinical settings that may include prenatal, intrapartum, postpartum, gynecology, and newborn care with direct-entry midwives, certified nurse midwives, physicians, nurse practitioners and naturopathic physicians. In these sites, students begin to apply their theoretical coursework to clinical situations. It is the intention that students are exposed to a variety of role models as they develop critical thinking and hands-on skills.

During the final year of Practicum students will work primarily with preceptors who provide full-spectrum maternity care, participating in clinic, home visits and births under the supervision of an approved preceptor. Preceptors are located throughout North America; in year 3 students have the option of participating in a short-term, foreign clinical. This rotation is intended to broaden the student's understanding of midwifery care in other cultural settings and health care systems. These experiences usually provide students with the opportunity to care for women in high-volume hospital settings where midwives are the primary care providers.

For the purposes of this handbook, the term preceptor refers to clinicians and practitioners who have been approved by the Department of Midwifery to serve as clinical instructors for our students.

The Department of Midwifery utilizes a secure, online clinical tracking system provided by TyphonGroup Healthcare Solutions ("Typhon"). Students and preceptors receive a secure login to Typhon. Students will enter all client contacts and clinical hours into this database and preceptors will review and approve (or not approve) the student's clinical skills and activities.

ELIGIBILITY FOR PRACTICUM

To be eligible for Practicum, students must:

- be in good academic standing;
- have completed Introduction to Practicum;
- be enrolled in Practicum;
- have the permission of the Practicum Coordinator to begin Practicum; and
- hold current certifications in advanced CPR and Neonatal Resuscitation.

PRACTICUM GOALS AND OBJECTIVES

The goal of Practicum is to master entry-level midwifery skills, defined as the skills necessary and within the scope of practice for entry into safe, independent midwifery practice.

The objectives of Practicum are to provide the graduate with:

- mastery of the hands-on skills necessary for safe midwifery care;

- the ability to clearly and thoroughly document relevant physical, emotional, and social information about clients, as well as the choices they make about their care;
- fluency in offering informed choice to clients, explaining the risk/benefit concept of decision-making and providing clients with thorough and appropriate information;
- the ability to make assessments of a pregnant woman's risk factors in relation to midwifery care and the planned site of birth;
- entry-level midwifery skills in identifying and responding to abnormalities of pregnancy, labor, postpartum and the newborn;
- a professional level of communication to effectively convey information to other healthcare providers concisely and accurately, and to exercise discretion and diplomacy with clientele, the medical community, and the public; and
- self-awareness of their own personal values and their impact on the midwifery care they provide.

CLINICAL INSTRUCTORS

All student clinical rotations are supervised by qualified and approved preceptors. Preceptors must be credentialed through the Department of Midwifery and must meet the criteria below.

Preceptors must:

- complete a preceptor application, an interview with the Practicum Coordinator and gain approval as a preceptor for the Department of Midwifery
- hold the Certified Professional Midwife (CPM) credential or be licensed or registered and practicing legally within their jurisdiction as an independent provider for a minimum of three (3) years. If a midwife can document a minimum of 40 births as an independent, primary midwife an exception may be made to the three year requirement.

Note: Because we value the art and science of out of hospital birth, we strongly encourage our out of hospital practitioners to hold the CPM credential which is the evidence of that training and expertise. CPMs will receive priority for student placements.

- have sufficient client volume in maternity and women's health care to adequately instruct, supervise and evaluate the student's clinical training.
- demonstrate a commitment to the training and education of midwifery students by making the time to teach skills, evaluate student performance and provide timely feedback, thus creating a comprehensive learning environment within the midwifery practice.
- provide quarterly clinical skills evaluation reports to the DoM for students in their practice.
- maintain currency in maternity and women's health care community standards. Provide evidence of at least 30 hours of continuing education over a three-year period by submitting copies of certificates of attendance at workshops and conference.
- participate in preceptor evaluation process which will include quarterly feedback from students about their experiences in clinical rotations and annual self-evaluations by the preceptor.
- sign an Educational Affiliation Agreement between the preceptor and Bastyr University Department of Midwifery. Students may not participate in any clinical site until the school has received an executed Educational Affiliation Agreement.

CLINICAL SEMINAR

The Clinical Seminar course is closely associated with Practicum and each student participating in a clinical rotation will be participating concurrently in Clinical Seminar. Students on a part-time track are not enrolled in Clinical Seminar during their first year, although some may be participating to a limited extent in Practicum. For the part-time student to whom this applies, the Practicum Coordinator will facilitate regular check-ins and provide oversight of clinical experiences. Students who take longer to complete clinical requirements may be asked to continue participation in Clinical Seminar.

REQUIRED BOOKS AND EQUIPMENT

1. This handbook outlines the requirements, policies, and expectations for all students enrolled in Practicum. It is the main resource for your questions about Practicum and you will refer to it throughout your time in the program.
2. Becoming a Midwife by Carolyn Steiger is a required text for the Introduction to Practicum course. Although this book is out-of-print the Department of Midwifery has permission to copy it for student use. A copy is available through the Bastyr bookstore.
3. Students are required to have the following equipment to participate in clinical rotations:
 - BP cuff and stethoscope
 - Watch (preferably one with a sweep hand, but if digital, it **must** show seconds)
 - A dependable vehicle
 - Pager or cell phone

LISTS OF REQUIRED SKILLS

Successful completion of Practicum requires mastery of midwifery skills described by the North American Registry of Midwives (NARM) Skills Verification Checklist. In addition, nearly all of the MANA Core Competencies are addressed during Practicum. Please refer to these documents for more detail.

The Department of Midwifery has adapted the NARM Skills Verification Checklist as the Entry-Level Skills Checklist. This list is inclusive of skills that are evaluated by the preceptor, in the classroom or during clinical examinations. Students are responsible for acquiring the required preceptor and faculty signatures and submitting the completed checklist to the Practicum Coordinator prior to graduation. (See below for more information on the Entry-Level Skills Checklist).

PRACTICUM SCHEDULE

The table below shows the number of Practicum credits per quarter for students on the standard full-time track and further breaks them out into approximate hours quarterly and weekly.

This chart should act as a general guideline for students and preceptors in gauging student involvement at a site. Please note: the approximate number of hours for each quarter are based on the standard number of credits assigned to Practicum during that quarter. This credit value was established to balance the amount of time and energy needed for theoretical coursework that the students are doing simultaneously. Unless a student has advanced standing, clinical participation should generally follow these guidelines.

Quarter	Credits of Practicum (1 credit = 30 hours)	Approximate Practicum hours per quarter	Approximate Practicum hours per week*
Year 1			
1 – Fall	0	0	0
2 - Winter	0	0	0
3 - Spring	2.5	75	9
4 - Summer	6.0	180	23
Year 2			
5 - Fall	4.5	135	17
6 - Winter	3.0	90	12
7 - Spring	4.0	120	15 minimum
8 - Summer	4.0	120	15 minimum
Year 3			
9 - Fall	7.0	240	30 minimum
10 - Winter	10.0	300	35 minimum
11 - Spring	8.5	255	32 minimum

Practicum Evaluation Methods

For every quarter students are enrolled in Practicum and participating in a preceptorship, they will be evaluated on clinical skills by the preceptor, the Practicum Coordinator and when necessary, the Student Progress Committee:

CLINICAL SKILLS EVALUATIONS

Clinical Skills Evaluations are completed by preceptors each quarter that a student is in a clinical site. The evaluations are organized into three levels of skill: beginner, intermediate and advanced. In general the levels of evaluations will match the developing skills of students in year 1, year 2 and year 3.

The preceptor will evaluate a student's skills and assess progress using a scale of "A" acceptable, "O" observed only, "M" mastered, "I" needs Improvement or "N/A" not applicable. Students are working to achieve "M's" on all their clinical skills evaluations. "A's" are satisfactory but it is expected that the majority of skills will be mastered before leaving this program.

Students will complete one skill level before advancing to the next level, however when they move to a new preceptor site it is not uncommon for the new preceptor to evaluate the student's skills at a level below where they ended at their last site.

By the end of this program students will have multiple evaluations in all three skill levels. To meet graduation requirements, students must have at least two advanced level evaluations that demonstrate mastery of the skills of an entry level midwife.

In addition to evaluating specific skills, preceptors will also be evaluating the overall level of a student's developing midwifery skills on a continuum as follows:

"Observing"

The student is expected to observe all aspects of client care. She may offer labor support at births, demonstrate sensitivity to client and preceptor needs and ask questions appropriately. She learns to identify and record contraction patterns and significant birth events and to set up and clean up at births.

"Emerging"

The student begins to identify client issues and participate in clinic visits. She demonstrates a growing grasp of theory as well as practices taking maternal vitals and fetal heart tones, and performs Leopold's maneuvers. In the birth setting, she assists with newborn exams, independently offers labor support, and begins to chart significant times and events. She is developing skills for monitoring vital signs and Apgar scores.

"Beginning Assistant"

The student is demonstrating basic communication skills by eliciting information and demonstrating active listening skills. She is able to identify areas of personal strength and weakness, to offer input with the preceptor on some education and informed choice issues, has become competent in taking fetal heart tones and blood pressures, and is beginning to chart and perform venipuncture in the clinical setting. At births she helps complete summaries and charting, monitors maternal, fetal, and newborn vitals, and assists with breastfeeding education.

“Assistant”

In the clinical setting the student independently takes maternal vitals and fetal heart tones, takes histories and begins to offer some basic education and informed choice. She actively identifies and researches client issues and is developing risk assessment skills. She assists the midwife in all aspects of care and charting at births and provides postpartum education at births.

“Expanding”

The student actively participates in all aspects of visits, solicits information and begins to counsel clients as well as to present informed choice with preceptor input. She demonstrates an ability to apply theory in the clinical setting. She reliably takes and charts maternal vital signs and is honing speculum exam skills. At the birth she delivers the placenta, accurately assesses blood loss, assesses Apgar score and progression of labor and offers education and advice. She assists the midwife with suturing.

“Capable”

The student is able to conduct visits with input from the preceptor, presents informed choice in all areas and topics, and counsels appropriately regarding common complaints. She accurately assesses fetal position, performs venipuncture, interprets lab results and performs risk assessment. At births she independently manages third stage, accurately assesses labor patterns, and performs the newborn exam. She is learning artificial rupture of membranes and manages the delivery of head and shoulders and suturing.

“Independent”

The student independently conducts prenatal and postpartum visits with clients, follows up with client issues and concerns, performs speculum exams and independently develops and presents informed choice in all areas. She is able to manage delivery and the immediate postpartum and actively assists with complications. She is able to repair simple lacerations and perform accurate cervical exams.

“Entry level”

The student has a firm grasp of theory and may independently conduct research. She is able to perform all skills without assistance, with accurate results and educates clearly and completely in all areas. She is able to independently manage all aspects of prenatal & postpartum care, labor, and delivery.

Preceptors will complete quarterly evaluations in Typhon and are expected to review these evaluations with the student at the end of each quarter. The Practicum Coordinator will send reminders to each preceptor of end-of-quarter deadlines but students can help facilitate this process by initiating a conversation with their preceptor to schedule a time to review the evaluations.

It is important to plan well ahead for end-of-quarter evaluations. Midwives and students are busy people. Please give your preceptor plenty of time for her to evaluate your progress and to have time to review your evaluation with you.

STUDENT PROGRESS

The Practicum Coordinator and in some cases the Student Progress Committee assess student progress using clinical evaluations from preceptors, instructor input, clinical exam results, completion of clinical paperwork and the number of completed clinical hours. Grades are reported to the Registrar's office and posted on students' transcripts. Practicum grades may be IP (In Progress), A/C (Achieved Competency), F (Failure) or I (Incomplete in the case of

personal emergency or serious illness). Because of the gap in time from the ending of a quarter and the receipt of that quarter's evaluations, all students will receive an initial grade of IP. A grade of "In Progress" will remain in place when a student has completed all of the above requirements with the exception of clinical hours. It is expected that students will make up these clinical hours in the next quarter resulting in a grade change to A/C.

Preceptors have a significant amount of responsibility in the education of students and their evaluation of skills is critical to the Department of Midwifery staff in assessing students' satisfactory progress in clinical rotations. Preceptors provide confidential information to the Practicum Coordinator, Department Chair and/or the Student Progress Committee in the form of clinical skills evaluations and in communications in writing, via phone or in-person. These communications are confidential and based on a need to know for legitimate educational interests in accordance with FERPA.

Practicum Grades

Practicum grades are earned by completion of the following criteria:

- A completed Preceptor/Student Contract submitted at the beginning of each quarter a student is participating in Practicum;
- Timely submission of Case Logs and Time Logs in Typhon. Case Logs and Time Logs must be submitted within ten days of the client visit or birth;
- Satisfactory progress on completion of Practicum credits as represented by clinical hours verified by the student's preceptor(s);
- Satisfactory progress on clinical skills as demonstrated by the quarterly clinical skills evaluations provided by preceptors as acceptable for level of training;
- Successful completion of the Basic Clinical Assessment (quarter 7) and successfully passing all stations of the Advanced Clinical Exam (quarter 10).
- Quarterly meetings with the Practicum Coordinator to review progress and discuss plans for future clinical site placements; and
- Completion of a quarterly Practicum Course Evaluation (submitted in Moodle).

CLINICAL EXAMS

All students must participate in and successfully pass the Basic Clinical Assessment (BCA) and the Advanced Clinical Exam (ACE). The primary goal of these exams is to objectively assess each student's clinical progress and identify any areas of weakness that need additional clinical experience opportunities.

The Basic Clinical Assessment (BCA) is offered each spring quarter. Full-time students take this assessment in their second spring quarter; part-time students generally take it their third spring quarter. The BCA consists of simulated scenarios and assesses the student in the following basic skills:

- 1) Conducting a routine prenatal visit;
- 2) Assisting at a birth and providing immediate postpartum education; and
- 3) Organizing and communicating basic education regarding common prenatal and postnatal topics and discomforts of pregnancy.

This assessment is an opportunity to evaluate a student's progress to date and identify any skills or areas that a student needs to strengthen. The BCA is not graded, however results will be shared with a student's preceptor(s) who will be asked to provide additional clinical opportunities and instruction in the areas of weakness.

The Advanced Clinical Exam (ACE) is offered to third year students in winter quarter (quarter 10 for fulltime students). The ACE is a multi-station objectively structured clinical exam (OSCE) designed to have students demonstrate competency of the following skills in simulated scenarios:

- Performing an initial midwifery prenatal visit which includes a complete physical exam and taking maternal history;
- Conducting a routine third trimester prenatal visit;
- Conducting a postpartum visit with a complication (e.g. failure to thrive, jaundice, maternal depression);
- Demonstrating telephone assessment and triage of a maternal complaint;
- Providing informed choice about a variety of antepartum or postpartum tests/procedures;
- Performing IV catheter insertion;
- Demonstrating basic suturing with aseptic technique;
- Managing an unexpected out-of-hospital breech delivery;
- Performing neonatal resuscitation; and
- Managing shoulder dystocia.

In the Advanced Clinical Exam, an evaluator with an objective checklist and standardized scoring system, scores the student's performance at each station. Students may receive a grade of Pass, Marginal Pass (which requires remediation or retake) or Fail. An appropriate remediation of a marginal score may be determined by the evaluator or by a group of evaluators for that particular exam.

A summary letter of the student's performance in the ACE will be sent to their current preceptor and will include a request for extra clinical opportunities in any areas of weakness that were identified.

Failure of any portion of the Advanced Clinical Exam requires a re-examination of that station. Students will receive one opportunity to retake a station. Subsequent retakes will incur an administration fee for each re-examination station. Failure of more than 50% of all skills tested in the Advanced Clinical Exam or of any part of a re-examination may result in a failure of the entire Advanced Clinical Exam and will require review by the Student Progress Committee to determine an appropriate plan for completion of the midwifery program which could result in termination.

Practicum Details

Full-time students are expected to participate in Practicum beginning in the third quarter of enrollment. The amount of time spent in Practicum increases as the program progresses and as the academic demands lessen. Students must be in good academic standing in order to be eligible to participate in Practicum, must have completed the Orientation to Practicum and have prior approval of the Practicum Coordinator. The Practicum course spans 7 quarters and the typical student can expect to participate in largely observational sites in the beginning, expanding in clinical opportunities, responsibilities and time commitments as the program progresses.

CLINICAL ACTIVITIES

Students are expected to participate in all clinical activities during a Practicum rotation. Students earn Practicum credits by documenting their hours spent in clinic and home visits and the client contacts in Typhon. These hours and client contacts must then be verified by the approved preceptor. Hours are tracked in two categories—direct client contacts (Case Logs) and additional clinical work (Time Logs).

Case Logs

The activities listed below may be claimed as clinical hours and client contacts in the Case Logs section of Typhon:

- Client visits (gynecology, prenatal, postpartum) including home visits and direct telephone contact with the client;
- Other in-person client contacts that may not be a complete visit;
- Births; and
- Student and preceptor consultation about a specific client case.

Time Logs

Students also receive credit for some activities that are not directly related to client care but are essential skills to a midwifery practice. These hours are tracked in the Time Logs section of Typhon and are not to exceed 10% of that month's clinical hours. (For example, if a student completes 50 hours of client care s/he may receive up to 5 hours for non-client care activities.) Some of the activities that students may claim are:

- Charting in patients' medical records;
- Participating in some limited office and/or clinic work, instrument cleaning, ordering and restocking supplies, data collection and reporting;
- New client consults (or "meet and greets"); and
- Student performance evaluation conferences with the preceptor(s).

Students may choose to volunteer more time for activities that do not count toward fulfilling graduation requirements. However if a student is consistently required by their preceptor to put in more than 10% of their clinical hours s/he should notify the Practicum Coordinator as this additional time may compromise the student's ability to maintain a realistic schedule and/or negatively impact academic performance.

Attendance at monthly onsites is mandatory and students must be off call. As a courtesy, please work with your preceptor to help make arrangements for back-up coverage during your attendance at onsite. Based on student availability, the Practicum Coordinator may be able to assist in identifying back-up coverage.

PRACTICUM MINIMUM REQUIREMENTS

1500 Practicum Hours to include the following minimums:

- 400 Intrapartum Hours and 800 Clinical Hours
- 720 Client Contacts
- 300 Prenatal Visits including:
 - 20 Initial Visits conducted by the student
 - 55 Routine Prenatal Visits conducted by the student
- 100 Postpartum Visits including:
 - 15 visits at <72 hrs postpartum conducted by the student
 - 15 visits at >72 hours postpartum conducted by the student
 - 10 final (6 week postpartum) visits conducted by the student
 - 10 additional postpartum visits conducted by the student
 - 50 Infant Visits > 12 hrs postpartum
- 50 Gynecological Visits including:
 - 20 pelvic exams performed by the student
- Attendance at 60 births, including:
 - 30 Out-of-hospital Births
 - 30 Supervised Primary Births
 - 20 Assisted/Involved Births
 - 10 Observed Births
 - 2 Planned hospital births at any level of participation
- 50 newborn exams, including 20 performed by the student
- 15 Continuity of Care contacts as the primary midwife under supervision as follows:
 - 5 Full Continuity of Care contacts that include:
 - at least 5 prenatal visits (spanning two trimesters)
 - the birth
 - the newborn exam
 - at least 2 postpartum visits
 - 10 Other Continuity of Care contacts that include:
 - at least two prenatal visits
 - the birth
 - the newborn exam
 - at least 1 postpartum visit

(*Note:* Continuity of Care requirements are different for registration as a midwife in Canada. Students planning to apply for Canadian registration should know the requirements for Provincial registration and document these births appropriately.)

Gynecology Contacts

At least 50 gynecology client contacts are required to graduate and at least 20 of these visits must be conducted by the student. These client contacts and hours are document in the Case Logs section of Typhon. Gynecology client contacts may be accomplished in a midwifery practice or in a site where general or well women's health care is provided. The supervising clinician may be a midwife, a nurse practitioner, a physician assistant, a physician or a naturopath in a primary care facility. The primary goal of a gynecology rotation is to expose you as a student midwife to gynecology, family planning and well-woman care, enabling students to integrate theoretical knowledge with real clinical situations. Occasionally students may be in a site where other primary care is provided in addition to women's health care which would allow the student to practice and/or observe more general health screening skills. These visits however do not count toward the minimums required by the Department of Midwifery for graduation.

Gynecology Rotation Learning Activities

Students may observe and/or participate in the following:

- Obtaining medical and sexual client history
- Physical exam
- Breast exam and breast self-exam instruction
- Pelvic exam including vulvar, bimanual & speculum exams
- Obtaining, processing and interpreting lab samples such as blood tests, PAP and cultures
- Birth control counseling
- Screening, diagnosis and treatment of common gynecological problems, including sexually transmitted infections, urinary tract infections, irregular menses, fibroids and pelvic pain
- Client counseling and education about women's health concerns

Whenever possible, and with permission of the client and the supervising clinician, students will be given the opportunity to develop their hands-on skills. When this is not possible, students will observe client care and discuss the case with the practitioner after the client visit. Any care by the student must be done with the clinician present.

Intrapartum Requirements

Students will participate in births as appropriate to their level of training and the opportunities provided in their preceptor sites. Students earn Practicum credits by documenting their hours spent at births as well as the client contacts. These hours and client contacts are documented in the Case Logs section of the clinical tracking system and must be verified by the preceptor.

400 hours of Intrapartum Care to include the following minimums:

- 10 Observed Births
- 20 Involved Births
- 30 Supervised Primary Births (at least 10 of which must be out-of-hospital)
- 50 Newborn Exams including:
 - 20 exams performed by the student
- 30 births must be in an out-of-hospital setting
- 25 births must be in the U.S. or student's home country
- 2 planned hospital births

Note: Washington State licensure requires a total 100 births. The additional 40 births can be in any category.

Intrapartum Activity

Important: All intrapartum hours must be directly supervised by an **attending clinician who is ultimately responsible for client care**. See Supervision of Practicum Work under Policies Guiding Clinical Rotations for more details.

During the first year of Practicum (Quarters 3-5) students may attend as few as 10 births and be primarily in the role of observer or assistant at births, but should be practicing hands-on skills whenever feasible.

By the final twelve months of the program, the advanced student should have an involved role and the opportunity to act in the role of primary midwife under supervision. Specific skills needed to fulfill "Assisted/Involved" and "Supervised Primary" births are listed below in the Definition of Births.

Other intrapartum graduation requirements include:

- A minimum of two maternity care practicum sites in the U.S. or in the student's home country
 - At least one of the preceptors must be a midwife
- One of these preceptorships must be for a minimum of 6 months during which the student actively participates in at least 15 births (6/15); the second site must be for a minimum of 3 months during which the student actively participates in at least 10 births (also known as 3/10). Active participation is defined as Assisted/Involved or Supervised Primary births.
- A minimum of two Advanced Clinical Skills Evaluations from an approved midwifery preceptor practicing in the United States or the student's home county. (Typically students will have several Advanced Clinical Skills Evaluations.)
- Mastery of the midwifery skills listed on the Entry-Level Skills Checklist.
- Students are expected to demonstrate growing clinical skills with the goal of assuming the role of primary midwife under supervision. Students will be involved in triage, client assessment and care planning and as skills develop eventually taking on a more active role at births, practicing the hands-on skills necessary for competent entry-level midwifery practice.

DEFINITIONS OF BIRTHS

The Department of Midwifery categorizes births on three levels of involvement that are based on NARM requirements: Observed, Assisted/Involved and Supervised Primary. Each category of birth should be accurately documented in Typhon and verified by the preceptor for students to receive credit for achieving clinical graduation requirements. The category of birth earned by a student is determined by the level of participation at each birth as follows:

Observed Birth (10 required):

A birth in which the student observes the birth but does not undertake significant midwifery care of the client. The student may participate in 0-11 of the Birth Skills (listed below and in Typhon) but is still largely in an observational role.

Assisted/Involved Birth (20 required):

A birth in which the student undertakes some of the clinical care of the client and actively participates in the birth as demonstrated by performing any 12 or more of the Birth Skills listed below.

Supervised Primary Birth (30 required):

A birth where the student acts as the primary midwife under supervision by making management decisions with the preceptor and performs all of the Primary Birth Skills that are done at that birth.

In some cases a preceptor may do one or more of the skills for reasons specific to that birth (for example, request of the mother or in an emergency) and in these cases if the student was still in the role of primary midwife under supervision and the preceptor agrees with this assessment the student may claim credit for a Supervised Primary Birth. Any Primary Birth Skills not done by the student should be noted in the reporting of this birth in Typhon in the Clinical Notes section.

Birth Skills:

Basic assisting skills:

- Monitor fetal heart tones throughout
- Provide labor support
- Assess contractions (freq/intensity/length)
- Perform at least one cervical check
- Assist preceptor at birth
- Facilitate breastfeeding
- Assume advocacy role in hospital
- Assist with infant resuscitation

Primary skills:

- Make initial labor assessment
- Perform all cervical exams
- Assess fetal heart tones throughout
- Educate client re progress of labor
- Perform artificial rupture of membranes (AROM)
- Provide perineal support
- Perform episiotomy
- Manage birth of head and shoulders
- Check/manage nuchal cord
- Suction newborn with bulb or DeLee
- Stimulate limp newborn
- Perform infant resuscitation
- Monitor for signs of placental separation
- Assist placental delivery
- Inspect placenta
- Assess blood loss and uterine involution
- Control hemorrhage
- Perform bimanual compression
- Perform manual removal of placenta
- Administer medications by injection or IV
- Place IV
- Insert urinary catheter
- Assess perineum
- Suture laceration
- Assess gestational age of newborn
- Provide postpartum education/instructions
- Participate in consult with other professional
- Facilitate hospital transfer
- Make management decisions
- Complete chart

Students will be working in private practices where preceptors may not be willing to relinquish all of these skills in any one birth. However with active participation in a variety of the skills, the experiences will accumulate into a well-rounded educational experience. Students with any concerns about their level of participation in a clinical site should speak with the Practicum Coordinator.

Missed Births:

Occasionally a student may arrive after the delivery of the baby but if s/he is able to actively participate in the client's care upon arrival, the birth may be reported as Observed provided that the Case Log for that birth reflects a significant amount of learning as verified by the preceptor.

Note: A missed delivery will only count when it is missed due to circumstances outside the student's control. Examples are precipitous labor or when the preceptor does not call the student in sufficient time to allow a timely arrival. Childcare difficulties or getting lost en route do not constitute a legitimate reason for missing a birth.

Attending Births as a Doula

Students are not precluded from working as a professional doula while enrolled in the Department of Midwifery; however it must be clearly documented, in writing, that the doula's client understands that she is not attending the birth in the role of a Bastyr University midwifery student or as a birth assistant. A copy of this contract must be provided to the Practicum Coordinator to be kept as part of the student's record. Doula services may count toward graduation requirements only for the two planned hospital births. Students may contact the Practicum Coordinator to inquire about any exceptions to this policy.

Policies Guiding Practicum Rotations

PRACTICUM CREDIT POLICIES

Graduation requirements for Practicum are a minimum of 1500 hours of documented, verified clinical activity which is the equivalent of 49.5 credits. These credits are distributed throughout the curriculum. Because of the irregularity and unpredictability of clinic work, the credits paid for in any one quarter may not coincide with the actual number of credits earned (as measured by the number of hours documented in practicum activity).

Each quarter the Practicum Coordinator will assess Practicum credits earned by students. Because birth work fluctuates depending on how busy a clinical site is, the participation of the student, etc. it may be necessary to adjust the standard Practicum track for a student. For example if a student has enrolled in 10 credits (300 hours) of Practicum over three quarters but has only documented 5 credits (150 hours) of Practicum the Practicum Coordinator may advise the student to not enroll in any further Practicum credits until s/he has earned the full 10.

Students who have not completed sufficient clinical hours or have not received adequate clinical skills evaluations from their preceptors will be required to continue in Practicum beyond the scheduled graduation time and also required to enroll in Midwifery Practicum Continuation for each quarter participating in Practicum.

Practicum credits (hours and client contacts) can only be earned by students who are in good academic standing and enrolled in Practicum course.

SUPERVISION OF PRACTICUM WORK

Under no circumstances is the student to act as a substitute or auxiliary staff for the clinician. The attending clinician is ultimately responsible and liable for the health care provided to the client. At all times the attending clinician is responsible for assessment of the client, scheduling and use of screening and diagnostic tests and ultrasound, clinical judgment, decision making, intervention and determination of a course of action.

There are infrequent circumstances where an advanced, year 3 student may conduct a clinic or home visit independently of the preceptor. If, for example, the preceptor and student have a full day of clinic and the preceptor is called to a woman in labor, she may ask the advanced student to complete the day's clinic visits while she remains readily available for consultation and instruction.

Note: Per NARM policy, all contacts calculated towards fulfillment of NARM clinical requirements and all skills signed off on the NARM skills checklist must be completed under direct supervision, meaning the preceptor is in the room with the student.

Under no circumstances is a Department of Midwifery student to attend any portion of intrapartum or immediate-postpartum care (within 24 hours of the birth) independent of a supervising clinician.

CONFIDENTIALITY

The midwifery community in any given geographic area is small and issues of confidentiality regarding clinician practice and client care can be problematic. **All students, preceptors, faculty and staff must hold to the highest standards in regard to respect for client confidentiality.** Students may share clinical case information only under the following conditions:

- To debrief with the supervising preceptor.
- To debrief with Department of Midwifery faculty within the context of case discussions at the school. In this case no identifying characteristics such as name, residence, profession, etc. of the client(s) may be used.
- In the de-identified Case Logs documenting births in Typhon
- To debrief with classmates during case discussions with Department of Midwifery instructors **in class only.**
- With appropriate Department of Midwifery staff when there is a question regarding standard of care or safety.

Under no circumstances will the student engage in conversations outside of the Department of Midwifery classroom regarding a client, her health, medical history, midwifery care, birth story or outcomes unless the client and the attending midwife have given their explicit permission to do so. The student shall request permission from the preceptor and the client before bringing a case to the classroom for general discussion with faculty and classmates. The preceptor has the right to instruct the student not to share case particulars with anyone, including the faculty and student's classmates.

Preceptors for the Department of Midwifery have a contractual relationship to provide clinical educational opportunities to the students and as such the Practicum Coordinator and preceptor may share information about student progress, skills assessment, practice concerns, etc. These communications will be treated as confidential, on an as needed basis for legitimate educational interests in accordance with FERPA.

Further, the student is expected to understand and follow confidentiality rights with regard to the HIPAA Privacy Rule, as required by law. Students will be provided with a HIPAA tutorial and quiz which they are required to complete demonstrating basic understanding of client confidentiality. Additional resources may be found at the U.S. Department of Health and Human Services <http://www.hhs.gov/ocr/privacy>.

CLIENT CONSENT

All clients should be informed that you are part of a midwifery team as a student of the Department of Midwifery at Bastyr University and are not a primary care provider. The preceptor should introduce the student to the client and is asked to use a written form soliciting the client's consent regarding the student's participation in her care. Additional consent from both the client and the preceptor should be secured prior to the student sharing any identifiable client case information with classmates and instructors and such sharing should only occur during a formal learning activity organized by Department of Midwifery faculty.

EXPECTATIONS OF STUDENTS IN PRACTICUM SITES

Student Availability

Student midwives are expected to report to their practicum sites as scheduled. It is the student's responsibility to be in communication with the preceptor to make arrangements for a start date and time. If the rotation begins at the start of a new quarter, the first day of the quarter is considered the first day of Practicum. Clear communication is the key to a successful clinical experience. Please arrive at the clinical site at least 15 minutes in advance of the first appointment of the day and be ready to work. Tardiness impacts everyone and is not professional behavior.

On-call

Students who are on-call to attend births must be ready and available to leave promptly in response to a call. This means the car is ready, gas tank filled; clothes packed in advance, food and snacks ready to go. Childcare arrangements, including backup plans, must be secure and arranged well in advance.

The student is responsible to have the preceptor's phone and pager number, back-up midwife's phone and pager number, client names, addresses, phone numbers, client estimated due dates and a map or directions to the clients' homes in your possession at all times when on-call.

Sobriety

While on-call and during and before clinic hours, students are to maintain sobriety. Sobriety is not limited to alcohol consumption and includes any prescription or non-prescription medication that may impair a student's judgment. A student may be terminated from the midwifery program for not complying with this policy.

Time Off-Call

The student is allowed 48 hours off-call, per month without needing to claim it as vacation time. This does not include mandatory, on-site class times. Time off-call should be negotiated with the preceptor with consideration given to the needs of the practice.

Vacations

During Practicum, vacation time may be arranged prior to placement in a site, and only in communication with the preceptor and Practicum Coordinator.

Students are allowed two weeks of vacation from Practicum per year in addition to the 48 hours per month. This may be taken in segments or all at one time and should be scheduled in advance and ideally between clinical rotations. **Notify the Practicum Coordinator and the preceptor of vacation plans prior to placement in a site.** Except in the case of a family emergency or illness, short-term plans may be made only with the advance approval of the preceptor and Practicum Coordinator. Student midwives are valuable assets to their clinical sites and as such an absence presents a hardship to the practice. Please minimize the impact of any absence by planning well in advance.

Sick Leave

During Practicum the student is expected to participate in clinical work in addition to intrapartum hours. Occasional and brief absences due to illnesses need no special arrangements other than clear communications with the preceptor. If a student misses one or more weeks of activities due to illness, that time must either be taken as vacation time or as an emergency leave of absence and could result in the need for extended time in the midwifery program. Students who

are seriously ill and predict they might be out for more than one week should notify the Practicum Coordinator in addition to the preceptor.

Student Appearance While in Practicum

Though much of what follows may seem obvious to you, it has been our experience that some students need guidelines in this area.

Midwives serve a wide variety of clients from all walks of life. When a preceptor agrees to take a student, s/he is opening the practice to a person whom s/he often does not know well. S/he has already established a relationship with the community and has a professional demeanor including standards of dress and conduct that best suits the families that s/he is serving. It is a sign of respect and gratitude to the preceptor for students to modify their appearance in order to appear professional to the clients in that practicum site. At a minimum, the Department of Midwifery expects its students to present themselves with clean and neat hair, fingernails that are clean and short, clean, pressed, unstained and modest clothing, and appropriate hygiene to control body odor.

Each preceptor will define professional dress in a different way. It is up to the student to identify dress expectations from the preceptor. If in doubt, use the preceptor's attire as a guideline and err on the side of modesty. Also, be aware that in many settings, the initial visit with a client is more formal than subsequent visits.

Some topics that you may need to discuss with your preceptor are: style of clothing appropriate for client visits (i.e. skirts, pants, scrubs, uniform, etc.); style of clothing appropriate for births; whether visible tattoos or any piercing needs to be covered or removed; appropriate hair and nail polish colors; and whether leg and armpit hair should be covered.

Be mindful also of common etiquette such as chewing food silently and not chewing gum, avoiding eating odiferous foods before clinic or at a birth, stepping out of the room to blow your nose or pass gas, etc. Also be aware that heavy perfumes and scents are overpowering especially in a small clinic room and some people are allergic to perfumes.

We recognize that it can be uncomfortable to work in a client population that is markedly different from your own. Sometimes dressing professionally for a given community feels like masking your identity. If you have concerns about working within a community that requires you to alter your appearance, please discuss this with the Practicum Coordinator. However, please also recognize that as a student you may not be able to express your religious, political or cultural beliefs with your preceptor's clients.

Hepatitis B Immunizations, Universal Precautions, TB and Rubella Screening

Students should be aware that the practice of midwifery, with its potential for exposure to bodily fluids, increases the risk of contracting HIV, Hepatitis B and Hepatitis C. For personal protection it is recommended that students seriously consider vaccination against Hepatitis B. To protect against HIV and other infections, Universal Precautions are taught throughout the curriculum and students are instructed to strictly adhere to these precautions in all clinical situations. Students should provide their own protective devices if they are not satisfied with the level of protection the preceptor uses.

Rubella is a highly contagious illness that can seriously harm a developing fetus if contracted in early pregnancy. Students should know their Rubella immunity status. If you are not immune, it is advised that the student be vaccinated against Rubella prior to participating in clinical work.

Most preceptors will assume that a student is Rubella immune and if you are not it is your responsibility to inform the Practicum Coordinator and the preceptor.

Pertussis is a highly contagious respiratory disease that can be very dangerous and even fatal for infants, young children and others whose immune systems are compromised. Because of the contagious nature of this disease and because of the recent Washington epidemic in 2012, students are strongly encouraged to protect themselves and their clients with a vaccination for Pertussis.

Washington State birth centers require that all employees (including students) be tested for TB. The Department of Midwifery follows the same requirements of Bastyr Natural Health Center as found on MyBU in policies: Clinic/Information/Clinic Information/Policies-Procedures/TB Policy. This policy requires that all students have annual screens. Screenings are offered on campus twice a year and at the BCNH clinic at reduced rates for students.

Practicum Documentation

Unless otherwise instructed, all documentation of clinical hours and client contacts must be entered into Typhon within ten (10) days of the client visit or the birth. Visits or births not entered within the ten days will not be approved except in case of special circumstances and only with the permission of the Practicum Coordinator.

Note: Students are strongly advised to have a system for duplicating information of clinical hours and client contacts until they are verified and approved in Typhon.

See: Appendix A: Typhon Data Entry Instruction.

Practicum activity will be accepted only when it occurs during enrollment in Practicum.

PRECEPTOR/STUDENT CONTRACT

At the beginning of each quarter in Practicum students are required to complete a Preceptor/Student Contract with their preceptor. This contract outlines learning objectives and expectations of the student and preceptor of each other. This form is found on the Department of Midwifery homepage and is to be signed by the student and preceptor and turned into to the Practicum Coordinator at the beginning of each quarter.

PRACTICUM COURSE EVALUATION

At the end of each quarter in Practicum students are required to complete a Practicum Course Evaluation found in the EASI section of Typhon. Students are encouraged to share substantive feedback that will be used to strengthen educational opportunities in clinical training. These evaluations are confidential but will be compiled into a report for the preceptor's use in supporting students in their clinical education. If the Practicum Coordinator has concerns about issues of safety she will first consult with the student prior to contacting the preceptor.

CLINICAL ROTATION EVALUATION

This evaluation is found in the EASI section of Typhon. When students have completed a clinical rotation they are asked to give feedback about that clinical training site. This information will be used by the Practicum Coordinator to evaluate the clinical site for future student placements and to give preceptors feedback about student experiences. The form itself is not shared with the preceptor and information will be shared in an anonymous format.

CONTINUITY OF CARE REQUIREMENTS

Client contacts will be tracked in Typhon but additionally, students who will be applying to the North American Registry of Midwives as a Certified Professional Midwife will be required to complete a paper tracking form found on the Department of Midwifery homepage under Practicum forms. This form requires that the student track and have preceptor signatures for all of the criteria of the Full Continuity of Care contacts: at least 5 prenatal visits (spanning two trimesters), the birth, the newborn exam, and at least 2 postpartum visits all as the primary midwife under supervision.

Note: These client contacts are to be signed by the preceptor verifying at the time of the visit and not retrospectively.

ENTRY-LEVEL SKILLS CHECKLIST

Each student will be provided an Entry Level Skills Checklist at the beginning of Practicum. This checklist is an abbreviated version of the North American Registry of Midwives (NARM) Skills Verification form. All of the skills represented on the Entry Level Skills Checklist must be signed by a preceptor who can verify that the student has mastered the skill. (*Note: There are four skills which require two preceptor signatures.*) Students are expected to keep this form throughout Practicum, accumulating signatures from instructors and preceptors each time a skill is mastered.

Note: The completed Entry-Level Skills Checklist is a requirement of graduation. Keep this form safe, make copies as needed, and have it signed as soon as a skill is mastered. Students should begin collecting verification signatures very early in Practicum and continue throughout the program.

Further points on filling out the Entry Level Skills Checklist:

- More than one preceptor may sign off on each skill although two signatures are only required of four skills.
- The four skills requiring two signatures are:
 - Performs an initial history and physical examination including vital signs;
 - Performs routine prenatal physical exams;
 - Performing a newborn exam; and
 - Performs thorough and appropriate maternal 4-6 week postpartum check-up.
- Periodically students will review with the Practicum Coordinator their progress with accumulating skills verification signatures. A thorough review will be done in quarter 10 to allow for contingency plans if numerous or key skills are not yet mastered.

Practicum Timelines

The following is a guideline for students in navigating Practicum.

Prior to placement in a clinical site

- Verify with the Practicum Coordinator that the clinical site has been fully approved and that there is a valid Educational Affiliation Agreement in place.

Daily in clinical site

- Complete Case Logs and Time Logs reflecting clinical hours and client contacts including births as they occur.

Monthly

- Review the Entry-Level Skills Checklist with the preceptor and have skills signed off as they are mastered. (To be fair to the preceptor this is done as a skill is mastered and the preceptor has recently seen the student perform the skill but at a minimum, review this form on a monthly basis.)

Quarterly

- At the beginning of each quarter complete the Preceptor/Student Contract, sign and turn it in to the Practicum Coordinator.
- About one month before the end of each quarter, initiate a conversation with your preceptor about scheduling a time to review the preceptor's evaluation of your clinical skills. Getting this on the calendar early helps make sure it happens!

At the end of each clinical rotation

- Complete the Clinical Rotation Evaluation found on Typhon. This evaluation is different from the quarterly Practicum Course Evaluations because the student is looking back at the experience in its totality and with a different perspective.

At the start of the student's final quarter

- Students will meet with the Practicum Coordinator to review clinical numbers, overall evaluations and the Entry-Level Skills Checklists.

Prior to graduation

- Submit a final, original signed copy of the Entry-Level Skills Checklist to the Practicum Coordinator.

Practicum Training, Planning, Advising and Communications

QUARTERLY STUDENT CONFERENCES

Students will meet with the Practicum Coordinator at least once per quarter to review progress and make plans for upcoming clinical placements. The purpose of this meeting is to identify training goals, to develop a plan for both long-term and short-term placements and to help the student outline specific learning objectives for the up-coming practicum rotations. An assessment of the hours and client contact numbers necessary for graduation shall be compared to the student's numbers reported to date. The student and Practicum Coordinator together will develop strategies and plans to optimize student success in learning objectives. Quarterly conferences will preferably take place in person, but if necessary may be held by telephone. The conferences are for vocational counseling purposes and are required but not graded.

During the Summer Quarters, when students are not attending onsite, they are expected to check in with the Practicum Coordinator at regular times.

GUIDELINES FOR DEVELOPING A POTENTIAL PRECEPTOR

The Department of Midwifery supports students being involved in preceptor site development. This is particularly important for students who are living or desiring clinical rotations in areas where we do not presently have established clinical sites. To facilitate efficient communications, the following guidelines have been developed for students wishing to explore a relationship with a preceptor who is not already an approved preceptor.

- Plan at least 6-12 months ahead when possible.
- During quarterly conferences with the Practicum Coordinator, evaluate the proposed site in order to determine that the nature of the site fits into your overall clinical plan--preceptor, location, timing, volume, length of stay, level of responsibility, call schedule and type of experiences to be gained are all important considerations.
- Communicate any interest in a particular site or preceptor to the Practicum Coordinator to determine if this particular site already has a history or relationship with us. Discuss the best way to approach the preceptor and defer to the Practicum Coordinator if communication is already established.
- Please do not initiate contact by yourself with an existing Bastyr University preceptor site.
- Make a plan with the Practicum Coordinator (including who will do what, how and by when) to initiate contact.
- Students should ask the Practicum Coordinator to review and/or edit any correspondence they are planning to send to a prospective site.
- The Practicum Coordinator has potential preceptor packets that can be shared with new clinical sites. Please ask for one of these.
- After initiating written contact, communicate with the Practicum Coordinator to create a follow-up plan.
- If there is preceptor interest, the Practicum Coordinator will send additional information as needed and make official contact with the preceptor to initial the process for credentialing and approval as a clinical site.

- Before beginning any preceptorship as a Department of Midwifery student, the site must have been officially approved and a signed Educational Affiliation Agreement must be on file. No practicum credits will be awarded for clinical experiences performed prior to approval of the clinical site.
- Keep your Practicum Coordinator informed about the nature and suitability of your site. If there are difficulties, please contact her for problem-solving or logistical support.

PRECEPTOR SITE ASSIGNMENTS

Clinical placement can be a source of anxiety for midwifery students because so much is invested in the practicum experience. We recognize the importance of making a good match of clinical training opportunities with our students, including location, clinical training expectations, time commitments, etc. Below are some of the considerations we use in determining clinical placements:

Student:

- Personal preferences for particular preceptors or location.
- Financial and family situation.
- Has the student already relocated for a Practicum rotation? Most students will be required to relocate for a portion of their clinical training.
- How much experience does the student need (numbers)?
- What kind of experience would complement what the student has done already?
- Does the student desire to do a foreign clinical rotation?
- Languages spoken.
- Personal connections the student has established.
- Will the overall experience be balanced between all the quarters of practicum?
- Will the student be able to meet minimal requirements?
- Previous evaluations from preceptors.
- Student's strengths and weaknesses.
- Student's personality.

Preceptor:

- Preferences for student skill levels.
- Volume of births.
- Homebirth/Birth Center/Hospital site.
- Volume and types of clinical experience (e.g. gynecology, hospital practice, etc.).
- Is it a commutable distance for students? (<1hrs)
- Past history with preceptor. Is there an established relationship?
- How much hands-on experience can a student get?
- Opportunities for Continuity of Care.
- Personality of the preceptor.
- Are there commitments to students from other programs?

We take all of the above and more into consideration for each student and balance it against the needs and desires of classmates and preceptors and do our best to make this a fair and equitable process.

STUDENT/PRECEPTOR WORKING RELATIONSHIP GUIDE

The following guidelines are intended to serve as a tool, to be used by the preceptor and student, as they create a unique working relationship based on a clear understanding of the needs and expectations of each. Recommended reading: Becoming a Midwife by Carolyn Steiger, Chapters 2 and 5.

Overview of Practice

Schedule an orientation of the clinical site, including:

- Clinic schedule
- Equipment
- Routine procedures
- Practice protocols for routine and non-routine care
- Time frames, such as length of prenatal visit, etc.
- Length of routine postpartum watch (how long will the student and preceptor be staying in attendance during immediate postpartum period)
- Overview of the practice – community context
- Introductory literature
- Other personnel
- Back-up arrangements
- Religious, ethnic or cultural issues particular to the practice that the student should be aware of and any expectations around these issues
- Any certifications, vaccinations, equipment, supplies, etc. that the student is expected to obtain prior to arriving at the preceptorship. (*Note: Licensed Birth Centers in Washington State have requirements for which the student is responsible. See Appendix B to this handbook.*)
- What expenses the student can expect to incur in relation to this preceptorship, if any

Student Roles and Responsibilities

Have the preceptor define student expectations around:

- Role at births
- Role in clinic and client care
- Expectations of student involvement in the day-to-day activities of maintaining a clinic
- Other ways of contributing to the practice

Communication: Establishing a System Founded on Mutual Respect

The student is a student of midwifery, not of life. Personal boundaries and differences must be honored and respected by all parties. *We strongly recommend that the student discuss the issues and questions presented here before a preceptorship is begun.*

- How will the preceptor introduce the student to the clients?
- Discuss confidentiality: professional and personal.
- When is a good time to ask questions? If the student has information that conflicts with that of the preceptors, when, where, and what would be an appropriate forum for addressing these differences?
- How will the preceptor give feedback to the student during client care and at other times?
- Identify an ongoing mechanism of feedback that works for both preceptor and student.

Appearance

Discuss any requirements regarding dress and appearance other than neatness and cleanliness. Be specific. Please refer to: Expectations of Students in Practicum Sites, Student Appearance While in Practicum contained in this handbook.

Professional Conduct

Discuss what this means in relation to student behavior and conduct.

Punctuality

It is the expectation of the Department of Midwifery that the student arrives at clinic in advance of any scheduled appointments and be prepared to work.

Availability

- What is meant by “on-call?” What is the maximum distance the student may travel away from the clinic or coverage area when on-call? What is an acceptable response time to a call or page? Is there any routine phone or pager codes being used to identify the call as urgent or not urgent, etc.?
- School policy is that the student is allowed 48 hours off-call/month. How should the student make arrangements for off-call time including required attendance at onsites? What would work best for the practice?
- Should the student work exclusively with this practice, or can the student also precept or attend an occasional birth with another clinician? If assisting another provider, how would timing be arranged, which responsibilities would take priority?
- May the student decline to attend a birth or to attend a particular client? Which reasons are acceptable, if any? Under what conditions will the preceptor “excuse” the student from her usual responsibilities (serious illness, another birth, sick child, death in the family, car trouble, childcare difficulties, etc.)?

Student Roles

Discuss preceptor expectations regarding student attendance at:

- Initial consultations - what is the student’s role during the interview?
- Initial physical exam and client registration and history intake--what is the student’s role during the intake appointment?
- Routine prenatal visit--what is the student’s role (observe, chart, vitals, counseling and education, clean up clinic area, hands-on, etc.)? Will the student be expected to attend all visits?
- Routine postpartum visit -what is the student’s role?
- Labor and Birth - when should the student expect to arrive? With the clinician? At a later stage of labor? How long should the student plan to stay? **Remember: It is a Department of Midwifery and NARM policy that students are always supervised by their preceptor during labor, birth and the immediate postpartum period.**
- Should the student plan to go to every birth or will this be determined only after the family approves and specifically asks the student to attend the birth? How is this relationship and invitation facilitated by the preceptor?

Other Issues

Please identify to the Practicum Coordinator of any issues pertinent to the success of this working relationship that have not yet been addressed. Include in this exchange any personal issues that may affect the quality of the student learning experience.

GRIEVANCE PROCEDURES

The Department of Midwifery is committed to providing students with exposure to a variety of styles of healthcare within the context of safe and reasonable practice. We are committed to honoring diversity in midwifery practice and pride ourselves on our affiliation with a variety of highly qualified preceptors. If a concern or interpersonal conflict exists between a preceptor and a student, it is strongly recommended that it first be resolved between the parties themselves. Confidentiality regarding a dispute should be maintained at all times. Students are encouraged to notify the Practicum Coordinator for advisement and input whenever there is a concern or a challenging situation.

BINDING CONTRACT

The Educational Affiliation Agreements and Preceptor/Student Contracts are binding agreements and it is expected that all parties to these agreements will act within the respective terms. If either party is unable to adhere to the terms of the contracts or Department of Midwifery policies, they should promptly initiate a dialogue with the Practicum Coordinator and work to remedy the discrepancy. If a mutually satisfactory solution is not identified, the Department of Midwifery may remove a student from a particular clinical site.

CLINICAL STANDARDS OF CARE CONCERNS

Occasionally issues of clinical competence, standards of care, and alleged misconduct are brought to the attention of Department's faculty or staff. Given the diversity of standards and styles of practice in the out-of-hospital arena nationwide, clinical concerns should be limited to those that involve legal concerns and safety issues for the mother, baby, or student.

The following procedure outlines steps a preceptor, student, or administrator at Department of Midwifery can take to resolve a concern.

1. **Direct Communication**: As stated above, we encourage direct communication between student and preceptor. If the student wants to remain at the site, it is in the best interest of the preceptor and student to hold frank, open and respectful discussions regarding standard of care issues.
2. **Involvement of the Practicum Coordinator**: If the student or person with the concern is unwilling to speak with the preceptor directly or the issue remains unresolved they should address their concerns to the Practicum Coordinator. The concerned party may be asked to put their concerns in writing and should be concise, objective, and factual, citing specifics. If the concern is in regard to a legal or safety issue, the Practicum Coordinator or Department Chair will contact the preceptor directly to discuss the issue. An opportunity for the preceptor to respond and clarify the situation will be provided. The student may or may not be involved in this dialogue.
3. **School Plan to Rectify**: If, after clarification and communication, it is apparent that there is a standard of care issue involving a legal or safety issue, a plan may be established between the Practicum Coordinator and the preceptor. Should the preceptor decline to discuss the situation or take action, the site may be closed to Department of Midwifery students. Rectifying the situation may include any of the following conditions:
 - The student is removed from the site permanently or until the issue has been addressed to the school's satisfaction.

- The preceptor outlines a plan for addressing the concerns raised and/or modifying care provisions to address the areas of concern. The student may or may not be involved in the site during this period of time, at the school's discretion.
- Anyone with first-hand information about safety or standard of care concerns is entitled to make a formal complaint to the State Department of Health.
- Involved Parties Notification Plan: The parties involved in the concern are notified, as appropriate, of the school's course of action.

APPENDIX A: Typhon Data Entry Instructions

This is a separate document found on Practicum course on Moodle.

APPENDIX B:

Working in a Birth Center in Washington

The following are requirements to working in a Birth Center in Washington State. It is the student's responsibility to provide their preceptors with evidence of the criteria outlined below.

Verification of AIDS Training

Students receive the components of the necessary AIDS training in Well Woman Health & Assessment, Clinical Skills 1 and in Gynecology. Upon request, the Practicum Coordinator will provide students with an AIDS training verification document for the student after all components have been completed.

Current Adult CPR

Please be prepared to show verification of certification to your preceptor when you go to your clinical orientation. Students are required to have current adult CPR for the Clinical Skills 1 course. If you did not take the Clinical Skills 1 class, or your certification has expired, you are responsible for getting this training.

Current Neonatal Resuscitation Provider Certification

Please be prepared to show verification of certification to your preceptor when you go to your clinical orientation. Students receive neonatal resuscitation training and certification as part of the Clinical Skills 1 curriculum. If you did not take the Clinical Skills 1 class, or your certification has expired, you are responsible for demonstrating current Neonatal Resuscitation Provider.

Negative TB (Mantoux) Test

Students are responsible for obtaining a TB test each year.*

Criminal Background Check

The State of Washington requires that everyone working at a birth center passes a criminal background check. Department of Midwifery students are all required to complete a criminal background check. The Practicum Coordinator will provide students with the information to complete this process. A criminal background check is also a requirement for licensure in the State of Washington.

*This test can be obtained at most King County Public Health Clinics in the Seattle area. (<http://www.kingcounty.gov/healthservices/health/communicable/TB.aspx>). TB testing is also offered periodically on the Bastyr University campus and at the Bastyr Center for Natural Health at discounted prices for students.

APPENDIX C:

Frequently Asked Practicum Questions

Q. How should I count time I spend at my preceptor site setting up or preparing for and/or participating in childbirth classes?

A. You can count some hours spent preparing for and participating in childbirth classes as clinic hours, but there are no client contacts earned for these classes. These hours should be recorded in the Time Logs section of Typhon. Students will not receive hour credits for repeated childbirth classes. Please contact the Practicum Coordinator for more information. Students may also choose to participate in childbirth classes independent of Practicum either as a volunteer or as a paid position in a midwifery practice.

Q. When my preceptor and I meet to discuss cases over lunch or debrief a birth, are these also clinic hours?

A. Yes. The time you spend in chart review or general discussion of clinical scenarios or clinic practices and protocols do count and are recorded in the Time Logs section of Typhon. Discussion with a preceptor about a specific client should be tracked in the Case Logs section of Typhon if they happen in connection with a client visit or birth.

Q. How much time after the birth can be counted as intrapartum hours?

A. You may count all the postpartum hours immediately following the birth that you and your preceptor spend with the mother and newborn as intrapartum hours recorded as a Case Log in Typhon. *Note:* Students are prohibited from providing care to the client when the preceptor is not at the site. When the preceptor leaves, the student leaves.

Q. How much of a newborn exam do you have to perform in order for it to count as performed, rather than observed?

A. You must perform the entire newborn exam to count it as performed vs. observed. For example, weighing the baby and putting drops in the newborn's eyes does not count as a performed exam.

Q. How do I record a situation when the following happens: a woman starts to go into labor, the midwife, student and laboring woman all meet at the birth center (home, hospital, wherever). We are all there for a few hours before it is decided that the mother is not in labor and can go home. We all meet up again later when the woman is more actively laboring, and indeed, she has the baby soon thereafter.

A. Any hours spent with a laboring woman count as intrapartum hours. If you are unsure whether the woman is actually in labor, ask your midwife. One way to ascertain this information is the patient's chart. If the preceptor counted those hours as part of the latent labor than you may as well. If it is not considered part of early labor, count it as clinic hours and a client contact.

Q. What if I am at a birth and I have to leave before the baby is born (for example, I have to leave to go to another birth)?

A. You can count the hours you spent with the laboring woman as intrapartum hours. Complete a Case Log for the birth, do not claim a birth under the Intrapartum Skills, but do list any skills you performed and check the box for "Intrapartum Hours Only." You must enter information in the Birth & Delivery section to receive credit for intrapartum hours. Include information in the Clinical Notes narrative section explaining why you were not at the birth.

Q. Can we count hours spent driving to home visits, births, etc?

A. Not unless that time can be legitimately counted as an educational experience. For example if you are driving with the midwife and spending that time reviewing midwifery cases, debriefing a birth and/or talking about clients or practicing triage phone calls, you can count the travel time as clinic hours either in Time Logs (for non-client specific discussions) or in a Case Log for a client and log only Preceptor Conference. If you are driving to a birth with your preceptor and you are discussing the client you can add the time as Preceptor Conference into the Case Log for that birth. Otherwise, travel time is not counted.

Q. Can we count Clinical Skills classes at school as clinic hours/contacts?

A. No. You are receiving academic credits for these classes.

Q. I did a postpartum visit with a mom and baby. How do I count this?

A. You will enter two Case Logs in Typhon—one for the woman and one for the baby. Divide the total visit time between the two clients.

Q. How do I count a prenatal or postpartum visit where I observed or conducted a gynecology exam?

A. If, during a prenatal or postpartum visit, you complete a gynecology exam (STI screening, speculum exam, Pap test, birth control counseling, etc.) you may count the contact as either an initial prenatal **or** final postpartum **or** gynecology visit depending on your preference and/or the numbers you may need.

Q. When should I think about doing a foreign clinical rotation and when should I begin to make these plans?

A. Foreign rotations are appropriate for the senior level student who has completed the Midwifery Care 6: Challenges in Practice and who has also participated in enough births at the Assisted/Involved and Supervised Primary level so that the student's skill level can be assessed as appropriate for a foreign rotation by the preceptor and the Practicum Coordinator. Summer quarter of the second year is a good time to begin discussions with the Practicum Coordinator about whether or not a foreign rotation is a desirable site for the upcoming year.

Additional Documents Submitted

The following documents were also attached with the applicant's follow up and reviewed by the department:

Bastyr University Course Information for Students – Winter 2013

- MW5307 - Midwifery Care 5: Postpartum & Newborn Care
- MW5324 – Clinical Skills 4
- MW4308 – Breastfeeding and Lactation Education

Midwives College of Utah – MDWF 246 - Postpartum Care Student Syllabus (09-01-09)

- Section One: Preparing for the postpartum period
- Section Two: The postpartum period
- Section Three: Handling common difficulties in the postpartum
- Section Four: Nutrition and exercise during postpartum
- Section Five: Abnormal situations in the postpartum period
- Section Six: Emotional, psychological, social, cultural, and sexual aspects of the postpartum period
- Section Seven: Postpartum visits and care schedule

Midwives College of Utah – HLTH 332 – Pediatrics Student Syllabus

- Section One: The Apgar score
- Section Two: Anatomy and physiology of the newborn
- (no section three included)
- Section Four: The physical examination of the normal newborn
- Section Five: The newborn history and examination from birth to six weeks of age – assessment forms and practice guidelines
- Section Six: Common newborn procedures
- Section Seven: Prophylactic procedures and immunizations
- Section Eight: Monitoring growth
- Section Nine: Dehydration and fluid therapy
- Section Ten: Safety and prevention – from birth to 12 months of age
- Section Eleven: Neonatal drug withdrawal [neonatal abstinence syndrome (NAS)]. The effects of tobacco, drugs and alcohol during pregnancy

Appendix D

Public Hearing Transcript

**Midwifery Scope of Practice Sunrise
Public Hearing Transcript
August 9, 2013**

The hearing was called to order at 9:03 am with initial instructions to participants. Kristi Weeks, hearing facilitator, introduced herself. She is the Director of the Office of Legal Services in the Department of Health and legislative liaison for the Health Systems Quality Assurance Division. She also introduced Sherry Thomas, coordinator of the sunrise review process, Deborah Johnson who's assisting with the review, and Sandi Green, timekeeper if needed. She next introduced the hearing panel, whose role is to make sure the department has all the information necessary to make sound recommendations. Two panel members are in the Health Systems Quality Assurance Division. These are Marlee O'Neill, staff attorney, and Barb Runyon, program manager in the Office of Health Professions and Facilities. She also introduced Meghan Porter, Communications and Evaluation Coordinator for Washington Traffic Network in the Environmental Public Health Division.

Ms. Weeks explained that the purpose of the hearing was for proponents to make their presentation and for opponents and other interested parties to comment on the proposal. She stated that after the hearing, there will be a 10-day written comment period before the department drafts the initial report. This is to allow for participants to provide additional information on topics brought up at the hearing, and allow those who could not attend the hearing to submit information

She also explained that the recommendations in the report will be based in part on the hearing. The report is expected to go to the Secretary of Health for approval in October. Ms. Weeks gave additional instructions for testifying, including sticking to the statutory criteria and avoiding political arguments that are not part of the sunrise process. She gave some tips for testimony based on experience in past hearings, such as indicating agreement with previous speakers, rather than repeating testimony, if points have already been made.

She then invited the applicants to begin and reminded them to keep their presentation within the 30-minute time limit so there is time for panel questions and for others to testify.

Following is a transcript of the hearing proceedings. The applicant's PowerPoint presentation is attached at the back of this transcript.

VALERIE SASSON: Good morning. Thank you for being here. I am Valerie Sasson. I am a licensed midwife, a certified professional midwife, current president of the Midwife's Association of Washington State, co-owner of the Puget Sound Birth Center, midwife for 14 years here in Washington.

ELIAS KASS: I'm Elias Kass. I'm a naturopathic physician and licensed midwife practicing in Seattle, and I'm also the treasurer of the midwife's association.

VALERIE SASSON: We are very grateful to Representative Cody for making this possible for us today and for your time and attention. Really, this is really a spectacular amount of preparation to be here today, so thank you.

I'm sorry that you can't actually see this, are the handouts sufficient for you to see?

PANEL: Yes

VALERIE SASSON: Ok, great. So, as you well know, the legislation that we all work under, RCW 18.50, was put into place in 1978 revitalizing an earlier law from the early 1900's. It has been over these 35 years really the most highly functional piece of midwifery legislation in the nation. In fact, the remainder of the states look to us for guidance as they are creating legislation in their own states. I think that's fairly remarkable. We have seen, in the 35 years, a tremendous growth of midwifery. Home birth had remained fairly stable, but since the onset of our malpractice insurance through the JUA, the OIC, in 1996, we've seen a growth of out of hospital freestanding birth centers. And really the tremendous growth in accessing pre-care has mostly come from those clients.

Since we began tracking in Washington State, the type of provider, in 1987, licensed midwives in Washington State have signed 35,000 birth certificates. So that's not just the clients we care for, most of us have at least a 14-15% postpartum or intrapartum transfer rate to hospitals. That is how many babies we actually caught and signed. You'll forgive my midwifery speak. We catch babies, we tend clients, you know so if you need me to translate that, please let me know. But, hopefully, you catch my drift. So, 35,000 babies safely delivered out of hospital with licensed midwives. The way that we have been caring for newborns, which I'll talk about in a minute, means that at least a conservative estimate of 100,000 newborn encounters as a consequence of those 35,000 births, roughly 3 per baby has already taken place since 1987. So, although the language of the sunrise review is that this is a change in our scope of practice, it is not a change in our customary care. So, therein lies the rub. What's normal for us? I'm not sure how familiar any of you are with midwifery care, but what's normal for us is that we're trained and licensed to care for well women, with healthy low-risk pregnancies, and to care for their newborns immediately postpartum. We are mandated to consult and refer in the presence of anything out of the absolute ordinary. Typically, what happens is that we provide prenatal care on the same schedule that everyone does. It is our custom to provide longer visits, so 30-60 minutes is a normal visit, but, again, on a regular schedule. We offer every test that is available to our clients. Our model of care is really a mutual decision making process. So, at the time that we are actually catching the baby, typically, we have a very developed relationship with our clients. We deliver the baby, do the immediate APGAR assessments, one every 5 minutes, and we are all certified in neonatal resuscitation by state requirements. We will offer and provide, according to our WAC, with legend drugs and devices, vitamin K and ophthalmic eye ointment. We can administer Hepatitis B vaccine and immunoglobulin to baby infants, babies whose parents are affected by Hepatitis B. Typically, we do a newborn exam within an hour of birth. A full head to toe, that's well documented in our training. We discharge clients to home with careful verbal and written information about what is normal for both the mom and the newborn and, typically, in my practice, we see clients typically for one postpartum home visit. There are midwives who see clients at home every day for five days. Typically, at least a two day home visit. And at that two day home visit, we're assessing for weight loss, adequate breast feeding. We're assessing for jaundice, bonding. We are at their homes, assessing for the appropriateness of the home environment, and we are offering that first newborn screening. We are, of course on call 24/7 for our clients so usually we'll hear in a couple of days from them on some umbilical issue, you know, why does my baby suddenly smell so badly? There's, you know, there's lots of contact in those first couple of days.

Those of you who have been with brand new parents know that as soon as you have a brand new family in a home with a new baby, the shit hits the fan. They really have, you know, it is a very disorienting time of life. And so, there's really no other way to say it. So, it's a very disorienting time of life. It's a developmental crisis. And so, I feel like the hallmark of midwifery care is to hold those families very close through that time. And, as a consequence, we have pretty exceptional rates of breast feeding. We have minimal rates of readmission to hospital for babies or admission for our clients really, because we're watching for jaundice and weight loss and promoting newborn wellbeing. Typically, we'll see clients back between 7-10 days, assessing again for mom's well-being, for newborn's well-being. We always

weigh the baby again, assessing for bonding and breast feeding. And we do offer the second PKU test at that time. So the second newborn screening is offered at that time.

We are, as an organization, recommending that clients make contact with a pediatric care provider while they're still pregnant. Who will they be seeing? And that they make an appointment to have their baby seen or at least make verbal contact with pediatricians in that second week. Often times, pediatricians I've worked with a lot will tell my clients, well if you're in midwifery care you don't need to come 'till 8 weeks. That is very customary in my community, because they know that they wouldn't necessarily be seeing a hospital based baby until 8 weeks either. So, I'm seeing the baby, or they would see the baby one week and then, but we're doing that visit. So, they would see the baby at one week or two weeks and then not again until 2 months. So, if we need them for anything, obviously, we will call. I think we'll touch on that again a little bit later. So, then we usually see people back in our office at three weeks, five weeks, seven weeks and those visits really are newborn care, limited to again, bonding, breast feeding. It's hard to ask families about sleep and breast feeding without talking about both mom and baby at the same time. It's sort of a family affair, both of those things. And we will weigh the baby in at every visit. My assumption in my practice is that babies are also being followed by pediatricians or at least they have contact, but again some of them aren't seen until 8 weeks on the preference of the provider and the pediatrician...the pediatrician and the parents both.

So, I want to say a little bit about why it is that we're here today - what happened in this 2013 legislative session. We were, as you know, running a bill that had three aspects - the CPM, the required peer review, and the piece about continuing education. And, as we were working towards that bill this session, it came to our attention, as a consequence of the third party carrier auditing one of our midwives, that much to our surprise, (perhaps a little naïve), but frankly, much to our surprise, there was not a connection between what we consider and have considered now for 35 years, our customary practice, our standard of care, and what was actually written in the scope of practice in our statute. And numbers of us looked it up, we couldn't believe it that it was absent; that we couldn't connect the dots, and really, that's what we're asking you to help us do today is to connect the dots between what is our customary practice and what is in statute. And so we, with I think tremendous efficiency added "and newborn care" to 18.50 and to the bill that we were running and were blocked and given the opportunity to be here at sunrise review. So, I think, that's all I have to say on that.

So, I just wanted to give some background about why it is that we feel so strongly that we are prepared to provide the care that I described to you. And you may know there are several pathways to become a licensed midwife in Washington State, the most common of which is to attend AMEAC, the Midwives Education Accreditation Council, AMEAC accredited school. Here in Washington State, Bastyr University, which actually is the one and only Master's degree granting program in the state for licensed midwives, is the local option. Many, many people apply through the Midwifery College of Utah. There are eight other AMEAC accredited schools around the country. With AMEAC accredited school graduation, you sit the licensing exam. In Washington State, it has two components; one is the piece that's the state exam that is primarily about our RCWs and WACs, in that it does ask questions about what are legend drugs and devices which include vitamin K for newborns and the ophthalmic eye ointment. We do carry resuscitation equipment, newborn airway devices. All that is included in our WAC. You sit that exam and then the NARM exam, which is the National Association of Registered Midwives, I think. Anyway, the NARM is the national exam that is now required by Washington State. That's a very comprehensive exam. There's a didactic part...so there's an in-person part and there's a written part and roughly 15 percent of the study guide for the NARM covers newborn up to eight weeks, so I would say roughly five percent of the exam is probably two weeks to eight weeks, and at least ten percent of that exam is specific to the first 48 hours of the newborn's life. I believe that in the documentation you were provided you have that study guide. Anyway, so that's the licensing testing in Washington State. We do adhere to the MANA core competencies. That's the national standard for

direct entry midwifery and the international standards are the ICM, the International Confederacy of Midwives, and they're essential competencies. The NARM exam reflects, the NARM again required in Washington State, reflects both the MANA and ICM standards.

ELIAS KASS: So, again, I'm Elias Kass and I am in kind of a unique position because as a naturopathic physician I provide pediatric care and so I receive referrals from other midwives to do pediatric care for the babies who are delivered in their practice. And I also am a midwife, so I catch babies and I continue to care for those babies. So, what we see is that midwives provide really comprehensive wrap around care of the mother/baby as a dyad and when you're working on breastfeeding, it's very, very hard to treat one side of the breast feeding equation without the other side of the breast feeding equation. There is no breastfeeding without both of them. And so, even in cases where people have transferred to the hospital for the birth, often times they come back to us postpartum for care. And so that becomes even more important because of the high degree of contact that we have because we're doing a home visit. You know in our practice, even if they deliver in the hospital, we still do a home visit after they come home to make sure everything is going well, again looking at jaundice, breast feeding, bonding, the home situation. So, that level of care, we're providing phone calls every day until the milk is in, in which we consider baby stool is yellow so that they're eating enough to be stooling regularly. So, we maintain that this obviously, that this is part of our training, that depending on the syllabi, that's either six weeks or eight weeks of newborn care. This care is customary and it's implicit in the statute. And so, what I'm going to talk about is what documents we have to guide our practice. So, there are two primary documents which I believe you have. One of them is the statement regarding the provisional care to newborns by a licensed midwife, which is our attempt, in advance of codifying in the statute, to express what it is that we do. What it is that parents can expect from us to safeguard their safety so that they know that we are providing for them APGARS, Vitamin K, eye ointment, Hepatitis B, if they are Hep B positive. And so that physicians, who perhaps are new to midwifery care, can come to understand what it is that we provide and to know if there are any gaps, what they need to be planning for those babies, what we need to be planning together. When the baby comes to them, will they know what has been provided to that baby up until then?

The other big document we have is the indications for discussion, consultation and transfer and that covers everything from antipartum care, intrapartum care, postpartum care and newborn care with various levels, so what it is that we should be having a conversation with somebody about. What it is that we should be having a conversation about with a physician. What should we be sending our clients or patients to be seen for. And so, that helps separate out by the gravity of the condition, the urgency with which they should be referred. It helps provide parameters, and so that's really important as a quality assurance piece within our professional organization and within our licensed body, so that people have sort of boundaries, you know we are all very well trained and it's really good to have a document to come back to that says like, hey, in our community what is it that we should be referring for. It's like oh, ok, well this amount of weight loss is concerning and we should be referring for that. So, I believe that you have a copy of that already. And so, what we recommend is that people make contact with a pediatric care provider before the baby is born. Let that person know that the baby has been born. And then have the baby be seen by two weeks. And as a pediatric care provider, I really love that because then I know that the baby has been born and I know that they're going to call me if there is a problem and sometimes that call comes from the parent and sometimes that call comes from the midwife. I've had midwives call at 2 am and say, hey we just had this birth and we're concerned about this, what do you think. And so, we'll talk it through and then I'll say hey, I really think that they should be seen, and then they'll take them to Children's or whatever the situation is. Or, it's like, you know I think that's ok. Here's what you can do then and then let's see the baby in the office tomorrow or the next day. And that's really important obviously with feeding issues, but sometimes there are much more serious things and I think that one of the things that midwives do so well, because the care is really tailored to well-woman and the well-newborn, is how really in-depth understanding of what normal is. And when you know what normal is,

you know what normal isn't. And you can recognize that. And you don't really need to know why it's happening or what it is or how to treat it. All you need to know is that you shouldn't and that you should find somebody who can. And so, we have a really well established practice of referring that's required by law, but also that's required by common sense and by the desire to provide excellent care, to find people the appropriate level of care. Whether that's an OB during pregnancy, whether that's a pediatrician, whether that's a hospital or an ER whatever it is, you need to be able to recognize what normal is, and what normal isn't.

So, you know, whether that's a murmur, whether that's a tongue tie, whether that's, you know I had a midwife call and say you know, this baby's got bruises. So we got that baby to the emergency room and that baby turned out had no platelets, had a very, very severe autoimmune thrombocytopenia and the midwife didn't need to know that the baby's dad had antigens that the mom didn't have and that's why all the platelets. All she needed to know was that that's not normal and let's get the baby to where they need to be and, and they'll figure out what's going on. And that's common across the entire medical system. We are always referring up to the appropriate level of care.

And so, one of the key components of the sunrise review is the cost efficacy if this process. And so, what we're asking is not that every single phone call and visit be codified into law. What we are asking is that the standard of care be defined broadly and the specific practices be left to the professional organization, much as, you know, the nurse practitioners code refers to the standard of care set forth by the professional organization. And that allows the care provider to evolve with the times. So, neonatal resuscitation is continuously evolving. You know the most recent iteration requires the use of a pulse oximeter in order to titrate the oxygen being provided. That's a new thing. And so, if we had to open up the legislation or rewrite the rules every single time there was a new thing; that would obviously be a tremendous burden. So, in the last couple of years, NRP was refined. They're considering adding new conditions, the new broad metabolic screening. We obviously provide both metabolic screenings. But if, for example, the second metabolic screening became mandated by law, that would be a big change that we would not want to have to go back to the rules to rewrite. The newborn hearing is evolving quite quickly within our community. That was traditionally a very hospital based thing. There are now several midwife practices that have brought in the equipment and that are offering drop-ins, which is great for families that don't really feel comfortable going to a hospital or a facility. Now there's the midwife drop-in they can go. They can get their audio emissions, and get their pass/fail. If they fail, again, we refer on. What's a screening measure. So, if they fail, we refer them to a facility that can do the full audiology testing. And so, that equipment is not in the legend drugs and devices, but it's something that's really, really important. The Department of Health recognizes it's really important. That the out of hospital birth community was one that was not getting screened adequately because of this gap. And so now we're bringing that technology into our community. We're bringing that screening to our families to make sure that all of our families can expect the same standard of care that they would receive if they had the baby in the hospital. The critical congenital heart defect screening is very, very new. Not all hospitals are even doing that. And so, that's something that midwives are beginning to bring into their practice again with that pulse oximeter, understanding the heart conditions that would lead to a fail. Understanding how to do the screening and then being set up in the community to know where to refer to. And Children's has a great program that they have a flow sheet and then they have the phone number, like if you have concerns, if the baby fails, we have a pediatric cardiologist that's available 24/7 that you can call. And Children's is a great resource and Medcon is a great resource that's available to every midwife in this state to call and to consult and get more information about where is appropriate for this one to go.

VALERIE SASSON: (INAUDIBLE)

ELIAS KASS: One more thing, is that ok? So, I brought something that I found recently, a study in pediatrics about newborn readmissions and how they are largely preventable. So, the top two reasons for

readmission at, I think, 40%, 40% feeding problems and 35% jaundice. So, these are things that we are asking parents about every single day. How's that baby eating? How's that baby stooling? How are they looking? And we're able to deal with those things on an outpatient basis. Obviously, if things are very severe, readmission. But, often, we can get home phototherapy. If we can work on breastfeeding, then we can fix these things, but the cost of readmission is \$5,000. So, this is a tremendous burden for the healthcare system we are effectively preventing. And I have copies of that.

VALERIE SASSON: I was describing to someone recently that my least favorite home visit at 2 days is when you walk into a brand new family's home and the mom and baby are holed up in a room where all the shades are pulled and the baby is wrapped like a little, you know, burrito, and they say, oh this baby is so good, all they do is sleep. And I know as soon as I turn the light on and peel that blanket back, I'm going to be looking at a squashed pumpkin, jaundiced case. No matter how much you say to people, you must nurse, you must nurse, the usefulness of going to their homes is fantastic.

Alright, so, back to how much I love this little graph. Sherry was incredibly clear with me in preparing for today that you really need to understand what is our intent. And, I'll be honest with you, our intent is to continue on doing what we're doing. That is our hope and that is what brings us here today.

This is a graph depicting what has happened for midwifery in the last, this is 9 years, but you know, roughly in the last 10 years. This is the trajectory of births that we have attended, licensed midwives of Washington State. So, from 2003 to 2012 we have effectively doubled the number of births that we're attending in Washington State. Midwives attend about the same number of births annually as are attended at the busy teaching hospital at the University of Washington. So, I just want to give you some context for that.

So, specifically, what do we need from the sunrise review? Three things:

- A recommendation to amend RCW 18.50.010 and to read as follows; you have the document there, we want the added verbiage "and to her newborn". That is the bill that we ran earlier this legislative session. And I feel rather strongly that we have enough support to back it up, because it reflects the customary standard of practice in our community.
- Secondly, as Elias said, what we would like is to address specific scope of practice in rule according to the secretary, rather than have it delineated in statute.
- And thirdly, we would like I think in keeping with the laws for the ARNP, the thinking included in our packet, to allow for ongoing input from our professional association in the rules process to accommodate evolving standard of care that Elias described.

So, very clearly, those are the three things that we are hoping from the sunrise review today.

Essentially, it came to our attention, as an opportunity to bridge the gap between what we believe to be covered. What we discovered is that their statute doesn't protect our customer care. We're not protected, our clients are not protected. We have...I have some difficulty with this, how do we meet your standards because what we're talking about is the 100,000, you know, encounters we've already done and it's using language about making something new, so we'll work on that. We'll see how we can manage that.

KRISTI WEEKS: Valerie, we struggle with that too because the statute is set up for new regulation, not expanded regulation, so don't feel bad about it.

VALERIE SASSON: That I have to explain it to you? That I have to make the dots connect?

KRISTI WEEKS: You do not.

VALERIE SASSON: I really need you to know, so, so thank you.

So, just reading for the room, unregulated practice can clearly harm or endanger the health, safety, and welfare of the public and the potential for harm is clearly recognizable and not remote or based on tenuous arguments. We know, based on what occurred in the early part of 2013, that if we are not able, the sunrise review is not able to connect the dots for us, to bring our customary practice into scope of practice, we know that the immediate effect is that third party payers will stop paying us. We know this because there's already been an audit and monies asked back for it. Not only are they going to stop paying us, they're going to ask us for money back. We know this because it's happened. I was, before becoming MAWS chair, I was the president of MAWS. I was, for ten years, the chair of JUA, the entity that runs midwives liability insurance. I can tell you that if we can't connect these dots, I am very concerned about issues of malpractice. If we can't make clarity for our midwives and our clients, we leave open a door that we didn't see open for liability issues. And I am extremely attached to the well-being of our (inaudible). We need it. And then, you know thirdly, just in response to A., we need our clients and our pediatric providers and our midwives, frankly, to have clarity about what we can and can't do. And, I think now is a great time for that.

So, B, the public needs and can be reasonably expected to benefit from assurance of initial and continuing professional ability. Well honestly, if we have done 100,000 in the last 15 years, and we're doubling in the last 10 years, I think we're looking at, you know, 300,000 newborn encounters that we would like to be able to perform in the next 10 years and our clients would like that of us.

And then, C, the public cannot be effectively protected by other means in a more cost beneficial manner. I think we know from the '93 study done by DSHS, Lauren Hawthorn's study, that you really cannot beat midwifery care and licensed midwifery care in Washington State for cost benefit. The quality of care at the price just can't be beat. I know you have a copy of that, and again, Jeff Thompson was quite an advocate for that while he was here and we're seeing other states look to us for this model. The language of the sunrise review makes this sound as though what we're asking you for is to forge a new trail. And I just want to say that we paved over this trail in 1978 when we made RCW 50 and we are well, the signposts are clear, we have clear training, we have clear graduation and licensing expectations, and we re-license every year. So, I think what we're asking for is not forging a new trail, but I think what we're asking for are streetlights. We're asking for illumination. What we need is clarity for us all to continue navigating safely. And I'm grateful for today. Thank you.

ELIAS KASS: Pictures.

VALERIE SASSON: Pictures!

KRISTI WEEKS: Finished?

VALERIE SASSON: I'm finished.

KRISTI WEEKS: Right on.

VALERIE SASSON: Ask me anything.

KRISTI WEEKS: Questions from the panel?

BARB RUNYON: I have a couple of questions, more like, the statistics of it. How many midwives do we license at DOH?

VALERIE SASSON: We roughly have just over 100 licensed. 110-115 licensed midwives in WA State at any given time. Some of them are licensed, but don't necessarily practice. And 75-80 of them at current count are MAWS members.

BARB RUNYON: So, not all of them are MAWS members?

VALERIE SASSON: Not all of them are MAWS members. But, a pretty good percentage.

BARB RUNYON: You'd say about 80% of them?

VALERIE SASSON: I'd say about 80% of them. I would say the vast majority of the midwives.

BARB RUNYON: Because I was listening to your presentation, you said that as your standards of practice change then your membership gets this information through the association, so I was interested in that. In terms of the 100 and 110 licensed midwives, where do they practice in terms of this state?

VALERIE SASSON: I would say that the vast majority of the midwives...

BARB RUNYON: Is it all over or?

VALERIE SASSON: It really is all over. Every county in Washington State is served by licensed midwives. On the eastern part of the state, they're driving much further distances than we are here. Certainly, the western portion of the state has the highest proportion of midwives. But we also have the highest, you know, population density. And the vast majority are offering home birth services and there are now, what... going to ask the audience, a dozen freestanding birth centers with at least three more in the works currently.

MEGHAN PORTER: So, if not every licensed midwife is a member of the association and you're setting the standards, how are you getting the information to the other midwives that aren't part of your association?

VALERIE SASSON: So, remember our standards are mostly set based on RCW and we have an active website and we run continuing ed for members and non-members twice a year. And our website is publicly available and all those documents are up and listed.

MARLEE O'NEILL: And sort of to piggy back on that, you know one of the things that we do in DOH is we discipline licensed midwives or any healthcare provider when they don't comply with the disciplinary act, their statute or rules, but, of course, the sort of guidelines MAWS puts out are not necessarily in rule or law and certainly a licensed midwife could say well, I'm not a member of MAWS, that doesn't apply to me, or you know, well, show me where it is in the statute, it's not there. So, do you have any...

VALERIE SASSON: But what is there is that we have a mandate to consult and refer. That is in the law, with any deviation from normal. So what we're doing is teasing out what we believe as an association is deviation from normal. A deviation from normal is stated in statute. Does that make sense?

MARLEE O'NEILL: Right, no I understand what you're saying, although it's not in statute, it's not specifically spelled out as it is in your policy?

VALERIE SASSON: No, it's not spelled out, but the statement, mandatory, you know, mandatory refer.

ELIAS KASS: I think that, I mean I haven't looked at every single health profession, but I think it's fairly common in the health professional statutes to not be explicit about what is standard of care. So that's defined by the standard of care in the community, as it is, you know, it varies vastly across communities the standard of care, in that naturopathic community might not be the same as (inaudible) community and Seattle might different than Yakima. So, I think it's very common across the professions to not spell out every single medical criterion.

VALERIE: And if you could help us find a way to have every one of those people be a MAWS member; that would be great. I mean we worry too about there being people who don't feel accountable. And so, again, that's part of the reason why we're here, trying to connect the dots.

MEGHAN PORTER: What is a newborn as far as you know?

VALERIE SASSON: So the definition of a newborn is the first 8 weeks, actually.

MEGHAN PORTER: Then why did you choose two weeks?

VALERIE SASSON: We chose two weeks because really, well, this was quite a discussion amongst us. Do you want to speak to that?

ELIAS KASS: Yes, so, we have a tremendous variety and I think it depends what sub-community people are a part of, their sort of orientation to the broader health and medical community. And we feel very strongly that midwives are totally capable of providing care through six weeks. And that's explicit in all the curricula, in the exams, and everything like that. So, as somebody who was instrumental in revising the indications document, and as somebody who provides pediatric care, I felt it was really important for me to start establishing that relationship by two weeks. Because by two months the vaccines are starting and I want to have discussions. People have tons and tons of questions, and I want to know that kid and I feel that two months is a little bit too late for me to see that baby for the first time. So, and like I was saying, sometimes you know the midwife or you know the pediatric care provider so well and you have this ongoing relationship and it's almost like home management, like you have this very easy relationship and you know them. But what we have felt in that indications document is that it is there to provide a structure and you might say that this is the firmest structure for the newest midwife to provide the safest care. And once you've been practicing for twenty years and you have all this experience, you can feel comfortable sort of going outside of that or informing your clients or deciding differently than that because you have the experience to do that but this should be the firmest guideline. We also felt that two weeks was something that we could potentially get and six weeks was probably not something that we could get and we feel it's so important to have this codified to be clear that this is something that we provide, that two weeks is a pretty good, uh . . .

MEGHAN PORTER: What you just said that eventually, they can deviate from that at 2 weeks?

ELIAS KASS: Well, if it's in the rule, then . . .

MEGHAN PORTER: So, if you want it in rule that its two weeks, but eventually you can deviate from that, that's kind of counter intuitive.

VALERIE SASSON: He was actually talking about the indications document.

ELIAS KASS: The indications document. So, the, the, yeah, so the two weeks is really like setting up the expectation that in Washington people are referring to pediatric care providers and I think that's important.

VALERIE SASSON: Can I add?

ELIAS KASS: Yes.

VALERIE SASSON: I just wanted to add and say we don't consider ourselves as standalone profession, you know. We are a profession in relation to other professions at all times and we, as an association, wanted to make sure that our members knew what our expectation is, that they will have their client... You know, we pass people on... we're one island in the archipelago of parenting, right? Off you go. We wanted to make sure that people had the next place to go. And, you know, we've heard stories of licensed midwives not referring on to pediatricians and then babies showing up in the ER with no pediatric care, and frankly we're trying to prevent that from happening. We're trying to police our own in some way.

MEGHAN PORTER: And that's good for your members but it's the people outside of your membership that is . . .

VALERIE SASSON: That's why again, we're looking to you to potentially put two weeks in rule, right?

MARLEE O'NEILL: You've talked about, I mean as we all know, the standard of care can change, there's new technology, so what type of continuing education is out there for licensed midwives to stay abreast of the latest technology or research, that type of thing?

VALERIE SASSON: So currently, there isn't a continuing education requirement on our Washington State license, right? Which is what we were trying to implement with this piece of legislation in this last session, so we will be running it again, right? It'll be, I think 30 hours over 48 months or 24 months, something like that. 30 hours in two years, I think is how that goes. And so, because we consider it unprofessional that it's not present. It is required for the national certification. So people who are NARM members, CPM, certified professional midwives have to be. Our recommendation for the state is in keeping with the national standard already. And so, we do, MAWS runs two different, oh, in addition to that, you have to have continuing ed to carry JUA liability coverage. Right. So in order to carry... So the JUA requires it.

BARB RUNYON: So, do 100% of all of our licensed midwives have that coverage and have that membership?

VALERIE SASSON: No, it is not required.

BARB RUNYON: It is not required.

MEGHAN PORTER: Do you know what percent has it?

BARB RUNYON: Is there a number of people who are (inaudible)?

VALERIE SASSON: The service carrier for the JUA is in the room and we could ask her.

ELIAS KASS: Could we bring her up, bring her to the table?

KRISTI WEEKS: No. (laughter)

ELIAS KASS: Oh, I'm sorry, I apologize.

KRISTI WEEKS: Ok, get up. Let her sit down. Please identify yourself. In the future, we will have people come up when you're done.

ELIAS KASS: Gotcha.

LIZ CHALMERS: Hi, my name is Liz Chalmers. I'm the administrator for the Washington State JUA (inaudible). There are currently 70 licensed midwives who have an active JUA policy.

BARB RUNYON: So 70%.

MEGHAN PORTER: And they have to be nationally certified, is that right?

LIZ CHALMERS: They have to be licensed in Washington State.

BARB RUNYON: So how about the national certification?

LIZ CHALMERS: No, it is not required.

MEGHAN PORTER: So, do you know the percentage of people who have the national certification?

LIZ CHALMERS: I don't. That is not something that we track.

VALERIE SASSON: I just want to clarify that the Washington State law is more rigorous by far than the national certification. In order to come to Washington State with a CPM, you must complete extra course work and additional clinical work in order to take the Washington State license exam. So we are nationally certified mostly. I think of it as a community service, because our license means more than theirs, than the certification does.

ELIAS KASS: There's also a requirement to carry malpractice at, you know, \$1,000,000/\$3,000,000 in order to receive third party payment, so in order to contract with a third party payer, you need that coverage. So that is another level of requirement that is not about the midwifery law, but that's about the overall financial work.

VALERIE SASSON: We're going to return to the question about continuing ed and that is that we, MAWS runs two conferences annually so, basically, full day continuing ed conferences in the Spring and Fall and they range on a variety of topics. The most recent topic relating to newborn care was about identifying oral abnormalities, frenulum and as it relates to breast feeding issues. We had an MD by the name of Marion O'Hara, coming to present and an occupational therapist. They co-presented on that. Previous topics related to newborns, we had neonatologists come and talk about identifying newborn infection. So, that's, you know, part of what we offer. So, two conferences annually. We do strongly recommend that licensed midwives attend the annual update in nurse midwifery that the University of Washington runs every February. So, that again is a full day conference. Because nurse midwives in a hospital do not care for newborns at all, that never includes newborn education. And then the national, MANA, the Midwives Association of North America, runs conferences nationally that take place in various places around the country. This coming October it will be in Portland, so I expect a number of them will attend.

BARB RUNYON: So, were you saying that nurse midwives do not take care of newborns at all?

VALERIE SASSON: They are licensed and credentialed and supervised differently than we are and so in order for them to do out of hospital birth, they have to take additional training over and above their nurse midwifery training. Because they, in hospital providers, they provide up to the birth and then they have pediatric staff in hospital. They don't care for the baby in hospital.

BARB RUNYON: Ok, but if they were doing it out of...

VALERIE SASSON: Out of hospital, then they are doing what we are doing.

BARB RUNYON: They're doing what you do, the practice is congruent, ok.

VALERIE SASSON: Exactly, yeah, and I can't really speak to how that works because I am not one.

BARB RUNYON: Ok

DEBORAH JOHNSON: I have a clarifying question regarding the two weeks. I'm not on the panel, but as I'm working on this, I'd like to clarify. The request that came over to us from Representative Cody had the two weeks in statute as part of the proposed language. If you go back to your slide, what do we need from the sunrise review? So, the two weeks would actually go into the RCW. Now what I'm hearing you saying, is leave that out of RCW, we'd like to talk about that during the rule making process.

VALERIE SASSON: It is my opinion that it belongs in rule and not in statute, but that's not for me to decide.

DEBORAH JOHNSON: Ok

VALERIE SASSON: It is my preference that it be in rule and not in statute.

DEBORAH JOHNSON: Ok

VALERIE SASSON: I think it's our, the associations preference. And forgive me for not adhering to the letter, I apologize.

KRISTI WEEKS: We're required to review the proposal that was sent to us by Representative Cody.

VALERIE SASSON: Yes.

KRISTI WEEKS: And (inaudible) two weeks by statute.

DEBORAH JOHNSON: Thank you.

VALERIE SASSON: I thought in our application, it said two weeks in rule. Maybe I'm mistaken.

KRISTI WEEKS: It might have, but we have to review the bill.

VALERIE SASSON: I understand.

KRISTI WEEKS: Any other questions?

MEGHAN PORTER: Yes, so I have a 13 month little guy.

VALERIE SASSON: Congratulations.

MEGHAN PORTER: Thank you. And,

VALERIE SASSON: Do, you know what I'm talking about then?

MEGHAN PORTER: Within 2 weeks he was circumcised.

VALERIE SASSON: Uh huh.

MEGHAN PORTER: Would you include that in your scope? I mean is that part of it?

VALERIE SASSON: Oh, no, no, no we're not surgical providers.

MEGHAN PORTER: That's what I was concerned about.

VALERIE SASSON: But education about the availability of circumcision is... We do talk to clients about it all. Yes, we talk to clients about circumcision and we refer to pediatric providers to make that happen, yeah.

MEGHAN PORTER: And is that clearly defined in your guidance document?

ELIAS KASS: Circumcision is not... well it's not medical standards of care, so.

VALERIE SASSON: It's considered cosmetic surgery.

MEGHAN PORTER: OK

ELIAS KASS: We certainly had talked about it though, and we talk about all of the newborn procedures. We talk about metabolic screening and what that means. We talk about the availability of the Hepatitis B vaccine, and that is on the schedule to start early. And if that's something that the family wants to do, then we have them see the pediatric care provider early so that they are on schedule with the Hepatitis B vaccine. Obviously, for the babies of Hep B positive moms, it's important that they receive Hepatitis B vaccine and immunoglobulin immediately. We provide that and that is pretty much it.

VALERIE SASSON: But we're finding customarily, that even the babies born in hospital are not circumcised right away. So the circumcision provider in my community usually waits until week two.

MEGHAN PORTER: No, they don't do it in the hospital.

KRISTI WEEKS: I think what Meghan might be getting to is the difference between standard of practice and scope of practice. So, it may be the standard of practice that y'all wouldn't even consider that. But the actual language is newborn care up to two weeks without any definition in law or potentially rule what that is.

VALERIE SASSON: But we are saying, you know as defined, the proposal is what we say and newborn care as defined in rule and then we make that more clear.

MARLEE O'NEILL: So, I guess to play devil's advocate, Elias, you had given that situation of the, and I'm not going to get the wording right, but the midwife who the newborn was pale and had low platelets and referred him to the... Why not, you know, why not just have them in the hospital with the MD that

they need to be referred to in those, you know, first few weeks of life, it can be so critical and you just don't know what might go wrong.

ELIAS KASS: They were home already. So this was a baby who was born at home with a midwife which we know is ok and this was on day three, where the midwife had gone to visit. Where, if they hadn't gone home from the hospital, nobody would have been at that house. So, she had gone to visit and she had looked at breastfeeding and she had looked at the baby, you know, we undressed the baby, we weighed them, we see their whole body and then she was concerned and then she called me. So, this is not something that would have been caught in the hospital, this was well after they had gone home. And it's totally possible that if they were in sort of the conventional realm that they would have gone to the pediatrician maybe on day 5 or something like that, but that would have been too late for that baby. So, what I'm saying is not that there would have been catastrophe if they hadn't been with a midwife, but that this is the system working, the system that's already in place, where the midwife is regularly visiting, regularly talking with and is making appropriate referrals.

VALERIE SASSON: Are you asking why have an out of hospital birth?

MEGHAN PORTER: Well, I mean I guess my question was, you know, this is such a critical point for newborns, would it just be better to have them, you know, with an MD who has a scope of practice that's broader than a midwife?

VALERIE SASSON: How would that look? Would we then discharge our clients to hospital? Would a pediatrician come to the home?

MEGHAN PORTER: Well, I don't know, I don't know, that's just my question. You know, this is such a critical time for babies and, and you know many babies are healthy and it's fine, and sometimes for those who aren't, it's pretty dire and pretty critical for them.

VALERIE SASSON: Which is why we're trained to recognize what's normal and what's not and refer.

MEGHAN PORTER: And how does your training compare to that of a pediatrician?

VALERIE SASSON: They are specialists in all baby care and we are specialists in recognizing what's normal and what's not. That's like saying what's the difference between a midwife and a physician? You know, I can't say how docs are? Can anybody answer you? You've sort of stumped me. It's apples and oranges, a very different education.

MEGHAN PORTER: As far as...Do you think you're trained to recognize the same things as a pediatrician? I mean, I'm assuming pediatricians have to know what's normal and what's not as well.

VALERIE SASSON: I am, and there is no aspect of this conversation that's about us claiming that we are equivalent to pediatricians.

MEGHAN PORTER: Right. No, no. Right, I understand that, but I mean they must be trained to recognize what's not normal too as part of their practice.

VALERIE SASSON: Yes. Right.

ELIAS KASS: Absolutely. Yeah, and one major difference is they recognize, diagnose and treat and we recognize and refer. So, it's a baseline level of safety and quality assurance we believe that we need. We're not intending to take the place of the pediatrician. We're not intending to manage all of these

things. What we're intending to do is to keep a really close eye on those babies and for the babies for whom their newborn course is totally normal, then we are safeguarding them through that totally normal. And if there's a deviation from normal, then we want to be sure that we're there to recognize and refer and get them in. Which is why it's so important to be established, you know, to have identified the pediatric care provider so that when there's a concern you know who to call, we know who to call, and we know where to send those records. We, the midwives association, have forms that are actually used all over the country. One of those forms is the newborn summary. It includes pertinent points on the delivery, all the details of the newborn exam, the APGARs, what newborn care provider (inaudible) and the follow up plan. So, there's a spot on there for the two day visit. How was the weight, you know, was the newborn screen done? And then that form is faxed to the receiving provider. And so that assures continuity of care. The physician knows the birth stats, which are obviously a really important thing. They have a, you know, a captured sense of the birth. They know if there was resuscitation. They know if there was a transfer. They know if they got vaccine or if they got a PKU. They know what happened. And it's very similar, I think, a little bit nicer looking than the summary that I get when babies are born in the hospital under different pediatric care, where it has the measurements of the initial exam.

VALERIE SASSON: When we were preparing for this, we put a call out to clients to ask them for their thoughts and, what they feel was valuable and several people came back and said I can't get an appointment with my pediatrician in shorter than seven days. So you can't get an evening or weekend appointment with a pediatric office. You know, even for a newborn, if you're discharged from hospital at 24-hours, you can't necessarily get in again. You can go to the hospital lab to have a 48-hour PKU done before the screen, but you can't necessarily call your pediatrician. I mean, some pediatrician's, sure. But, they don't do home visits and they don't necessarily routinely make accommodations for, i.e., I have a well baby and I need to be seen on day three. I don't see that happening very often.

ELIAS KASS: I sometimes have babies who are born at the hospital and they want an early discharge and so they'll call me, and they'll say hey, the hospital wants to know if my baby can be seen tomorrow, I'll say yeah and I'll come and do a home visit. Or yeah, you know, we're open that day so we'll work them in. And I, you know, the availability, I think, and sort of, like, the high touch. Like midwifery is a very high touch practice and that high touch means that, even if there's not a really big calamity, there could be something brewing and because we're talking to them so often, and because there's this relationship, we can pick out those, like, that's such a good baby, he sleeps so much. We know when we hear that, even if the parents aren't concerned, we're concerned and then we're asking those follow up questions. How many times have they eaten? How many times have they urinated? How many times have they stooled? What color is the stool? Are there crystals? How does their skin look? ...All these things. And then we can go to their house and we can see. Or sometimes we're so concerned that we say, you actually need to bring that baby in. You know, sometimes I meet people at the ER, sometimes they come and say the baby's breathing really, really fast and is grunting and I read on that handout that you gave us and those instructions that you gave us right after the baby was born that that sound's not good. I'd say, well yeah, let's meet at Children's and have them checked out. It's about high touch.

VALERIE SASSON: And again, I feel like we're trying to describe for you what we know to be unique about our model of care. This holding of the mother/baby through this time as a dyad isn't customary in medical care. You know, medical care is specialty oriented and the specialty of midwifery is that we offer this, we offer care for the mom and baby together. So, we're asking you to understand that our customary practice includes that and we know it's not the same as other practitioners. To us, that's an asset.

KRISTI WEEKS: Any other questions?

MEGHAN PORTER: So, do you do...I don't know if I missed this, do you do the heel stick for newborn screening?

VALERIE SASSON: Yes, that's the newborn screening.

ELIAS KASS: Which is also called PKU, through the Department of Health

MEGHAN PORTER: PKU.

ELIAS KASS: Would wish that nobody refer to it as the PKU because it includes so much more.

VALERIE SASSON: That's one of 35 different things they're testing for now.

ELIAS KASS: And we all have provider numbers with them and so, you know, there's two spots for provider numbers. There's who drew it and who's the ongoing pediatric care provider. So, the pediatric care provider also receives the copy of that report.

VALERIE SASSON: And the Department of Health did come and train at a MAWS continuing education event at a conference on how to do that work.

BARB RUNYON: So, the question that I have, do all of the midwives in Washington State, do they use this same format?

VALERIE SASSON: No, we don't use that same format. We, this is a MAS sponsored form. We are, as is most of the nation, transferring to electronic medical records, right? And so this form, I believe was dated 2005. And we have...the primary electronic medical model that the midwives are using is actually out of Virginia. And we have been through lots of beta testing with them trying to make it really specific to our model of care. So, they have taken from our forms to incorporate, but this form is not duplicated on that. So, I still use this

BARB RUNYON: But the components, all of the components you would say would be standard across the 110 midwives.

VALERIE SASSON & ELIAS KASS: Absolutely.

BARB RUNYON: And when would you, for example the APGAR score, when would you refer if they related to what the APGAR score is?

VALERIE SASSON: An APGAR score equal to or less than six at five minutes is an indication for transfer.

BARB RUNYON: Ok.

ELIAS KASS: And those APGARs are really about indications for need for ongoing resuscitation, which is obvious, well beyond the score, but, you know, obviously babies are needing continued respiratory support, then we're absolutely transferring.

VALERIE SASSON: And again, that's in the indications document.

BARB RUNYON: Ok

MEGHAN PORTER: That is just association members, right?

ELIAS KASS: That's on the website everybody has access to.

MEGHAN PORTER: Just because it's on the website doesn't mean that everybody has it, though.

VALERIE SASSON: That's right.

ELIAS KASS: But, I mean, by explaining it, there is nothing about a baby who is requiring ongoing chest compressions or ventilations, obviously. Oh, no, I think we'll just do this at home.

MEGHAN PORTER: Obviously, but the point I'm making is that just because it's on your website and just because the association members have it, doesn't mean it's widely used. I mean, there's still 20% that may not have that and their training may not be the same, you know?

ELIAS KASS: Yeah, and that's where the quality assurance from the licensing. And that's why we have such a high appreciation for the processes of the department of health. And in trying to streamline the licensing because all of that does take into account the curriculum and the exam that Washington State has specifically crafted, that has a higher standard, just continuously assures that regardless of their association with MAWS, they are highly trained. And that is something that the Department of Health is maintaining in the licensing department.

VALERIE SASSON: Again, 15% of that licensing exam is about newborn care.

MEGHAN PORTER: Yes, but, you're saying, you know, you want to have the standards on your website that are going to change based on what's going on. Well, what if somebody got their license 20 years ago? they're not a member of the association, and this guidance is changing constantly. How do they know what the change is and if it's not defined in scope, what if you reach beyond the scope? If you reach beyond the scope of what your scope is, because of the guidance on your website, how do you know when to stop? Where is that grey, where is that area where you say, ok this is going to be a scope of practice change?

VALERIE SASSON: Now, I can understand, I hear your concern. It would be great if we could have 100% compliance. I'm pretty sure that our compliance is better than ACOG honestly in terms of membership. But what we...

MEGHAN PORTER: I don't know what ACOG is.

VALERIE SASSON: ACOG is the American College of OBGYNs, you know, like 30% of OBGYN's belong, right. So we are aware of that and I think I just want to call you back to our track record. We've been licensing midwives for 35 years. And we have had, you know, this many number of births and this many number of newborn encounters and here we are, we have not, you know, bankrupted our Department of Health with lawsuits or complaints. I think that the system is functioning. I think how it is, is functioning. I think we can trust our training and our licensing and our community.

ELIAS KASS: Sorry, every health profession and every health professional has an obligation to keep themselves up to date.

MEGHAN PORTER: I agree, I totally agree with you.

ELIAS KASS: And that's why most professions have a continuing education requirement. We want to have that continuing education requirement. And, you know it's just like PAP guidelines right. Those are changing every single year. If you trained 20 years ago, you think that woman has to have a PAP every year and now it's like actually a 5 section criteria, blah, blah, blah. So, you know, care is always evolving and it's our responsibility to keep up to date.

VALERIE SASSON: And again, we are trying, we got all the way to the Senate who didn't have a chance to vote on our bill that included those three things: continuing education requirement, a peer review requirement and it included a mandatory data collection, so that we can turn around and be more accountable. We are looking to improve professional accountability. And that wouldn't just be limited to our members, you know, that would come along with your license.

MARLEE O'NEILL: So, do your quality management programs have an incident review?

VALERIE SASSON: Yes.

MARLEE O'NEILL: Do you have any idea of the number or percentage of incidents at all that relate to newborn care?

VALERIE SASSON: I would not know the answer to that.

ELIAS KASS: There are sentinel events that are listed that include admissions to the QMP.

MARLEE O'NEILL: But how many of them are reviewed?

ELIAS KASS: We could easily get that information.

VALERIE SASSON: Yeah, we could get that information. Would you like us to get that information?

MARLEE O'NEILL: I'm not sure it's necessary.

VALERIE SASSON: Ok. The QMP does contribute to what we choose to be our continuing education content.

MARLEE O'NEILL: So, do you have a significant number of issues around X?

VALERIE SASSON: Yeah, absolutely, yes.

ELIAS KASS: And those are often skilled also, you know, we had an issue that came up with midwives doing non-stress tests. And then the QMB didn't feel that the skill level was there to interpret them, so we had a couple of sessions that had like an experiential component where it was like, here's a strip, get in your group, what do you think? What are the features? How would you interpret this? What should you do about this? So, there's a really good feedback process to continuing in scope.

VALERIE SASSON: There aren't very many of us, so. What else can I do for you?

KRISTI WEEKS: I'm not hearing any more questions at this time, so why don't we go ahead and take a quick break to 10:15 and then we will resume with public testimony. If you want to testify, please make sure you are signed in.

ELIAS KASS: Would you like copies of the newborn admissions study?

KRISTI WEEKS: Yes

<BREAK>

<RESUME>

KRISTI WEEKS: Ok, we are going to go ahead and get started. We will now take public testimony. You will be called up in the order in which you signed in. The first person is Liz Chalmers, but she was a maybe.

LIZ CHALMERS: I'm going to be a definite.

KRISTI WEEKS: You're going to be a definite. (laughter)

(Inaudible)

DEBORAH JOHNSON: No, no, I'm sorry. The applicants are out talking in the lobby there.

KRISTI WEEKS: I told them we were going to start.

SHERRY THOMAS: Is Valerie here?

VALERIE SASSON: (inaudible) Yes.

SHERRY THOMAS: I was just making sure you were here. I was just making sure you were back.

LIZ CHALMERS: So, my name is Liz Chalmers, I have a number of roles in the birth world, as I already mentioned. I'm the administrator of the liability insurance system for the midwives. I'm one of the owners of the Puget Sound Birth Center. I'm a childbirth educator, but my most important role in the birth world is as a mom. I have 4 children ages between 23 and 13. They were all caught by midwives; two in the hospital and two outside the hospital. And I just can't fathom a model where midwives don't provide newborn care, from the moment the baby is born. They were providing care before the baby was born, so when, you know, the appointment before birth I'm asking, you know, questions about the baby and want to know how big the baby is, do you know how fast his heart rate is, and all those kind of things, the midwife is helping me with that information. And then, the moment the baby is born, I don't expect her to stop providing that care. And when I see her the next day, at home, she comes to visit me and my baby, I'm gonna be asking about my baby. My focus isn't on me anymore. My focus is on my baby. And she's right there, and yeah maybe if an MD would come and live with me for a couple of weeks, then I could get that same sort of scrutiny of my newborn all the time and answering all my questions. But they're not there and the most I could likely see them in that first two weeks is once. So, I just think because the midwife is right there, because they have the training, because they're specialists in recognizing that boundary between normal and not normal, they are just ideally placed and I can't fathom a world where that doesn't happen. Thank you.

KRISTI WEEKS: Are there any questions for Miss Chalmers? Ok, thank you. The next person who signed up was Victoria Malloy.

VICTORIA MALLOY: Hi. I have to do the...I should have brought those things. Sorry. I submitted in writing so my entire written presentation is part of that section but I just wanted to introduce myself and point out why I'm in support of this revision to this amendment. And also just to outline some of the things that I included - there are live links in my presentation regarding the medical billing guidelines put

out by Washington State Medicaid for providing new service to the Medicaid clients. I work with a number of different midwifery practices as a medical biller. I'm also a midwifery consumer and benefitted from this same kind of care for my children who were born at home as well. But, my primary role now is to be an advocate for consumers in the context of making choices around their care. Also, the majority of my practices who I work for who do approximately 20% Medicaid clients as they're normal clientele load of woman who are seeking care for out of hospital births from licensed midwives. So, I think that's a pretty significant percentage and that was one of the reasons why I included the billing guidelines for planned out of hospital births from providers from Washington State Medicaid. The other, one of the things that I end up talking to in terms of consumer contact is prices and costs and how much is this kid gonna cost me? Especially, now that the economy has been so rough for the last year, a lot of people are proactive in trying to figure out if the choices that they want in terms of the type and location of care are financially feasible for them in the context of whether they're paying for it through a third party payer or through a private pay unless they are a Medicaid client, but then the state is paying. So, I do a lot of consumer counseling around choices and one of the biggest factors we talk about is the cost savings that they will incur for a baby who is born outside the hospital. And that was the reason I included the CHARS data, which is the DOH CHARS data and there is a link to that in my submission as well. And it's a really long document so; literally you have to go to line 200 something or other to find the section of it that is related, specifically, to normal newborn charges for inpatient stays. And most are discharged within 24 to 48 hours after delivery.

So, just in terms of benefit to the cost in having this amendment go through, when I'm dealing with consumers around their choices I think this is a really important aspect that...I stated in my summary that I believed that the submission of the applicants establishes very well the safety of this care and the prevention of public harm around this issue. And so I mostly wanted to come and speak about the public benefit to having this be outlined and to be assured that it can be a continuing benefit includes benefit to the state in context of financial savings in that realm. So I mostly just wanted to outline those things and then to ask if you have any questions of me while I'm here.

KRISTI WEEKS: I don't think anybody does. Thank you.

VICTORIA MALLOY: Ok. Thank you.

KRISTI WEEKS: Susan Rainwater? And special friend who has been very well behaved, thank you.

SUSAN RAINWATER: Well let's not jinx it.

KRISTI WEEKS: I did forget about that. You're right.

UNKNOWN: You get to go to the front.

SUSAN RAINWATER: My name is Susan Rainwater. This is my daughter Loretta. So I am currently a client of midwifery services. Loretta was born at the Puget Sound Birth Center, caught by midwives and I am currently 36 weeks today of number two and we're planning for a home birth this time. So, I just wanted to come and kind of add support with our experiences, kind of speaking of the newborn continuity of care. We did have a pediatrician, a family practitioner set aside, already planned, notified, appointment arranged. So, that was already set up even before her birth, because that's something that you discuss when you're pregnant. But I can say the three day visit to our home was amazing. That I couldn't function, there's no way I could have gotten out of my house. At that point I was in my bathrobe and everything was going well, everything was good. We then had her two week appointment out of the house with our family practitioner that we had found, lined up, right down the street. Everything seemed great. That consisted of my partner and I and Loretta talking about how we don't sleep. She eats all the

time. The physician joked that that's what happens. That's what all newborns do. Eat all the time and you don't sleep. You know we talked about that. It was very black and white. Very checklist oriented. They hadn't met our family before so everything seemed great. We were in and out. And it wasn't until later, it was actually at our... we had a, I believe, a three week and then a five week follow up at the Puget Sound Birth Center with the midwives. Where I remember it was my fifth week appointment, postpartum visit, where Valerie actually was checking on Loretta. We commented again that she's eating all the time, and we're not sleeping. But the difference was that she knew us and so when I said I wasn't sleeping, I was having a hard time, she knew I was having a really hard time, that I wasn't taking this lightly, that I wasn't just a frazzled new mom. And so, she knew that we were at a breaking point and she knew that that wasn't normal. And so, once we kind of talked about what we were expecting, what was going on, it was recommended that...she actually had some, most likely she may have had some reflux issues, which then affect everything. She was eating constantly. She wasn't sleeping, therefore no one was sleeping. You know we had a lot of things going on but we didn't know that and when we saw the family practitioner, they didn't ask the questions. They didn't know us as a family and so they didn't know how important me saying I'm tired, I'm exhausted, what that actually looked like because we didn't have that prior relationship. So, I... that was absolutely lifesaving because she did end up having really severe reflux. And so we were finally able to kind of get her treated by a specialist down the road. And things changed completely, like black and white. We were able to function again. And then we realized that that wasn't normal, but we didn't know. And so, when we saw the family practitioner, they didn't know either. Because they didn't know us as a family to recognize when we said we needed help that we weren't just new parents who were just being overly tired, dramatic. So, I can just kind of speak to that and so I didn't know if you had questions or if there were any questions as far as my perspective?

(inaudible)

KRISTI WEEKS: No. Doesn't look like it, but thank you so much for coming and testifying. It's nice to have that perspective. Ok, and finally Audrey Levine.

AUDREY LEVINE: Hi, my name's Audrey Levine. I am a licensed midwife for an Olympia family practice for 13 years and was the past president of the Midwives Association for four years before I turned the reigns over to Val Sasson. So, I wanted to speak to the letter from the Association of Washington Healthcare Plans because there are numerous things in there that I think need to be responded to. The first is on page two of their letter when they're talking about patient safety and quality of care. It talks about the important things that need to happen within the first few weeks of life. And they talk specifically about the PKU screening, or advanced screenings, which as we've said, is something that licensed midwives provide. In the third paragraph, they talk about the difference between licensed midwives and certified nurse midwives and as Elias and Val have spoken to, certified nurse midwives do not care for newborns. It's not a part of their training unless they're doing out of hospital birth in which case they go on and do additional training. But typically what happens in a hospital setting is that the newborns are handed over after the birth to the pediatric team and then when nurse midwives, you know, the nurse midwives essentially do postpartum follow up the way OBs do postpartum follow up once women are discharged from the hospital, and they do a six week visit. That's it. So, it really is not relevant how certified, well it's relevant in the sense that we actually have more training and caring for midwives than those CNM's do. Under scope of practice expansion, not clarification, it says "we believe the delivery of the newborn would include the immediate heel stick test and capturing birth weight". That newborn screen doesn't get done until the baby is 24 hours old. That is standard of care, so the hospital, they don't do it right away, you know, it's done before babies are discharged from the hospital. The same is true for the screening for the critical congenital heart defects. 24-48 hours after the birth is when that test gets done. And then, in that last paragraph, it says "we have significant concerns with this practice about midwives providing services to newborn for two to six weeks post-partum" and my question is, based on what evidence? So, it seems to me that the onus is on those who are opposing this to

demonstrate that there have been problems with licensed midwives providing this care for newborns. And I would argue that, you know, that the care that we have provided that there's demonstrated beneficial outcomes for babies who have fewer admissions for things like jaundice and feeding problems. If you also look at what pediatricians provide to babies when they come...after they are discharged from the hospital a pediatrician usually sees the baby in like three or five days. What is the care that's provided at that point? Weight check, jaundice check, checking vitals, right. So it really is a duplication of services, and at the same time, I think Elias's point is really well taken, that there is value for the family and this is why in our indications document we had recommended that parents establish a relationship with a pediatric provider prenatally because:

- a) If there's a significant concern, we want the baby to be seen by somebody that the parents feel comfortable taking the baby to and that they've already met with, and
- b) If, you know, it's important for that relationship to develop, you know, well beyond the point where they're talking to parents about vaccinations which is often a hot topic for families that have chosen out of hospital birth.

So, and then, finally, when it talks about cost implications, again, I would say, where's the evidence? I would argue that, as I said we have fewer admissions for pathological jaundice and feeding problems and so I just don't see that that is based on evidence when they argue that there are cost implications to us providing this care.

BARB RUNYON: When you were presenting your initial proposal to the legislature in this last session, were these the same objections that were presented at that time or are these similar?

AUDREY LEVINE: I don't think that they gave us anything specific.

VALERIE SASSON: No, I don't think they gave us anything specific.

BARB RUNYON: Ok

BARB RUNYON: Ok, I was just curious.

AUDREY LEVINE: As far as I know, we didn't get a letter like this, detailing what the objections were. We just know, and it was not the Washington Association of Health Plans, but one particular third party that had audited this midwife that was standing in opposition of that particular bill.

BARB RUNYON: Ok. Do you know which payer that was?

AUDREY LEVINE: We do.

BARB RUNYON: Would you care to share that?

AUDREY LEVINE: Sure, it was Premera.

BARB RUNYON: Ok. Premera, Ok.

AUDREY LEVINE: And so I was a little surprised when I heard from our lobbyist that the Association of Health Plans had written a letter in opposition because there had not been too broad opposition. You know, it had been that one particular payer and so this makes me... I'm curious about where this is coming from, kind of what the real underlying issue is. I have a hard time believing that it's about health

and safety because as I said, they don't have evidence to demonstrate that we have not been safely providing the care.

KRISTI WEEKS: Anything else? Thank you. At this time, would the proponents like a brief follow up, rebuttal, answer questions?

VALERIE SASSON: The proponents would be...

KRISTI WEEKS: That's you.

VALERIE SASSON: Yes. (inaudible)

KRISTI WEEKS: Proponents, applicants, that's

(inaudible)

ELIAS KASS: I have a very specific follow up. Again, this is Elias Kass... to the health plan opposition where the health plans have been paying for newborn care for years and years and years and there's never been an issue, so the cost concerns seem a little bit out of place given that they have been paying and had not had any problems. So there's no additional cost expected to that. We're just expecting them to continue their customary practice and for us to continue our customary practice.

VALERIE SASSON: Yeah, specifically since 1996, since we were afforded liability insurance through the OIC, liability coverage that allowed us to become contractees with third party carriers and every, single contract I have, I mean you name it in the state of Washington, I have it. Everything from Aetna to Group Health to DSHS, you know, all the DSHS plans, Premera, Blue Cross, Blue Shield. They all pay me to provide the care we've already described for at least two weeks and they have been doing it my entire career which is now, I'm in my 15th year.

MEGHAN PORTER: And what exact services do they pay you for? Just one follow up visit, two, three?

VALERIE SASSON: They pay us for the immediate postpartum care, so the newborn exam, and any additional care. So, for instance, if a baby requires oxygen, resuscitation, then that's an additional billing code. They pay for the newborn exam so, the newborn exam and care immediately postpartum. They pay for the vitamin K and the eye ointment, the administration of and the actual substance itself. They pay for the home visit. They pay for the exam and the administration of the newborn screening. And, again, any additional billing, so failure to thrive, jaundice.

ELIAS KASS: And those are typically billed as evaluation and management codes.

VALERIE SASSON: Yeah, so (inaudible) codes. And, then at the 7-10 day visit, they pay again for the performance of the second newborn screening and a cursory, really, just a 10 minute office visit for weight and general well being.

MEGHAN PORTER: So how long after birth do you see the mother? How many weeks? How many times?

VALERIE SASSON: How many times? I see people typically through seven weeks.

MEGHAN PORTER: Through seven weeks. So each time you said that you weigh the baby and everything?

VALERIE SASSON: Each time we weigh the baby.

MEGHAN PORTER: Do you bill for those?

VALERIE SASSON: I personally don't bill for the newborn past the two week visit, past the 10 day visit.

MEGHAN PORTER: But, so...

VALERIE SASSON: Unless I had a failure to thrive baby who I was seeing more often with pediatric permission, right. So if a pediatrician said, look why don't you weigh this baby, but that would have been a conversation between me and a pediatrician.

MEGHAN PORTER: So if we put two weeks into this statute, then that's going to make it so payers can stop paying after two weeks, correct?

VALERIE SASSON: Yes.

MEGHAN PORTER: So, does that mean the care will stop after two weeks, you won't weigh the baby, because you won't get paid for it? Is it all, is it more about money, I mean that's..

VALERIE SASSON: Here's the thing, we were told very explicitly by a third party carrier, why should we pay you to do postpartum care, to do newborn care? We know you'll do it anyway. So, there is a payment issue. But the second issue is, people come to our office and they want to know how much the baby weighs and I want to know how much the baby weighs. Am I charging for that visit? No. Am I charting that I weighed the baby? Yes, I am. So there's the liability issue, did I provide care? So, typically what I do at a postpartum visit at three weeks, five weeks, seven weeks, and frankly for mom's who are suffering from any kind of postpartum depression, I see them at nine weeks and sometimes eleven and I don't bill for those. But, I'm not going to let them go until they're on their feet, right? And so, what I do is I chart the weight of the baby. How is breastfeeding going? How is elimination going? And I say, in newborn care, if that's true, or I say recommended newborn care, I'm sorry, pediatric care. So, I will chart right in there, in pediatric care, but I chart the weight. So, I just want to make sure that I'm clear about that. Does everyone do that? I have to say, I don't know the answer to that.

MEGHAN PORTER: I was going to say, if people are charging for those additional weigh-ins and all that stuff, that will give the...

BARB RUNYON: Beyond the two weeks.

MEGHAN PORTER: Beyond the two weeks, that's gonna give the payer the right to stop paying them for those, so, is that gonna cause a problem in the midwife community?

VALERIE SASSON: I think that Victoria, who is the biller for the majority of the midwives in, certainly, the Puget Sound area could answer that better than I could. Because I'm not aware of how many people are billing past two weeks.

ELIAS KASS: I think it's also worth pointing out that routine postpartum care is bundled in with the global maternity code, and that doesn't matter, so we get the same amount of money whether we do the

one visit the OBs or the nurse midwives do or the six visits that we actually do. We're not paid anything for any of those visits.

VALERIE SASSON: That's right.

ELIAS KASS: So, I think the reality is that we're providing lots of care that we're not being compensated for because it's good care. And we would love to be getting more for postpartum, to have codes that accurately reflect what we do, that we're doing six visits and not one and catching all these problems. Because by six weeks, anything that can go wrong has already gone wrong and is irrevocable. We can't really do much about the milk supply at six weeks, it's gone. So, that's one of the difficult realities of wanting to do right is that sometimes we don't get paid for it.

VALERIE SASSON: Yeah, and we certainly are not gonna let payment dictate best practice.

KRISTI WEEKS: Ok, thank you.

ELIAS KASS: Do you have any other summation comments?

VALERIE SASSON: I just, again want to really thank you for your time and your thoughtfulness and I don't mean just time spent up to today, but the time you're about to spend to try to decide what to do. We really appreciate it. I left the house this morning and told my 18 year old that my goal today was to make her proud and to ensure that the care that I have been able to receive for her was available when she was a mom and so I certainly hope that that's what we can do together. Thank you so much.

KRISTI WEEKS: Thank you. Ok, I'm back to the script.

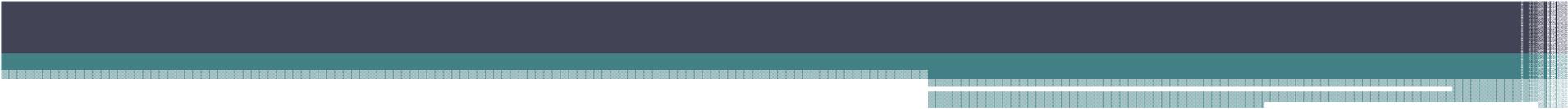
Thank you for taking part in this public hearing. We mean that. Here are the next steps in the process. There is an additional 10 day written comment period starting today through August 19th at 5pm for anything you feel has not been addressed. We will share an initial draft report with interested parties in September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you. We will incorporate rebuttal comments into the report and submit it to the Secretary of the Department for approval in October. Once the Secretary approves the report, it is submitted to the office of financial management for approval to be released to the legislature. OFM provides policy and fiscal support to the governor, legislature and state agencies. It will be released to the legislature prior to the legislative session in January of 2014 and will be posted to our website once the legislature receives it. That is all and thank you.

See next pages for applicant's PowerPoint presentation.

Midwifery Scope of Practice Sunrise Review

August 9th 2013





What brings us here today?

- Legislation, 1978
- Growth of midwifery
- How many birth certificates?
- How many newborn encounters?
- What is the standard of care for newborns by licensed midwives?
- Legislation, 2013

How is newborn care reflected in education & licensure?

- MEAC Accredited Schools
 - Bastyr University
 - Midwifery College of Utah
 - 8 others
- NARM
- MANA Core Competencies
- ICM Essential Competencies for Basic Midwifery Practices

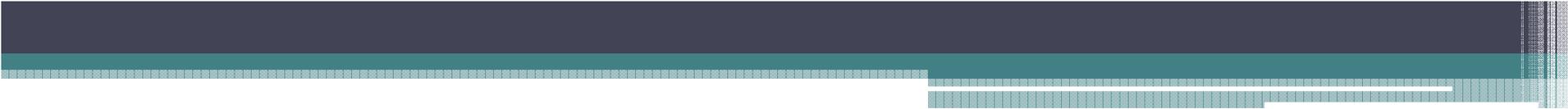
Midwives provide
comprehensive
wrap-around care
of the mother-baby dyad





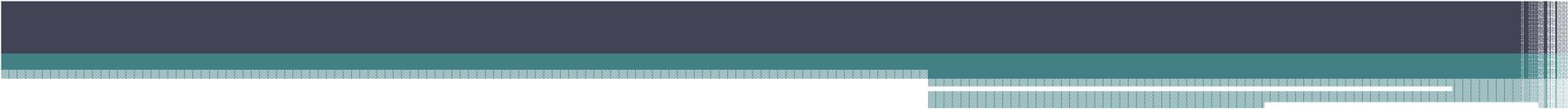
Statement Regarding the Provision of Care to Newborns by Licensed Midwives

- Describes the care that licensed midwives provide to newborns
- Helpful in coordinating care with physicians



Indications for Discussion, Consultation and Transfer of Care

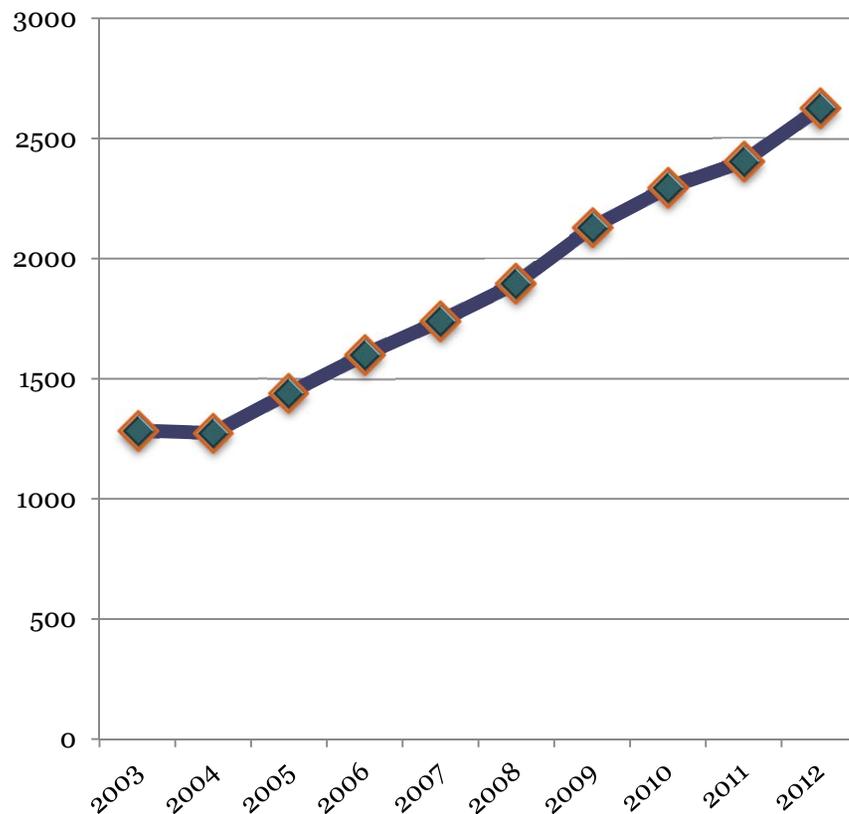
- Provides a structure for community standard of care defined by our professional organization
- Provides for professional accountability
- Recommends establishing care with pediatric provider before baby is born
- Strongly recommends pediatric care visit by 2 weeks



Routine care is evolving...

- NRP is being refined continuously
- Newborn metabolic screening
- Universal newborn hearing screening
- Critical congenital heart defect screening

Our intent is to continue to provide exceptional care to mothers and their newborns.



Births Attended by
Licensed Midwives in
Washington State
2003-2012

What do we need from this Sunrise Review?

A recommendation to:

- Amend RCW 18.50.010 and 1991 c 3 s 103 to read as follows:

Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages **and to her newborn** or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant.

- Address *scope of practice* in Rule
- Allow for ongoing input from MAWS in the Rules process to accommodate evolving standard of care

Does our request meet Sunrise Standards?

- a) Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for harm is easily recognizable and not remote or based on tenuous argument;
- b) The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability;
- c) The public cannot be effectively protected by other means in a more cost-beneficial manner.



Appendix E

Written Comments

**Midwifery Sunrise Review Comments
As of August 8, 2013**

Melanie Dickson	<p>My name is Melanie Dickson, I have been a licensed midwife in Washington since 2006, and I have had two babies with midwives in Port Townsend. I am writing to express my support of midwifery care for well newborns in the first 6-8 weeks postpartum. This care generally includes 1-4 home visits followed by 3-4 office visits, during which time the midwife will evaluate both mother and baby. Among other things, the midwife will assess feeding, elimination, and weight gain, check for jaundice, check vital signs, and answer parents' questions. Occasionally a baby will need to be seen by a physician and midwives have the ability to distinguish between normal and abnormal in the newborn period. Parents are very satisfied with this care and it saves the state money because for clients with Medicaid, midwifery care is high quality and low cost. Please help ensure that this integral part of our care remains recognized and reimbursed.</p>
Joyce Tseng Seattle, WA	<p>I am in full support of the Midwives' Association of Washington State's proposal to clarify that Licensed Midwives' scope of practice includes care of the well newborn in the postpartum period up to 6 weeks.</p> <p>I felt wonderfully supported throughout my pregnancy, labor, and first weeks postpartum thanks to my midwives. My two midwives were people that I established relationships with and felt comfortable with - and it was important to me that they would be same people who would be there for me and my newborn postpartum. I want to know that future families in Washington State can also feel the same support. The health of the newborn baby and postpartum healing of the birthing mom are interconnected.</p> <p>Please clarify Licensed Midwives' scope of practice to include care of the well newborn up to 6 weeks of age.</p> <p>Thank you for your consideration.</p>
Janet Miller	<p>I urge the Sunrise Review Committee to clarify that Licensed Midwives' scope of practice includes care of the well newborn in the postpartum period up to 6 weeks.</p> <p>My son received careful, thorough, and knowledgeable care from our midwives for the first six weeks of his life (in September 2012). This was essential for my family because we were able to work with the care practitioners that we were comfortable with and who understood our values and particular concerns/needs. Also, it allowed us six weeks to select a pediatrician for our son's future care. This period of time was critical for us as new parents.</p> <p>In addition, the health of the newborn baby and postpartum healing of the birthing parent are linked closely together. It was absolutely necessary that the midwives assessing our baby's early growth and development were the same health care providers who were providing us with breastfeeding support and postpartum care.</p>

	<p>Please clarify Licensed Midwives' scope of practice to include care of the well newborn up to 6 weeks of age.</p>
<p>Shalena Sequeira Redmond, WA</p>	<p>I would like to leave a comment about how my newborn was cared for by my Midwives.</p> <p>My son was born in the Puget Sound Midwives & Birth Center and was cared for by my midwife Dr. Sunita Iyer and her assisting midwife. I was informed in advance about what would be required once the baby arrived procedure and documentation wise. We were informed of the shots and elected to do what our family was comfortable with. They were very professional and I was happy to be able to continue the care of my newborn with my midwife who I had become so comfortable with.</p> <p>I do hope that care for infants upto 2 weeks of age is added to the scope of midwifery care so they may be able to do their wonderful job without any potholes.</p>
<p>Jamine Blesoff, ND Mariposa Natural Medicine, PLLC Seattle, WA</p>	<p>My husband and I had a healthy out of hospital birth experience, thanks to the midwives we worked with. One of the many amazing parts of our experience with them was their post-partum follow-up and care. They did home visits for weight checks, checking in on how baby was breastfeeding, and metabolic screening tests. As a health care provider myself, i can say they provide great newborn care.</p> <p>In our case, our midwife caught early on some mechanical and neuromuscular deficiencies in our baby with regards to her limited ability to feed and gain weight appropriately. They immediately referred us to a doctor for a frenotomy and onto to Seattle Childrens Infant Feeding Clinic for additional assessment.</p> <p>They provided great care to me and my newborn daughter.</p>
<p>Catherine Carter</p>	<ul style="list-style-type: none"> * Include care of well newborns in statute * Define scope of practice in rule to include care of well newborns * Allow for ongoing input from MAWS to accommodate evolving standard of care <p>As I understand research in this area, money spent caring for children birth to 3 is very very well spent! There is a clear correlation with reduced prison populations and other indicators of the health of a society.</p>
<p>April Haugen</p>	<p>Midwives provide continuity of care to numerous families in WA state. Part of this care includes care of the newborn. It is vital that this care continues and RCW 18.50 includes the care of well newborns. It is also important that the RCW defines the midwives scope of practice to include well newborn care and also allow for ongoing input from MAWS to accommodate the ever evolving standard of care.</p>
<p>Elizabeth Bauer, ND, LM Adjunct Professor, Bastyr University</p>	<p>I am writing to encourage Newborn Exam Well-Child Visits to be included in the Midwifery Scope of Practice for Washington State. I practice near Bellingham Washington in a small rural town called Ferndale. Just yesterday a patient of mine made a point of saying how thorough my newborn care was in the post partum period compared to what her friends in standard medical practices are receiving. She said she was surprised how the babies who are sent home one day old from the hospital only saw</p>

<p>Kenmore, WA</p> <p>Practicing in Ferndale & Bellingham, WA</p>	<p>a doctor at a week old and again at the 2 month visit. In midwifery care she received a home visit in the first few days of life, and office visits at 2,4,and 6 weeks all prior to the 2 month well child visit. She feels, as many of my patients do, that the extra support has helped her transition to becoming a confident parent and most importantly the visits have helped her become a successful nursing team with her baby. And for my part, I feel I am able to detect any early problems in the newborn and truly embody preventative care for the baby. I have a network of Pediatricians I can refer to whenever needed, and Pediatric Hospitalists at St Joseph Peace Health Hospital who are available if an emergency presents itself while the child is in my care.</p> <p>I was trained to do newborn care and I want to continue to provide excellent care to my patients, both for the mother and the baby dyad. Please support this measure.</p>
<p>Maya Horrocks</p>	<p>I believe strongly in the mother-baby dyad. As a part of standard of care, midwives have been providing care for well newborns! It is time that this care is protected by the law to allow proper compensation to hard working, underpaid midwives!</p>
<p>Caitlin Wheaton, LM, CPM, MSM Journey Midwife Services, LLC Seattle, WA</p>	<p>I urge the Sunrise Review Committee to clarify that Licensed Midwives' scope of practice includes care of the well newborn in the postpartum period up to 6 weeks. As a newly licensed midwife, I can attest to my training in the care of well newborns, including screening for conditions that require a higher level of care than I provide. This is the current standard of care provided by Licensed Midwives in Washington. I completed my clinical training last year and attest to the fact that the 9 different midwives I worked with over the course of my training in Washington assess and evaluate well newborns and consult on their condition or refer when necessary. As a recent graduate, I am starting my own practice and could not afford to be penalized by third party payers for practicing within my scope and giving my clients the continuity of care they expect and desire.</p> <p>Lastly, some pediatricians will not care for babies under 8 weeks of age, so for those that are well and do not require pediatric evaluation, keeping their baby in my care during that time give my clients more choices in pediatricians, rather than being restricted only to those who will see babies under 8 weeks of age. Please clarify Licensed Midwives' scope of practice to include care of the well newborn up to 6 weeks of age.</p>
<p>April Nault</p>	<p>I would like to add a comment of support for the scope of Midwife's practices to include 2 weeks of care to a newborn.</p> <p>As a mother of two, both home births, the continued care from my midwife for myself and more importantly my children was essential in the early postpartum stage.</p> <p>I had a relationship with my midwife, she understood me & my children and our needs during that time. She was both highly qualified and capable to have the newborn checks many providers do within the first two weeks.</p> <p>After our first few weeks of postpartum care from my midwife I started to see our pediatrician for each one of my children. The few postpartum weeks of care from my midwife did not limit the practice of our pediatrician. Our pediatrician was even encouraged at the extension of care beyond just the birth. Once her scope of practice ended in those postpartum weeks, our pediatrician was happy to then take over. It was a</p>

	<p>natural transition.</p> <p>I hope that including an extended scope of practice for LM's will be made permanent. It is good for moms, newborns & the overall picture of maternity care in our state.</p>
<p>Jennifer Boelter, LM, CPM, LMP Pacific Natural Birth, LLC Seattle, WA</p>	<p>As a Washington State Licensed Midwife, I regularly witness the great value that caring for mother and baby in the first weeks after birth provides for each family.</p> <p>Each baby receives care from a practitioner who has been caring for him/her throughout pregnancy, labor and birth.</p> <p>Each mother is able to remain at home, resting, healing and learning to care for her newborn's needs without the need to schedule an office visit in the first days after birth.</p> <p>Please support the addition of the following to RCW 18.50:</p> <ul style="list-style-type: none"> * Include care of well newborns in statute * Define scope of practice in rule to include care of well newborns * Allow for ongoing input from MAWS to accommodate evolving standard of care
<p>Jami Milliken</p>	<p>I am in favor of this bill, I personally have had my pregnancy care and post pregnancy care through a midwife. I feel the care I receive was amazing!</p> <p>I will always use a midwife for my pregnancy care.</p>
<p>Ashley Allman Seattle, WA</p>	<p>I was notified of the pending legislation regarding midwifery care of newborns and wanted to provide a comment. As a mother who has birthed in the hospital and at home, I can say that the care provided by my midwifery team was above and beyond anything I experienced in the more 'traditional' maternal/post partum care setting. My midwife visited us regularly post partum and brought a wealth of support and knowledge to help us as we and our new baby boy adjusted to life in those first few weeks following his birth. The care that was provided was exemplary. The first few weeks following a baby's birth can be a challenging time for parents, and the midwife's visits provide support for nursing, general newborn care, the mother's emotional and physical well being and so much more. It is a gift to be able to stay home and still receive professional care - I so valued the ability to avoid driving and doctor's offices after my son was born, and would not have been able to stay in the comfort of my own home had it not been for the in-home newborn care provided by my midwife. I can't say enough positive things about this service that midwives provide, and the importance of it continuing as an option for pre/post natal families.</p>
<p>Emily Black Seattle, WA</p>	<p>My son and I had to go out of our way for prenatal midwife care, had to fight like you wouldn't believe for our amazing home birth, and would have felt many levels of loss had insurance obstacles continued by preventing us from continuing our postnatal (including well baby) care through these trusted, experienced, knowledgeable professionals.</p> <p>Add my name to those who feel the scope of care provided by midwives should be represented in all documents as including care for the well infants they ease into the world. Midwives are worth our every ounce of trust, respect and support.</p>
<p>Krista Herling</p>	<p>I would like to comment that midwives always care for newborns and they should be viewed as a provider for the newborn not only for the mother. My midwife gave much more care than any of my other babies born at a hospital ever received. They should be</p>

	<p>compensated fairly for their care.</p> <p>Please make sure that they are not stripped of their rights as a provider for newborns. Midwives are awesome and they do a wonderful job!</p>
Rachel Radtke	<p>I'm writing to express my support of expanding the legal scope of practice of licensed midwives in WA state to include newborn care for healthy newborns. I am a mother of 3 living in Kenmore, WA. My youngest two children were born at home, with the assistance of Licensed Midwives. Newborn care is essential aspect of midwifery. My newborns have benefited from a midwife's assessment of checking for any congenital defects that may have been missed or undetectable by ultrasound, normal reflexes, observations for signs of jaundice, routine supplemental vitamin K, and performing the metabolic screening test. These are all accepted parts of a midwife's responsibility after the birth. If a midwife did NOT perform normal healthy newborn care, she would be considered irresponsible by her peers, and it would harm her reputation among clients like myself. Yet, because newborn care is not under the "legal definition" of the midwife's scope of practice, there is a risk of them not receiving fair compensation from insurance companies.</p>
Catherine Cashatt Las Vegas, NV	<p>I am writing in support of the proposed changes to the midwifery scope of practice statute to include the following:</p> <ul style="list-style-type: none"> * Include care of well newborns in statute * Define scope of practice in rule to include care of well newborns * Allow for ongoing input from MAWS to accommodate evolving standard of care <p>I gave birth to my daughter (2006) and son (2009) in Washington with the support of licensed midwives. The care they provided to us in the post-partum period was extremely valuable - they provided well newborn care to our babies in our home and ensured that everything from breastfeeding to newborn care was successful. It would have been a hardship in those first days and weeks to have to seek additional outside care for our newborns.</p> <p>Midwives are specialists and experts in the care of well mothers and newborns and provide a much needed and highly valuable service to the community. Please do not delay in approving these changes to the statutes regarding the midwifery scope of practice.</p>
Veronica Wannberg	<p>I had a child at home last November and was attended by a Certified Midwife and her Assistant. I was very pleased with her care of myself and my newborn during labor and delivery and for the days afterwards. I would encourage you to include newborn care in the statute that is being reviewed soon.</p>
Lisa Oberstadt Snohomish, WA	<p>I have recently been made aware that the Washington midwife standard of care is not adequately represented in state law. I would like to add my support of midwifery and its importance for the newborn child. The midwife who helped me with my youngest daughter was knowledgeable and supportive both during pregnancy and labor, and after birth. I felt that the care my newborn received from the midwife equaled and even surpassed the care I received with previous births in a conventional hospital/doctor</p>

	<p>setting. Please help the Licensed Midwives receive the representation and protection they need to continue serving women and infants.</p>
<p>Amy Miller San Diego, CA</p>	<p>I have had two successful home births, one in Washington State and one in California. Both experiences my husband and I both felt like the midwives went above and beyond for our family treating the whole mom and baby. They took precautions through out the pregnancy, making available the appropriate testing that any OB/GYN would have out sourced, and yet gave three times the amount of care and attention that I would have received from traditional care. Please fight for our midwives to keep birth as normal as possible, something that has been going on since humans have walked the earth. Keep high risk pregnancies in the hospital, and normal pregnancies in the location that the mother wishes; be it the hospital, birthing center or home.</p>
<p>Victoria Malloy Alternative Medical Billing Seattle, WA</p>	<p>I am writing as an interested party in support of the applicant’s request regarding the upcoming Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50.010.</p> <p>I am a small business owner and the focus of my business is to provide medical billing services for midwives and consumers of midwifery care in Washington State. My clients include both Licensed Midwives and Certified Nurse Midwives. The consumers of midwifery care whom I serve are using birth centers, hospitals and their homes for the location of their deliveries. I work closely with clients who are covered by the State of Washington’s Medicaid coverage for pregnancy, as well as with clients who are insured by third party payors and clients who have no insurance coverage at all. I have been a midwifery medical biller for 15 years.</p> <p>I am also a consumer of midwifery care provided by Licensed Midwives (both of my children were born at home and received their newborn care from Licensed Midwives).</p> <p>A large part of my work with expectant mothers and their families revolves around assisting them in making financially feasible choices that coincide with their personal preferences for provider type and location of delivery for their pregnancies, births and care of their newborn children.</p> <p>In my work in billing for midwifery to Washington State Medicaid, I use the following document as a guideline for billing for well newborn care provided by Licensed Midwives in the out of hospital birth setting. This document is the Washington State Health Care Authority’s Medicaid Provider Guide for Planned Home Births and Births in Birthing Centers. On page 6, Licensed Midwives are included as eligible providers per the reference to “chapter 18.50 RCW”. Page 10 contains a supply list which includes items specific to care of a well newborn. We have been successfully billing and being reimbursed by Medicaid and third party payors for well newborn care provided by Licensed Midwives. A link to the document is here:</p> <p>http://www.hca.wa.gov/medicaid/billing/documents/guides/plannedhomebirths_bi.pdf</p> <p>Many pregnant women desire midwifery care, but first want to ensure that it is affordable, so I am often their first point of contact when making provider and birth location choices. I do my best to assist them in estimating their out of pocket costs, and births at home or in a birthing center are most often significantly less expensive for consumers and insurers as compared to a birth in the hospital. A major aspect of this cost savings is in regards to well newborn care.</p>

	<p>Hospitals routinely bill thousands of dollars per child for inpatient facility nursery fees for normal, healthy inpatient babies (who are often “rooming in” with their mothers during the inpatient stay). For details on hospital fees for normal newborns, please see the 2012 CHARS data here:</p> <p>http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS/CHARSStandardReports.aspx</p> <p>The link to the document titled “Hospital Census and Charges by DRG” includes information stating that the mean charge by Washington hospitals per day for a normal newborn in 2012 was \$1991.72, and that mean charge per normal newborn at discharge was \$3243.87 (please see line 27733 of this document for the averages for inpatient charges by hospitals for normal newborns).</p> <p>For newborns born at home or in a free standing birth center, costs are significantly lower – normal care includes exam and medications on day of birth and follow up visits to ensure health of the newborn and for state-mandated newborn screening tests to be administered. On average, these charges amount to less than \$500 in billed charges per well newborn. The inpatient nursery fees not being billed to insurers or consumers represent a significant cost savings without any compromise to well newborn (or maternal) health or well being.</p> <p>In the interest of consumer choice, safe and effective care of mothers and well newborns, and cost savings to both consumers, Washington State Medicaid and third party payors, I believe the request of the applicant on behalf of Licensed Midwives practicing in Washington State meets the criteria for a Sunrise Review recommendation for amendment to RCW 18.50.010.</p> <p>I believe it is well established in the application for the Sunrise Review for Midwifery Scope of Practice that Licensed Midwives are adequately trained and are currently safely providing well newborn care for babies born at home or in a free standing birth center. Because of this, no potential harm to the public would result from this amendment.</p> <p>I also believe that the clarification of scope of practice for Licensed Midwives care of well newborns will benefit consumers in terms of access to preferred provider type and location of birth. It will also result in continued or increased cost savings to consumers, to Washington State Medicaid and to third party payors.</p> <p>Thank you for considering my input. I would like to receive any updates or further Sunrise Review communications issued regarding these proceedings.</p> <p>Tue 8/6/2013 11:27 AM</p>
<p>Ron Harper Duvall, WA</p>	<p>Four of my five children were born with the assistance of and under the care of midwives. Two were in the hospital, two at free standing birth center. In two of those cases (one in each location), our children are only alive today thanks to the care of the midwife during the days <i>after delivery</i>.</p> <p>The most severe example would be my son born just over a year ago. During the next day post-partum check on mom and baby, the midwife noticed a very slight elevation in the heart rate of my new son. She took no chances, did the right thing, even going with</p>

	<p>us to Children's for further testing and staying with us for the first few hours until she was confident that right care was being taken. That child, as it turns out, had Group B Strep - a very serious, often deadly infection that at a minimum can cause severe mental and physical disabilities if not caught in the first few hours of infection. Thanks to this super attentive, qualified midwife, my son received the care he needed quickly and today is a perfectly healthy and happy 13 month old.</p> <p>It is important that we legally clarify this important role of the midwife to both a) make sure they get paid for this great work but more importantly b) are allowed to legally continue in this important work.</p> <p>Please push this through.</p>
<p>Irene Onofrei Seattle, WA</p>	<p>I'd just like to send a note ahead of the hearing in Olympia this Friday regarding the clarification of a midwife's scope of practice for newborn care. Both of my children were born under the care of a midwife in Bellevue (2010 and 2012). Shortly after the birth, my midwife sat with me while I nursed and walked me through a booklet of postpartum mom and baby care, basically a newborn instruction manual, where I would keep track of my temp and baby's temp, feedings and bowel movements for the first three days of life. The manual detailed what was normal behavior and what was cause for concern. After 48 hours, my midwife came to our home and sat with and went through the log as we discussed in detail how baby and mom were doing. Being able to call on my midwife at any hour in those first weeks postpartum was so valuable. I found myself in such a daze after both births from lack of sleep, hormonal changes, and the reality of addressing this tiny human's every need, that having a trusted midwife with a wealth of knowledge and reassurance just a phone call away was truly priceless. Even though we had a pediatrician lined up, I know for a fact I would not have received the same quality or quantity of care for myself and my newborn if I had to call the ped's office with all my questions and concerns in those first 6 weeks. With the help of my midwife, we got off to a great start and I would want the same for every family that chooses midwives for prenatal, birth and newborn/postpartum care. Thank you for taking the time to read my thoughts!</p>
<p>Barrie Rein Thunemann Snoqualmie, WA</p>	<p>I am writing on behalf of midwifery care in WA State. I am a mother and consumer of midwifery care for the birth of my second child. I live in Snoqualmie. The care I received was supportive, comprehensive and very helpful. It was much better quality of care than the care I received after the birth of my oldest child which was in a Hospital in WA State. I support the following recommendations regarding midwifery care.</p> <p>We are requesting that the review board recommend the following to Secretary Weisman and Assistant Secretary Jensen:</p> <ul style="list-style-type: none"> * Include care of well newborns in statute * Define scope of practice in rule to include care of well newborns * Allow for ongoing input from MAWS to accommodate evolving standard of care
<p>Liz Chambers Midwifery Support Services Redmond, WA</p>	<p>I am a four-time consumer of midwifery care, as well as being the administrator of the Washington State Joint Underwriting Association for Midwives and Birth Centers, a childbirth educator, and one of the owners of the Puget Sound Birth Center in Kirkland WA.</p> <p>I strongly support the clarification of the role of Licensed Midwives in providing care to the mother <i>and baby</i> during the newborn period.</p>

	<p>As a new mother in the daze of early parenting, I greatly appreciated having a familiar, trusted, experienced professional assisting with breastfeeding technique, keeping a watchful eye for variations from normal in my baby, and reassuring me on the normal variations. The same midwives who monitored my babies' well being in utero provided continuity of care in those first weeks after birth. It never occurred to me that they wouldn't. How would it even work if they didn't provide that care? How can they provide breastfeeding advice without also scrutinizing the baby's role in milk transfer? How could they ethically respond to a new mom 2 days after birth asking "Is it OK that my baby is a little yellow?" with "Sorry, that's outside my scope of practice, drive to your pediatrician or take the baby to urgent care and ask there" while knowing that the slight yellow is just normal jaundice that will resolve with lots of breastfeeding? The midwife is sitting right there next to mom and her new baby, at the home visit a day or two after the birth, and again 1-2 weeks later. Please clarify in statute and rule that licensed midwives continue to provide care to newborns during those postpartum visits, so that this care is protected for all new families going forward.</p>
<p>Emi Yamasaki McLaughlin, LM, CPM, MSM Journey Midwife Services, LLC Seattle, WA</p>	<p>I urge the Sunrise Review Committee to clarify that Licensed Midwives' scope of practice includes care of the well newborn in the postpartum period up to 6 weeks. As a newly licensed midwife, I can attest to my training in the care of well newborns, including screening for conditions that require a higher level of care than I provide. Also, this is the current standard of care provided by Licensed Midwives in Washington. I completed my clinical training last year and attest to the fact that the 6 different midwives I worked with over the course of my training assess and evaluate well newborns and consult on their condition or refer when necessary. As a recent graduate, I am starting my own practice and could not afford to be penalized by third party payors for practicing within my scope and giving my clients the continuity of care they expect and desire. Lastly, some pediatricians will not care for babies under 8 weeks of age, so for those that are well and do not require pediatric evaluation, keeping their baby in my care during that time give my clients more choices in pediatricians, rather than being restricted only to those who will see babies under 8 weeks of age.</p> <p>Please clarify Licensed Midwives' scope of practice to include care of the well newborn up to 6 weeks of age.</p>
<p>Heidi Lane</p>	<p>I am writing in a comment in regards to the Midwifery Scope of Practice Sunrise Review since I will be unable to attend in person on Friday.</p> <p>My husband and I welcomed our baby boy in April of this year under the care of the midwives at Puget Sound Birth Center. In regards to postpartum and newborn care, we found the care the midwives provided to be invaluable. At our home visit which took place two days after delivery, the midwife found that our baby's temperature was a little low and told us how to keep him warm. I wouldn't have thought he would be cold since it was warm out so I was grateful she caught this. She showed us how to hold him in natural light to check the status of his jaundice. She also weighed him and checked to see how breastfeeding was going. She gave me a great recommendation for a breastfeeding book (The Womanly Art of Breastfeeding) which helped me tremendously.</p> <p>At the follow-up visits, the midwives answered all of my questions and helped make me feel more confident in myself as a new mom. Their support postpartum helped me both emotionally and mentally. It was comforting to know that my husband and I were not alone. Especially since our baby did not get to see his pediatrician until 2 weeks of age.</p>

	Please continue to allow midwives to provide postpartum care of new infants and their mothers. It would be devastating to take this away.
Lee A. Burdge, DC Kenmore, WA	I would like to register my support for establishing language that protects a licensed midwife's ability to render care for the newborn and be eligible for third party payment for services rendered.
Erin Baca	I just wanted to say that my midwives were indispensable in the care of my baby just after he was born. Even though I had to transfer to a hospital they visited to make sure baby and I were doing well. We continued to see them for 6 weeks after birth. They helped with our breastfeeding problems and my recovery. Midwives are able to provide care out of hospital to low-risk, healthy pregnant women and it makes sense that they continue that care for healthy, low-risk mothers and babies.



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August 3, 2013

I am submitting comments on behalf of ARNPs United of Washington State (AUWS), the professional association of the state's advanced practice nurses, which includes nurse practitioners, nurse midwives and nurse anesthetists. AUWS is submitting comments in support of the scope of practice for licensed midwives (LMs) providing care to newborn infants.

The education of LMs includes didactic content and clinical experience preparing them to assess and manage the care of newborn infants. In Washington State, this education occurs at the graduate level. The requirements for licensure as a LM are rigorous and assure LMs meet high standards. LMs have a long history of providing care to newborns and are cognizant of when consultation and refers is necessary.

AUWS supports explicitly including the care of newborns in the scope of practice of LMs. This will assure the public understands that LMs are authorized to provide care to newborn infants, assure LMs are reimbursed for the services they are educated and competent to provide, and protect LMs from disciplinary action that might occur if their scope of practice is not clearly defined. This is an important access to care issue at a critical time when primary care services are in short supply across the state.

Sincerely,

A handwritten signature in black ink that reads "Louise Kaplan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Louise Kaplan, PhD, ARNP

Chairperson, AUWS Legislative Committee



The Association of Washington Healthcare Plans

August 7, 2013
sunrise@doh.wa.gov

Transmitted electronically to

The Honorable John Wiesman, DrPH, MPH

Secretary of Health

Washington State Department of Health

Health Systems Quality Assurance

PO Box 47850

Olympia, WA 98504-7850

Re: Midwifery Scope of Practice Sunrise Review

Dear Secretary Wiesman,

On behalf of Association of Washington Healthcare Plan (AWHP) member healthcare plans, thank you for the opportunity to provide input as part of the Department of Health's (DOH) sunrise review of a proposal to change the scope of practice for midwives to include the provision of medical aid to an infant up to two weeks of age.

AWHP is an alliance of our state's fifteen largest Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), and Disability Insurers. Its diverse membership is comprised of local, regional, and national healthcare plans serving the needs of consumers, employers and public purchasers. Together, AWHP member healthcare plans provide health care coverage to over 4 million residents of Washington State.

Healthcare Plans recognize and value the care Licensed Midwives provide expectant and new mothers; however, we have significant concerns with the proposal to expand their scope of practice to include infant medical services. We hope the following comments will be of assistance during your review.

Patient Safety and Quality of Care

The first few weeks of an infant's life are highly critical to his or her health. During this time, infants are at the highest risk for complications such as newborn infections and sepsis, metabolic disorders, poor feeding and poor weight gain, jaundice, and congenital conditions, including heart murmurs.

During the first few weeks of life, newborns should be seen and cared for by a trained medical doctor who can properly diagnose and provide evidence-based care and treatment for potential life and health threatening conditions or diseases --- as well as administer and document recommended immunizations including PKU screenings at the appropriate age. Patient safety and evidence-based care are not supported when a Licensed Midwife replaces a medical doctor's care during the newborn's first weeks of life. Based on these important patient safety concerns and quality of care issues, AWHP healthcare plans are opposed to the proposed scope expansion which results in selecting an extremely high risk period for midwives to care for newborns.

It is also important to note the distinction between a Licensed Midwife and a Nurse-Midwife. Licensed Midwives receive less training and their licensure is more restricted. Healthcare Plans recognize and support mid-level practitioners playing an important in the healthcare system, however, it must be an appropriate one that supports patient safety, quality of care, and effective use of resources.

Even if the midwifery training and curricula were expanded to address some newborn care, we strongly urge against expanding the scope for midwives to perform newborn care. The level of care provided by pediatricians with appropriate pediatric training and exposure to a variety of newborn care issues cannot be attained through an increase in training alone which tends to focus on the care of a normal newborn. Supervised in-patient newborn management will not address the myriad of issues that arise if the newborn has complications, which is of utmost concern. We are also uncertain as to whether licensed midwives can utilize the appropriate diagnosis and coding criteria that are needed to submit codes for providing newborn care.

Scope of Practice Expansion, not Clarification

Licensed Midwives scope of practice is focused on care of the pregnant woman during and post delivery, not infants. The proposal submitted to DOH for Sunrise Review is clearly seeking to expand the scope of practice of Licensed Midwives to include infant medical care as RCW 18.500.010 distinctly states that midwifery is rendering medical aid "to a woman during prenatal, intrapartum, and postpartum stages". We believe the delivery of a newborn would include the immediate heel stick tests and capturing birth weight and other characteristics that are documented soon after delivery and may be performed by a midwife.

If licensed midwives are currently providing services to a newborn for two to six weeks postpartum despite the well-defined language in the statute, we have significant concerns with this practice for the reasons stated above. We believe it is clear that licensed midwives do not perform pediatric care and the services that are provided to a newborn during the first two to six weeks of life require pediatric attention and expertise.

Despite proponent's description of the proposal as merely a clarification of scope, we do not believe this is an accurate characterization and have concerns about current practices that may be followed. The

proposed scope expansion is not consistent with Licensed Midwives licensure and training. Provision of “medical aid” or medical services to infants, as called for in the proposal, is not within their scope of licensure or training.

Cost Implications

If newborn care is provided without appropriate training and level of expertise, there will be an increase in the number of complications and associated costs. Consultation requirements with a physician are described in the statute, but expanding the scope of practice to include newborn care for up to 2 weeks increases the range of time that newborn infections and conditions may occur under the care of an individual who is not a pediatrician.

Again, we hope this input is helpful and thank you for the opportunity to provide comments for your consideration. Please do not hesitate to contact me with any questions or to discuss.

Sincerely,



Sydney Smith Zvara

Executive Director

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AWHP members include Aetna, Amerigroup, Cambia Health Solutions, CIGNA, Columbia United Providers, Community Health Plan of WA, Coordinated Care, Group Health, Kaiser Permanente, Molina, HealthNet, Premera Blue Cross, Providence Health Plan, SoundPath, & United Healthcare.

Midwifery Sunrise Comments

Received During Post-Hearing Comment Period

Cortney George	<p>I'm sending my comments in lieu of the DOH Sunrise Review regarding Midwife scope of practice in WA state.</p> <p>I am a mother of two children born under the stellar care of midwives from the Puget Sound Birth Center in Kirkland. I not only feel that I had exceptional prenatal care and care during the birth of my children, but the care and expertise that was given to my newborns was fantastic.</p> <p>One of the most remarkable aspects of the midwifery care that I and my newborns received, was the extensive knowledge that my midwives expressed. They were always sure to educate us about every issue and potential issue that may arise throughout the pregnancy and post partum time.</p> <p>I feel that the education that midwives receive in the state of WA is more than extensive enough to properly care for well newborns as evidenced by my experience and the experience of countless others that I have spoken to.</p> <p>I am also a chiropractor who sees families and have had numerous contacts who have expressed the same comfort and gratification with their midwifery experiences.</p> <p>Please consider defining midwives scope of practice to include the care of well newborns.</p>
Elizabeth Adams Everett, WA	<p>I had my second child with the Puget Sound Birth Center in Kirkland. Here's my two cents: Having midwives provide well baby care is convenient, economical, and just makes sense! Why drag a newborn to a clinic full of runny noses and coughing when your midwife makes house calls? Healthy little babies can be taken care of by midwives just fine!</p>
Heather Chorley, LM Seattle Home Maternity Services	<p>I have been a Licensed Midwife in WA State for over 14 years. During that time I have cared for hundreds of women and newborns. The care we provide to the population of women and families who choose to birth in free-standing birth centers or at home has always included care and screening of the newborn from the moment of birth and in the early weeks of life. Over the course of my career, I have identified critical health issues in newborns prior to an appointment with their chosen pediatric doctor. Because of our early and meticulous follow-up after birth, we are able to identify early feeding issues/problems and prevent serious weight loss. Some of the more serious issues identified have led to the following diagnoses: Down Syndrome, Prader Willi syndrome, congenital heart defects, jaundice, failure to thrive, pyloric stenosis, prolonged Q-T syndrome (heart abnormality). In some cases the families we serve are disinclined (against our advice) to take their newborn to any other provider in the early weeks of life. The</p>

	<p>trust they have in us and our skilled care ensures that their newborns are followed closely in the early days and weeks and any abnormality is identified early and appropriate care is arranged. Please include specific language in support of this newborn care are already providing.</p>
<p>Annie Moffat Bainbridge Island, WA</p>	<p>I have been a Licensed Midwife in WA State for over 14 years. During that time I have cared for hundreds of women and newborns. The care we provide to the population of women and families who choose to birth in free-standing birth centers or at home has always included care and screening of the newborn from the moment of birth and in the early weeks of life. Over the course of my career, I have identified critical health issues in newborns prior to an appointment with their chosen pediatric doctor. Because of our early and meticulous follow-up after birth, we are able to identify early feeding issues/problems and prevent serious weight loss. Some of the more serious issues identified have led to the following diagnoses: Down Syndrome, Prader Willi syndrome, congenital heart defects, jaundice, failure to thrive, pyloric stenosis, prolonged Q-T syndrome (heart abnormality). In some cases the families we serve are disinclined (against our advice) to take their newborn to any other provider in the early weeks of life. The trust they have in us and our skilled care ensures that their newborns are followed closely in the early days and weeks and any abnormality is identified early and appropriate care is arranged. Please include specific language in support of this newborn care are already providing.</p>
<p>Janna K. Stults, MPH</p>	<p>I am writing to support the scope of practice of Licensed Midwives (LMs) to include the provision of well-newborn care for up to six weeks postpartum. LMs are trained to assess and care for the normal newborn, as well as have clear guidelines which require referral to a pediatrician or other pediatric provider. Care provided by LMs is high-quality and cost-effective, assuring the health of infants born in out of hospital settings.</p> <p>Both my daughters were born at Puget Sound Birth Center with LMs of Eastside Midwives, in 2011 and 2013 respectively. They received immediate assessment and care including a full physical exam, monitoring of temperature, heart and respiratory rates, administration of eye prophylaxis, and vitamin K administration. We received a visit from a LM at 48 hours postpartum to screen for hyperbilirubinemia, perform a physical, assess feeding and weight, and collect blood for the Washington State newborn screening test. In the following 6 weeks, my daughters and I received in-office care, including collection of blood for the second Washington State newborn screening test. Additionally, we received continuous support, encouragement, and resources to ensure successful breastfeeding. Our daughters were both assessed by their pediatrician at 5 days of life, but required less follow-up because they were cared for and monitored by our midwives until 6 weeks of age. The care we received by LMs was both high-quality, cost-effective and recommended by the AAP within their guidance on care of infants in planned home birth; newborn care was provided alongside postpartum care, providing</p>

	<p>timely assessments, continuity, and close-monitoring of both my babies and me.</p> <p>Please include the care of well-newborns up until 6 weeks of age within the clinical scope of practice of LM.</p>
<p>Claire Mars</p>	<p>Our midwife team was a wonderful support to us as we transitioned into parenthood with our newborn. Their home visit within the first 24 hours was wonderful and so encouraging. I love that they are never rushed and take the time to answer all of my questions. They also take the time to encourage me like a close friend would. My relationship with them is so much more than client/provider. I would hate to be forced to go to a practitioner for those visits. It is wonderful to see them same people you built a relationship with for 9 months and you trust.</p>
<p>Karen E. Hays, DNP, MN, CNM, ARNP</p>	<p>I am writing in support of including wording in any and all official documents that describe the Licensed Midwives (LMs) scope of practice to include care of the newborn.</p> <p>I started my career as a Licensed Midwife 20 years ago, but am now a Certified Nurse-Midwife (CNM) and Advanced Registered Nurse Practitioner (ARNP). I have practiced midwifery in Washington State in the home setting, in licensed birth centers, and in 3 different hospitals. I am on the faculty of the midwifery training programs at both Bastyr University and the University of Washington. I am a pro tem member of the ARNP SubCommittee of the Nursing Care Quality Assurance Commission (NCQAC). I am also a Medical Reserve Corps volunteer, and understand the importance of providing health care practitioners with the legal authority to practice to the full extent of their training because when disasters strike, it's "all hands on deck" and all providers of all licenses need to step up in order to protect the public health and serve the needs of the victims and survivors. Licensed Midwives' participation is integral to planning for maternity services, breastfeeding support, and newborn care, particularly during natural disaster and biological threat responses. The pediatricians and family practitioners will all be needed to care for the wounded and the ill; the midwives and nurse practitioners will be needed to provide routine care and health preservation and illness prevention activities.</p> <p>Licensed Midwives in Washington State are required to study newborn care in the classroom setting, and their extensive clinical training provides them with hundreds of hours of caring for newborn babies and teaching families how to care for the new baby. It is accepted and expected that midwives provide clinical services for both the mother and the neonate immediately after the birth and during the first transitional weeks. Simultaneously, midwives require that their clients establish a relationship with and present the baby to a pediatric care provider before the midwife completes her course of care for the family so that there are no gaps in health care for the baby. Furthermore, midwives are required by law to have consultation and referral mechanisms in place for when clinical situations deviate from the normal course at any time. This implies that midwives are recognized to be trained and competent to screen for and recognize complications, and differentiate the well newborn from the ill or potentially ill newborn.</p> <p>Thank you for your assistance in ensuring that Washington State remains at</p>

	<p>the top of the list in terms of being recognized for providing quality, comprehensive maternal-newborn care services for all of its residents.</p>
<p>Oesa Hauch</p>	<p>I am a Bothell resident and two-time consumer of midwifery care. Both of my children were born into the hands of midwives and the care I received was invaluable. I also actively work with other birthing families in the greater Seattle area as a birth doula and childbirth educator. I have had the opportunity many times over to see the highly positive impact that midwives have on new families. It is vital to all Washington families that they have access to the continued care that midwives in our state provide.</p> <p>With that in mind, I would like to add my voice to that of others asking that the review board recommend the following to Secretary Weisman and Assistant Secretary Jensen:</p> <ul style="list-style-type: none"> * Include care of well newborns in statute * Define scope of practice in rule to include care of well newborns * Allow for ongoing input from MAWS to accommodate evolving standard of care.
<p>Celeste Groenberg</p>	<p>Please allow Licensed Midwives to continue to provide newborn care in the first 6 weeks postpartum.</p> <p>Licensed midwives are educated experts on well newborns and are knowledgeable to recognize what is abnormal.</p> <p>I am a mother who has only birthed with midwives for my 4 children, and the care that I have received for my babies in the weeks postpartum was impeccable. I especially appreciated the midwives coming to my home, to do Newborn Screening, and well baby visits. I felt so much more comfortable to not bring my babies out of the house to be around other germs in a doctors office unnecessary.</p> <p>Please continue to assure that midwifery care is covered by health insurance, including newborn care.</p>
<p>Bev Schubert, LM, CPM Little Mountain Midwifery</p>	<p>As a licensed midwife in Washington State I strongly urge you to support the addition of the following to RCW 18.50:</p> <ul style="list-style-type: none"> Care of well newborns Define scope of practice in rule to include care of well newborns Allow for ongoing input from MAWS to accommodate an evolving standard of care <p>In an effort to provide safe and professional care all newborns receive thorough and timely evaluations and screenings, while mothers in our care are able to spend the first few days postpartum in bed recuperating from birth, knowing that the her well</p>

	being and the health and safety of her newborn is being monitored by a trained and licensed professional. Continuity of care is essential during this time and to overlook the midwife's role would be remiss.
Julie Kevon	I would like to share a quick testimonial. I had my midwife do a home visit when my baby was 48 hours old. This is standard procedure for their practice. Upon the visit, the midwife noted that my son was extremely jaundiced. We thought it was normal. My midwife found an on-call Physician from the practice we told her we wanted to use for JJ's pediatrician. We received a call w/in 30 min from the physician and were in the office for a bilirubin blood draw. We received a phone call from the Dr 3 hours later that instructed emergency transfer of my son to Children's NICU. My son's bilirubin count was elevated enough to put him in danger of permanent brain damage. We wouldn't have seen the symptoms until it was too late. My midwife helped him receive the medical care he needed to save his life potentially. She went above and beyond the diagnosis and helped us get the care he needed on a weekend evening! I hope this testimonial can help you make an informed decision.
Sanelle Aurilio, CPM Wenatchee Midwife Service and Childbirth Center	I would like to share a quick testimonial. I had my midwife do a home visit when my baby was 48 hours old. This is standard procedure for their practice. Upon the visit, the midwife noted that my son was extremely jaundiced. We thought it was normal. My midwife found an on-call Physician from the practice we told her we wanted to use for JJ's pediatrician. We received a call w/in 30 min from the physician and were in the office for a bilirubin blood draw. We received a phone call from the Dr 3 hours later that instructed emergency transfer of my son to Children's NICU. My son's bilirubin count was elevated enough to put him in danger of permanent brain damage. We wouldn't have seen the symptoms until it was too late. My midwife helped him receive the medical care he needed to save his life potentially. She went above and beyond the diagnosis and helped us get the care he needed on a weekend evening! I hope this testimonial can help you make an informed decision.
Manjeera	I would like to share a quick testimonial. I had my midwife do a home visit when my baby was 48 hours old. This is standard procedure for their practice. Upon the visit, the midwife noted that my son was extremely jaundiced. We thought it was normal. My midwife found an on-call Physician from the practice we told her we wanted to use for JJ's pediatrician. We received a call w/in 30 min from the physician and were in the office for a bilirubin blood draw. We received a phone call from the Dr 3 hours later that instructed emergency transfer of my son to Children's NICU. My son's bilirubin count was elevated enough to put him in danger of permanent brain damage. We wouldn't have seen the symptoms until it was too late. My midwife helped him receive the medical care he needed to save his life potentially. She went above and beyond the diagnosis and helped us get the care he needed on a weekend evening! I hope this testimonial can help you make an informed decision.
David Springer, MD, MPH Associated Clinical Professor, University of Washington	I have been a pediatrician in Washington state for 32 years. I have attended many homebirths and fielded many calls from midwives regarding status of newborn babies. The care and referrals provided by certified midwives for newborns in the first week of life has always been appropriate and timely. The American Academy of Pediatrics on April 13, 2013 issued a policy statement: AAP Issues Guidelines for Care of Infants in Planned Home Births. In summary the Academy recognized

	<p>some woman prefer a home birth for their babies. Further, the attendance of a a certified midwife with resuscitation oxygen, nearby phone contact if needed and following taught guidelines for infant warming,detailed physical exam, monitoring temperature, heart rate, and respirations with appropriate eye prophylaxis, hepatitis B when indicated, vitamin K, feeding assessment, and hyperbilirubin screening is all that is needed by new baby. The comfort, knowledge, and trust garnered by the certified trained midwife is the best solution for monitoring of home born newborns in first three to seven days of life. I have taught newborn care at the midwifery school in Seattle. The students are eager to learn newborn assessment and have sufficient background to perform all the tasks recommended by the Academy of Pediatrics. Newborn care and assessment needs to be included in the legal role of the certified midwife.</p>
Carly A. Bridge, ND	<p>I am writing in support of the Sunrise Review to close a loop-hole allowing Licensed Midwives to be reimbursed by insurance companies for providing newborn well-care. As a Naturopathic Physician who completed a Family Practice Residency, I saw hundreds of newborns, many of whom were delivered by midwives. The care both these babies and their mothers received was extraordinary. During the pregnancy, these families would commonly schedule a “meet and greet” with me, at the request of their LM, to establish care with a primary care physician. At these appointments, I would explain the flow of care once delivery occurred. Unless the midwife was doing a follow-up home visit between 24 and 72 hours, I would always see newborns for their initial exam between days 3 and 5. If the LM was doing home visits, then I would see the newborn between days 7 and 10. I always received chart notes of the delivery and the initial newborn screening exam, as well as a phone call from the LM if they had any concerns about either Mom or baby. I found the level of care LM’s provided to go beyond conventional standards.</p>
Heike Hornsby, LM, CPM	<p>Thank you for giving me the opportunity to comment on licensed midwives newborn care clarification in the law.</p> <p>In specific I would like to comment on the letter from the Association of Washington Health Care Plans.</p> <p>This Association represents 15 third party insurers according to their letter head.</p> <p>Aetna Amerigroup Cambrian Health Solutions Cigna Columbia United Providers Community Health Plan of Washington Coordinated Care Group Health Kaiser Permanente Molina Health Net Premera Blue Cross Providence Health Plan Sound Path United Healthcare</p> <p>As a licensed Midwife I have been contracted with 11 of those plans for up to 17 years. ALL of them have been paying for Newborn Care And most of them have it specifically named in our contract as a service that they expect me, as a Licensed Midwife to provide to their members.</p> <p>The other 6 plans are not available for purchase in our area, so I can not comment on them.</p> <p>Obviously the Association of Washington Health Care Plans does not know what what their members are already expecting and reimbursing for Licensed Midwives.</p>

	<p>Licensed Midwives have been providing this care since 1996. If their would have been a lack of skill or education resulting in sad outcomes, the public and the Department of Health would have been made aware of that via complaints or Liability Law Suits.</p> <p>I also wonder how we would be expected to provide Breastfeeding advice without being able to talk about the Baby. He/She is an active part of evaluating successful Breastfeeding.</p> <p>If I see a baby with poor weight gain, am I now to not counsel this mother? Am I to tell the mother to go see her Pediatrician and hope she will take that advise and has the resources to get their ASAP?</p> <p>Licensed Midwives are educated and experienced in evaluating Newborn well being. We are also the providers that have access to the mother/child unit 3 times in the first two weeks of the Newborns life. Current studies have clearly shown that that is one of the main factors in diagnosing a unwell baby. To deny families this cost effective, proven safe and evidence supported care is frankly irresponsible.</p> <p>More than once have I send a two or three week old baby to the hospital who's life threatening condition could be treated in time and would have been missed with standard evaluation timing of first day and than again 7-10 day Pediatrician visit. I.e. the baby with liver disease that turned jaundice on day 12 and the mother did not notice it and was not concerned enough to go to a pediatrician. She thought her baby was fine. Only a standard postpartum visit at the Midwives exposed severe disease. This child would not be with us today without standard Midwifery care.</p> <p>Please, do not take this away from mothers and babies. 3/4 of the time during a postpartum visit is spend on answering questions about the baby. Just like it should be.</p>
Karen Dugan	<p>I am writing in support of the Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50 to clarify LM's role in newborn care. I believe that LM's scope of practice should include care of newborns in the first 6 weeks. LM's are trained in normal newborn care and in recognition of deviations from normal including when to consult or transfer care.</p> <p>I have had three children under the care of LM's in WA. The care that was provided to me and my newborn children was of the highest quality. I would like to make it clear that they in no way replaced the role of our children's pediatrician, but complemented it. In fact, our pediatrician recommended and supported the care of our newborns by LM's because he recognized them as experts in normal newborn care. LM's are experts in normal newborn care. Please recognize it, honor it, and clarify it in the law.</p>
Nicole Kistler	<p>I am writing in support of the Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50 to clarify LM's role in newborn care. I believe that LM's scope of practice should include care of newborns in the first 6 weeks. LM's are trained in normal newborn care and in recognition of deviations from normal including when to consult or transfer care.</p> <p>My only child received care from a Licensed Midwife in Washington, and I was impressed with exceptional quality of that care. I would like to make it clear that</p>

	<p>they in no way replaced the role of our children's pediatrician, but complemented it. In fact, our pediatrician recommended and supported the care of my newborn by LM's because he recognized them as experts in normal newborn care. LM's are experts in normal newborn care. Please recognize it, honor it, and clarify it in the law.</p>
Michelle Seligman Seattle, WA	<p>I am writing in support of the Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50 to clarify LM's role in newborn care. I believe that LM's scope of practice should include care of newborns in the first 6 weeks. LM's are trained in normal newborn care and in recognition of deviations from normal including when to consult or transfer care.</p> <p>I have had two children under the care of LM's in WA. The care that was provided to me and my newborn children was of the highest quality. I would like to make it clear that they in no way replaced the role of our children's pediatrician, but complemented it. In fact, our pediatrician recommended and supported the care of our newborns by LM's because she recognized them as experts in normal newborn care. LM's are experts in normal newborn care. Please recognize it, honor it, and clarify it in the law.</p>
Amy Kastelin	<p>I am writing in support of the Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50 to clarify LM's role in newborn care. I believe that LM's scope of practice should include care of newborns in the first 6 weeks. LM's are trained in normal newborn care and in recognition of deviations from normal including when to consult or transfer care.</p> <p>I have had two children under the care of LM's in WA. The care that was provided to me and my newborn children was of the highest quality. I would like to make it clear that they in no way replaced the role of our children's pediatrician, but complemented it. In fact, our pediatrician recommended and supported the care of our newborns by LM's because she recognized them as experts in normal newborn care. LM's are experts in normal newborn care. Please recognize it, honor it, and clarify it in the law.</p>
Hilary Sparrow Seattle, WA	<p>I am writing in support of the Sunrise Review for Midwifery Scope of Practice for the proposed amendment to RCW 18.50 to clarify LM's role in newborn care. I believe that LM's scope of practice should include care of newborns in the first 6 weeks. LM's are trained in normal newborn care and in recognition of deviations from normal including when to consult or transfer care.</p> <p>I have had three children under the care of LM. The care that was provided to me and my newborn children was of the highest quality. I would like to make it clear that they in no way replaced the role of our children's pediatrician, but complemented it. In fact, our pediatrician recommended and supported the care of our newborns by LM's because he recognized them as experts in normal newborn care. LM's are experts in normal newborn care. Please recognize it, honor it, and clarify it in the law.</p>
Crystal Ogle, SM	<p>I'm writing in FULL SUPPORT of the Midwives Association of Washington State's proposal regarding midwifery statute RCW 18.50 and newborn care. As a soon to be graduate of an accredited midwifery school, I hope to apply for licensure in the state of Washington this year. I feel my education and required experience in newborn care as well as that of any midwife granted licensure in our state, has more than adequately prepared us to provide care for healthy newborns in the first few</p>

	<p>weeks of life. I feel that we are able to recognize deviations from normal in newborns and appropriate times for consultation and referral when necessary. In fact, both academic testing as well as proof of skills and experience obtained before being granted licensure prove we've met the requirements to provide newborn care and recognize deviations from normal. After reading the Association of Washington Healthcare Plan's letter regarding this proposal, I feel moved to comment. It appears, after reading this letter, that they are not fully aware of our training, education, and experience requirements. Licensed midwives are trained to recognize signs and symptoms of every newborn condition they listed in their letter including: infection, sepsis, metabolic disorders, poor feeding, poor weight gain, jaundice, congenital disorders, heart murmurs and when to refer or consult for such conditions. We are required to be educated in Genetics, Embryology, Neonatology, and Pediatrics. We also provide PKU screenings on a regular basis and know the appropriate times to collect such screenings. In fact, since we see the mother and newborn multiple times (about twice as often as other providers) in the first few weeks of life, we have more of an opportunity to catch concerning conditions. Again, I urge you to consider our education, training and experience requirements and support midwives in providing care to newborns in the first few weeks of life.</p>
<p>Loren Riccio, ND, LM, CPM Fern Valley Natural Health PLLC</p>	<p>I strongly urge the committee to clarify language in statute RCW 18.50 to include newborn care for midwives. Midwives provide a level of accessibility, close care and monitoring that is not possible for pediatricians to provide in the first few weeks of life.</p> <p>As a practicing midwife I have had instances where I am in contact with families either by phone and/or daily homevisits with families that are having challenges with breastfeeding or even just transitioning to being new parents. These families need the compassionate and patient care only a midwife can provide. Midwives are more than qualified to recognize when to refer and have an extensive network of providers that work collaboratively. I had a recent birth experience where for non-urgent reasons the mother was transferred to the hospital for delivery. After discharge, I was called by the attending CNM and told she was concerned about this mother's adjustment postpartum and felt that she was at high risk for postpartum depression and concerned for her ability to care for her newborn. She went on to say that she was reaching out to me as her midwife because she felt that the quality care that we provide as midwives is incredible and very personal and something that they just cannot offer through the hospital. I have had several instances where I am concerned about the baby's weight gain and potential failure to thrive and urge the family to follow up with their pediatrician. In many of these cases when closely following up with these families, I often find they did not follow up with the pediatrician because they hadn't called, could not get an appointment or the only available appointment was too far out from when they really needed to be seen. I have gone to homes to follow up on newborn weight gain and feeding issues on weekends, evenings and holidays, times when other newborn providers would not have been available. I have also seen in instances where nursing and weight gain problems arise that pediatricians are quick to put the baby on formula rather than</p>

	<p>take the time to assess or address breastfeeding issues, including not referring to a lactation consultant if they do not have the time or training themselves. Many of these mom's become upset and come back to their six week postpartum visit with midwives feeling like a failure because of the lack of support they got from their pediatrician. Pediatricians are not always available at all hours of the day and all days a week to serve these families like midwives. I am concerned that the pediatric community is not available to take on the influx of neonates should this level of care be denied to midwives. This may lead to increases in neonatal morbidity due to lack of access and follow through or result in an increase in hospital congestion due to neonatal concerns that could have been addressed or appropriately referred by the midwife.</p> <p>I am also a practicing Naturopathic doctor. I have had several midwives in the community refer neonates to me over many years. I am always impressed by the level of communication, compassion and concern these midwives have for the families they serve. Their referrals are always timely and appropriate. These referrals have been for a variety of concerns such as jaundice, failure to thrive, ankyloglossia, wheezing, dermatitis, thrush, reflux, umbilical hernia, abnormalities on newborn metabolic screening, infection and polydactyly. Midwives are qualified to care for the well neonate and are experts in normal. They are competent to recognize when something deviates from normal and refer as indicated. By spending a substantial amount of time with the families they serve, they have greater potential for observation and opportunity for education toward greater outcomes for mom, baby and family unit.</p>
<p>Anna Evershed, ND Cascade Natural Medicine</p>	<p>I am writing this letter on behalf of the wonderful midwives of Washington state. As a primary care provider with an emphasis on pediatrics, I know the value of attentive, personalized care. Midwives epitomize this type of care. Many of my patients have been delivered by midwives and their parents state that the post-partum care provided to both them and their babies was crucial to navigating those first few exhausting, disorienting weeks. These mothers and fathers have established a trusting relationship with their midwives and so the transition to initial newborn care is seamless and stress-free.</p> <p>My relationship with midwifery is personal as well as professional. I delivered my wonderful son with midwives and could not have had a better experience. It was not an easy labor/delivery but the midwives provided me with a secure environment, unwavering support and incredible care. The fact that post-partum the midwives could do check-ups for both me <i>and</i> my baby was invaluable. I cannot imagine trying to schedule and attend check-ups for both of us in separate locations.</p> <p>Suffice it to say, I am a very strong supporter of clarifying the language to explicitly allow newborn care for this group of well-trained and committed professionals.</p>
<p>Arika Dortero, ND West Seattle Natural</p>	<p>My name is Arika Dortero, and I am a Naturopathic Physician practicing in Seattle. The focus of my practice is primarily seeing children. I am writing this letter to</p>

Medicine	<p>support keeping newborn care within the scope of midwives.</p> <p>I often see babies who were cared for by midwives between 4 and 8 weeks of age. If there are any problems or concerns with a baby’s growth or health the midwives will refer the family sooner. I have not seen a family of a newborn who was cared for by midwives where there was something wrong and the midwife did not contact me. I feel very confident about midwives ability to quickly respond to neonatal needs and make appropriate referrals. I also feel the care they provide to families truly helps support a confident and healthy transition into new parenthood.</p> <p>I also have personal experiences with midwives that support my feelings that they are highly skilled in caring for newborns. My midwifery team came to my home to do check-ups on my son and also greatly assisted in my concerns about him. They were able to provide all the care he needed such as weight checks and metabolic screening testing.</p> <p>I think it would be tragic to exclude newborn care from the scope of midwifery, as they are highly trained professionals who have been providing care to moms and babies for ages.</p>
Brad Stephens, MD	<p>"As a pediatrician, I fully support the Midwives' Association of Washington State <i>Statement Regarding The Provision of Care To Newborns By Licensed Midwives</i>. Licensed Midwives can provide comprehensive care to mothers and their newborns. They can also be an important link between pediatricians and families with newborns. Working with Licensed Midwives I have seen appropriate and timely referrals for concerns regarding infection, jaundice, Down Syndrome, and congenital heart defects. I have also seen and personally experienced the professionally appropriate clinical assessment and treatment of both mother and newborn and exemplary education and emotional support for the whole family."</p>
Susan Rainwater, MSW	<p>I am writing in support of the Midwives Association of Washington State's (MAWS) proposal regarding solidifying midwives scope of practice and newborn care. I also had the opportunity to testify at DOH headquarters regarding this issue and would like to again provide my support and clarify a few points.</p> <p>I received prenatal and post-partum care for my oldest daughter (Loretta) by the Lake Washington midwives through the Puget Sound Birth Center and am currently receiving prenatal care for my upcoming planned home-birth. The health care services I receive with my team of midwives is unlike any I have ever experienced and I am extremely grateful for the care provided by midwives in Washington State. I feel respected, valued, and supported in all areas by my team of midwives and their support staff.</p> <p>Following the birth of my oldest daughter (who is now just over two years old), a very serious health issue was noticed by my midwife. After talking with her about what we were experiencing (lack of sleep, non-stop nursing, and my daughter</p>

	<p>constantly crying and spitting up), my midwife immediately stated that the level that we were experiencing these things was not considered "normal." She explained that although it is normal for new parents to be sleep deprived, newborns to nurse very frequently, and young babies to cry, the frequency that we were experiencing these events was not "normal" and was quite extreme. She recommended that we follow-up with a different practitioner who could further address these concerns and a referral was made. This appointment truly saved our sanity and I cannot imagine how our lives would have continued had this appointment not occurred. Our daughter was later diagnosed with reflux and ultimately required medication for her condition, until her body was able to repair itself and her esophagus was able to fully develop. This appointment occurred just past my daughter's two week mark (I previously misspoke when I stated it was at a five week appointment) and we were able to see the recommended provider when she was only three weeks old.</p> <p>It is important to note that our daughter's condition was also over-looked by a family health practitioner whom we had seen during her two week well baby appointment. We explained all of the same details that we were experiencing, but nothing we stated was considered to be "abnormal." Had we not maintained our well baby post-partum appointments with our midwives, our daughter's condition would not have been address timely and who knows how much time would have passed.</p> <p>Not only can I speak in support of the MAWS proposal based upon my own life experiences, but I am also a former state social worker who holds a Master's degree in Social Work in Clinical practice with Children and Families. I can also attest to the importance of the midwives practice of care for newborns, mothers, and families from a clinical perspective of being a strong protective factor in supporting new families.</p>
Edward Byrne Kirkland, WA	<p>All three of my children were delivered by Midwives, my two daughters in WA and my son in Montreal, Quebec. With all three, the quality of our pre-natal and postpartum care was immeasurable. In the current era of clinic-driven care, home visits are a rarity. Having our Midwife, with whom we already had a deep connection with, come to our home in the first weeks of having our children was a huge blessing. We were able to get advice, talk about our concerns and generally celebrate our healthy baby without the stress of a long drive and exposure to public spaces, in the comfort of our home.</p> <p>When considering the benefits of Midwifery, many assume it ends with the birth itself. I can only express that the wholistic aspect of the experience, before, during and especially after the birth of the baby is what makes choosing midwifery one of the best decisions we made for our children as well as ourselves. Maintaining the continuance of post partum care by licensed Midwives should be, in my opinion as a parent, supported by our community and clearly defined by Law.</p>

Appendix F

Other States

Appendix F – Regulation in Other States

Alaska

<http://commerce.alaska.gov/dnn/Portals/5/pub/MidwivesStatutes.pdf>

Definition	<p>“Practice of midwifery” means providing necessary supervision, health care, and education to women during pregnancy, labor, and the postpartum period, conducting deliveries on the midwife’s own responsibility, and providing immediate postpartum care of the newborn; “practice of midwifery” includes preventative measures, the identification of physical, social, and emotional needs of the newborn and the woman, and arranging for consultation, referral, and continued involvement when the care required extends beyond the abilities of the midwife, and the execution of emergency measures in the absence of medical assistance, as specified in regulations adopted by the board.</p>
Scope	<p>Infant Care. (a) A certified direct-entry midwife shall consult with a physician concerning an infant who (1) has an Apgar score of seven or less at five minutes; (2) has a congenital defect; (3) has tachycardia of 170 or above, bradycardia of 100 or below, or cardiac irregularities; (4) develops jaundice within 24 hours of birth or significant scleral icterus within one week of birth; (5) has an abnormal cry; (6) shows signs of prematurity or intrauterine growth restriction (IUGR); (7) had meconium stained fluid before birth and has any indication of respiratory compromise; (8) is lethargic or does not feed well; (9) has edema; (10) develops grunting respirations, retractions, central cyanosis, or apnea; (11) has a pale, generalized cyanotic or grey color; (12) weighs less than five and one half pounds or 2,500 grams; (13) does not urinate or pass meconium within 24 hours of birth; (14) requires greater than one minute resuscitation by bag and mask or any cardiopulmonary resuscitation; or (15) appears weak, flaccid, or abnormal in any other respect.</p> <p>(b) Within two hours of birth, a certified direct-entry midwife shall administer appropriate eye prophylaxis to the newborn infant in accordance with 7 AAC 27.111.</p> <p>(c) A certified direct-entry midwife shall offer, to one or both of the parents, to administer intramuscular vitamin K to the infant for the prevention of acute and late onset hemorrhagic disease. If a parent consents to the administration of the intramuscular vitamin K, the certified direct-entry midwife shall administer the vitamin K within two hours of birth. A certified direct-entry midwife shall note in the client’s records a parent’s acceptance or refusal of intramuscular vitamin K.</p> <p>(d) A certified direct-entry midwife shall ensure that the newborn receives metabolic blood disorder screening in accordance with 7 AAC 27.510 - 7 AAC 27.580. The certified direct-entry midwife shall use a metabolic blood disorder screening kit obtained from the Department of Health and Social Services.</p> <p>(e) A certified direct-entry midwife shall recommend to the client an evaluation of the infant by a physician within one week of birth or sooner if it becomes apparent that the infant needs medical attention.</p> <p>(f) A certified direct-entry midwife shall complete and file a birth certificate within seven days after the birth in accordance with AS 18.50.160.</p>

Arizona

<http://www.azdhs.gov/als/midwife/>

(new rules; to become effective July 1, 2014)

Definition	<p>“Midwifery services” means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery or postpartum care.</p>
Scope	<p>Responsibilities of a Midwife; Scope of Practice. During the postpartum period, the midwife shall:</p> <ol style="list-style-type: none"> 1. During the 2 hours after delivery of the placenta, provide the following care to the client: <ol style="list-style-type: none"> a. Every 15 to 20 minutes for the first hour and every 30 minutes for the second hour: <ol style="list-style-type: none"> i. Take vital signs of the client, ii. Perform external massage of the uterus, and iii. Evaluate bleeding; b. Assist the client to urinate within 2 hours following the birth, if applicable; c. Evaluate the perineum, vagina, and cervix for tears, bleeding, or blood clots; d. Assist with maternal newborn and infant bonding; e. Assist with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate; f. Provide instruction to the family about adequate fluid and nutritional intake, rest, and the types of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, signs and symptoms of postpartum depression, and any symptoms that may pose a threat to the health or life of the client or the client’s newborn and appropriate emergency phone numbers; g. Recommend or administer under physician’s written orders, the drug RhoGam to an unsensitized Rh-negative mother who delivers an Rh-positive newborn. Administration shall occur not later than 72 hours after birth; and h. Document any medications taken by the client in the client’s record to an unsensitized Rh-negative client who delivers an Rh-positive newborn; 2. During the 2 hours after delivery of the placenta, provide the following care to the newborn: <ol style="list-style-type: none"> a. Perform a newborn physical exam to determine the newborn's gestational age and any abnormalities; b. Comply with the requirements in A.A.C. R9-6-332; c. Recommend or administer Vitamin K under physician's written orders to the newborn. Administration shall occur not later than 72 hours after birth; and d. Document the administration of any medications or vitamins to the newborn in the newborn’s record according to the physician’s written orders; 3. Evaluate the client or newborn for any abnormal or emergency situation and seek consultation or intervention, if applicable, according to these rules; and 4. Re-evaluate the condition of the client and newborn between 24 and 72 hours after delivery to determine whether the recovery is following a normal course, including: <ol style="list-style-type: none"> a. Assessing baseline indicators such as the client's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, activity with any recommendations for change; b. Assessing baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, and bowel and bladder function with documentation of meconium, and providing any recommendations for changes made to the family; c. Submitting blood obtained from a heel stick to the newborn to the state laboratory for screening according to A.R.S. § 36-694(B) and 9 A.A.C. 13, Article 2, unless a written refusal is obtained from the client and documented in the client’s record and the newborn's record; and d. Recommending to the client that the client secure medical follow-up for her newborn.

	<p>screening blood test for metabolic disorders. If arrangements for this screening have not been made, the midwife shall notify the county health unit or retain the written objection pursuant to Section 383.14, F.S.</p> <p>(9) The midwife shall conduct the Healthy Start Postnatal Screening for the infant or assure that it will be done.</p> <p>(10) Within 5 days following each birth, form DH 511, Certificate of Live Birth, available from the local county health department, must be completed and submitted to the local registrar of vital statistics. (a) For births occurring in a hospital, birth center or other health care facility, or en route thereto, the person in charge of the facility is responsible for the preparation and filing of the certificate, and for certifying the facts of the birth therein. Within 48 hours of the birth, the midwife shall provide the facility with the medical information required for the birth certificate. (b) For births occurring outside a facility wherein a licensed midwife is in attendance during or immediately after the delivery, the midwife shall prepare and file the certificate.</p>
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Idaho

<http://ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=MID>

(See <http://www.nacpm.org/Resources/nacpm-standards.pdf> for referenced material.)

Definition	"Practice of midwifery" means providing maternity care for women and their newborns during the antepartum, intrapartum and postpartum periods. The postpartum period for both maternal and newborn care may not exceed six (6) weeks from the date of delivery.
Scope	NACPM Scope and Practice Standards. The Board adopts the Essential Documents of the National Association of Certified Professional Midwives as scope and practice standards for licensed midwives. All licensed midwives must adhere to these scope and practice standards during the practice of midwifery to the extent such scope and practice standards are consistent with the Board's enabling law, Chapter 55, Title 54, Idaho Code.

Minnesota

<https://www.revisor.mn.gov/statutes/?id=147d&view=chapter>

Definition	Within the meaning of sections..., a person who shall publicly profess to be a traditional midwife and who, for a fee, shall assist or attend to a woman in pregnancy, childbirth outside a hospital, and postpartum, shall be regarded as practicing traditional midwifery.
Scope	The practice of traditional midwifery includes, but is not limited to: ...postpartum care of the mother and an initial assessment of the newborn; and... providing information and referrals to community resources on childbirth preparation, breast-feeding, exercise, nutrition, parenting, and care of the newborn. ... A licensed traditional midwife may administer vitamin K either orally or through intramuscular injection, postpartum antihemorrhagic drugs under emergency situations, local anesthetic, oxygen, and a prophylactic eye agent to the newborn infant.

Florida

http://www.doh.state.fl.us/mqa/midwifery/info_2010laws.pdf

Definition	<p>“Midwifery” means the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent; the practice of advising the parents as to the progress of the childbirth; and the practice of rendering prenatal and postpartal care.</p>
Postpartum Scope of Practice	<p>(1) Care of the newborn shall include: (a) Clearing the airway of mucus. (b) Clamping and cutting the umbilical cord. (c) Obtaining a cord blood sample for laboratory testing for type, Rh Factor, and direct Coombs test when the mother is Rh negative. (d) Assessing the newborn’s condition according to Apgar scoring at one (1) minute and five (5) minutes and record the results of each assessment. (e) Weighing the infant. (f) Instilling prophylaxis into each eye or retain the written objection pursuant to Section 383.04 and 383.06, F.S. (g) Administering vitamin K prophylaxis. (h) Examining the newborn and reporting any abnormalities or problems to the physician including low Apgar score. (i) Providing for infant bonding with parent. (2) The midwife shall consult, refer or transfer the infant to a physician if any of the following conditions occur: (a) Apgar score less than 7 at 5 minutes. (b) Signs of pre- or post-maturity. (c) Weight: if less than 2500 grams. (d) Jaundice. (e) Persistent hypothermia, meaning a body temperature of less than 97° F rectal after 2 hours of life. (f) Respiratory problem. (g) Exaggerated tremors. (h) Major congenital anomaly. (i) Any condition requiring more than 4 hours of postdelivery observation.</p> <p>(3) Care of the mother shall include: (a) Observation for signs of hemorrhage. (b) Inspection of the expelled placenta to insure that it is intact and free from defects or abnormalities. (c) Palpation of the fundus to insure that it is firm. (d) The midwife shall instruct the mother in self care and care of the infant including feeding and cord care.</p> <p>(4) The midwife must remain with the mother and infant for at least 2 hours postpartum, or until both the mother’s and infant’s conditions are stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse, respirations, bladder functioning, fundus firm and lochia normal. Infant stability is evidenced by established respirations, normal temperature, and strong sucking.</p> <p>(5) If any complications arise, such as a retained placenta or postpartum hemorrhage, the midwife shall consult with a physician, or transport the patient for emergency medical care dependent upon the urgency of the situation.</p> <p>(6) A follow-up visit shall be made between 24 and 48 hours following delivery, unless conditions warrant an earlier visit. The midwife may arrange for such a visit to be made by a physician, certified nurse midwife, registered nurse, or another licensed midwife. The patient shall be instructed to have a postpartum examination within 6 to 8 weeks after delivery or sooner if any abnormalities exist or problems arise.</p> <p>(7) If the mother is Rh negative, the midwife shall obtain the laboratory tests results of the cord blood studies, and if the infant is Rh positive, assure and document that the mother receives Rho immune globulin within 72 hours of the delivery.</p> <p>(8) The midwife shall instruct the parents regarding the requirement for the infant</p>

Montana

http://bsd.dli.mt.gov/license/bsd_boards/ahc_board/board_page.asp

Definition	"Practice of direct-entry midwifery" means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period [up to 6 weeks following birth].
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New Mexico

<http://www.health.state.nm.us/PHD/midwife/LMRule.pdf>

(See <http://www.health.state.nm.us/PHD/midwife/NMMA%202008%20practice%20guidelines.pdf> for referenced material.)

Definition	"Licensed Midwifery" means the provision of health care and management of women in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to 6 weeks of age. This care occurs within a health care system which provides for midwifery protocols, medical consultation, co-management or referral and is in accord with the "Standards and Core Competencies of Practice for Licensed Midwives in New Mexico" and the "New Mexico Midwives Association: Practice Guidelines".
Scope	The licensed midwife may provide care to women without general health or obstetrical complications as defined by the Standards and Core Competencies of Practice for Licensed Midwives in New Mexico and the New Mexico Midwives Association: Policies and Procedures, or equivalent approved by the NMMA and the Division. Such care includes:... Immediate newborn care

New York

<http://www.op.nysed.gov/prof/midwife/midwifelaw.htm>

Definition	The practice of the profession of midwifery is defined as the management of normal pregnancies, child birth and postpartum care as well as primary preventative reproductive health care of essentially healthy women, and shall include newborn evaluation, resuscitation, and referral for infants... A licensed midwife shall have the authority, as necessary, and limited to the practice of midwifery, to prescribe and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests...
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Oregon

http://www.oregon.gov/OHLA/DEM/pages/midwifery_laws_rules.aspx

Definition	"Direct entry midwifery" defined. As used in ORS 687.405 to 687.495, "direct entry midwifery" means: (1) Supervision of the conduct of labor and childbirth; (2) Providing advice to a parent as to the progress of childbirth; or (3) Rendering prenatal, intrapartum and postpartum care.
Scope	(d) Newborn Care — The LDM must: (A) Provide health care to the newborn; (B) Provide support and information to parents regarding newborn care; (C) Determine the

	<p>need for consultation or referral as appropriate; (D) Evaluate anatomy and physiology of newborn and support of the newborn's adjustment during the first days and weeks of life; (E) Evaluate newborn wellness including relevant historical data and gestational age; (F) Assess and educate the mother regarding nutritional needs of the newborn; (G) Educate mother regarding state laws concerning indications for, administration of, and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period; (H) Educate mother regarding causes of, assessment of, appropriate treatment and emergency measures for newborn problems and abnormalities; (I) Adhere to state guidelines for the administration of vitamin K and ophthalmic prophylaxis pursuant to ORS 433.306 and OAR 333-021-0800; and (J) Ensure infant metabolic screening is performed and documented according to the Department of Human Services recommendations unless the mother declines, as provided [in specific rules].</p>
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Pennsylvania

<http://www.pacode.com/secure/data/049/chapter18/subchapatoc.html>

Definition	<p>Midwifery practice—Management of the care of essentially normal women and their normal neonates [during the first 28 days following birth]. This includes antepartum, intrapartum, postpartum and nonsurgically related gynecological care.</p>
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South Carolina

<http://www.scdhec.gov/administration/regs/docs/61-24.pdf>

Definition	<p>Midwifery Services. Those services provided by a person who is not a medical or nursing professional licensed by an agency of the State of South Carolina, for the purpose of giving primary assistance in the birth process either free, for trade, or for money, provided, however, that this shall not preclude any medical or nursing professional from being licensed in accordance with this regulation. This definition shall not be interpreted to include emergency services provided by lay persons or emergency care providers under emergency conditions.</p>
Scope	<p>Care of the Newborn: 1. Immediate Care. Immediate care includes assuring that the airways are clear, Apgar scoring, maintenance of warmth, clamping and cutting of umbilical cord, eye care, establishment of feeding and physical assessment. 2. Eye Care. The midwife shall instill into each of the eyes of the newborn, within one hour of birth, a prophylactic agent such as silver nitrate or a suitable substitute. 3. Metabolic Screening. All requirements for metabolic screening shall be made clear to parents. The midwife shall notify the county health department in the county where the infant resides within three days of delivery in order for a specimen to be obtained. 4. Subsequent Care. In the days and weeks following birth, care includes monitoring jaundice, counseling for feeding, continued facilitation of the attachment and parenting process, cord care, etc. 5. Infant Care. In consultation with parents, the midwife shall encourage that the infant be seen by a health care provider within two weeks of birth. 6. Provision of Information. The midwife shall assure that the parents are fully informed as to available community resources for emergency medical care for infants,</p>

	well-baby care, or other needed services.
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Wyoming

<http://plboards.state.wy.us/midwifery/PDF/RulesRegs/CHAPTER7.pdf>

(See <http://www.nacpm.org/Resources/nacpm-standards.pdf> for referenced material.)

Definition	The practice of a licensed midwife consists of providing primary maternity care that is consistent with a midwife’s training, education and experience to women and their newborn children throughout the childbearing cycle, and includes identifying and referring women or their newborn children who require medical care to an appropriate health professional.
Scope	Scope and Practice Standards. A licensed midwife must adhere to the following scope and practice standards when providing antepartum, intrapartum, postpartum, and newborn care. (a) NACPM Scope and Practice Standards. The Board adopts the Essential Documents of the National Association of Certified Professional Midwives as scope and practice standards for licensed midwives. All licensed midwives must adhere to these scope and practice standards during the practice of midwifery to the extent such scope and practice standards are consistent with the Board’s enabling law.

Appendix G

Principles, Guidelines, Position Statements on Midwifery Practice

Appendix G

Principles, Guidelines, Position Statements on Midwifery Practice

World Health Organization

The WHO offers its Standards for Maternal and Neonatal Care (<http://whqlibdoc.who.int/hq/2007/a91272.pdf>) as “[an] example of the many evidence-based practice guideline documents” that are issued by international or national authorities and can be adopted by reference. “Having explicit, written, standards allows for not only more standardized, uniform, measurements, but also allows the clients, families and communities to know what level of midwifery care to expect.” The WHO maintains that “it is neither necessary nor efficient” for individual regulatory entities to develop such standards, “because the evidence that underpins clinical practice is ever evolving. Best practice standards change rapidly. Practitioners should be able to incorporate new recommendations for practice, and not be constrained in their practice by the need to await the updating of regulatory language.” In other words, a scope of practice is necessary, but it should be basic and flexible enough to absorb changes in professional standards. The WHO’s scope of midwifery practice is based on “the ICM definition of the midwife. The ICM recognizes the scope of midwifery practice to include: education and counseling on sexual health and provision of contraceptive methods; provision of support, care and advice during pregnancy, labour and the postpartum period; the conduct of births on the midwife’s own responsibility; and the provision of care for the newborn and the infant.”

International Confederation of Midwives (ICM). Taken collectively, the ICM uses several resources referred to as its “core documents” to guide midwifery practice.

(<http://www.internationalmidwives.org/what-we-do/global-standards-competencies-and-tools.html>) In addition to the WHO’s observation on its scope of practice, the ICM’s Global Standards for Midwifery Regulation could be characterized as focusing on midwives’ empowerment and autonomy:

“The midwifery profession determines its own scope of practice rather than employers, government, other health professions, the private health sector or other commercial interests. The scope of practice provides the legal definition of what a midwife may do on her own professional responsibility. The primary focus of the midwifery profession is the provision of normal childbirth and maternity care. Midwives are required to demonstrate the ICM essential competencies for basic midwifery care regardless of setting, whether it be tertiary/acute hospitals or home and community-based services/birthing centres. The scope of practice must support and enable autonomous midwifery practice and should therefore include prescribing rights, access to laboratory/screening services and admitting and discharge rights. As autonomous primary health practitioners midwives must be able to consult with and refer to specialists and have access to back up emergency services in all maternity settings. Associated non-midwifery legislation may need to be amended to give midwives the necessary authorities to practise in their full scope. For example, other legislation that controls the prescription of narcotics/medicines or access to laboratory/ diagnostic services may need to be amended.”¹

Citizens for Midwifery. This is a membership organization for consumers and practitioners. In conjunction with MANA, NARM, and MEAC, the group developed and continues to promote the Midwives Model of Care[®]:

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<http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/GLOBAL%20STANDARDS%20FOR%20MIDWIFERY%20REGULATION%20ENG.pdf>

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention²

North American Registry of Midwives. NARM supports legal recognition of midwives at the state as well as federal level, acknowledging licensure to be “a valuable tool in providing access to competent and accountable professional midwives.” It supports and affirms the values and principles in ICM’s Global Standards for Regulation. Keeping in mind that the NARM test is used for Washington midwives and that the group promotes its CPM credential, it espouses “a framework that dovetails certification with licensure to provide access for consumers to a comprehensive professional provider who maintains the skills necessary for safe practice as well as being accountable to the public.”

Further, NARM supports an individualized, client-centered scope of practice which it calls Shared Decision Making: “the collaborative process that engages the midwife and client in decision-making and facilitates the incorporation of client preferences and values into the plan of care.” Extending this to the discussion of allowed scope, NARM states:

“Restrictive laws that don’t allow for patient autonomy place the midwife in challenging legal jeopardy when the statute or regulations limit midwifery-led care. When consumers experience licensure of midwives as a mechanism to restrict their choices among care options that support physiologic birth they are more likely to seek unlicensed midwives and midwives are more likely to resist licensure in order to support women’s access to autonomy in the decision making for their own care.”³

NARM also observes that scope-of-practice barriers challenge the development of sustainable, affordable educational pathways, noting that legally limiting the scope of practice to less than the entire competency of the profession results in limited educational opportunities and lost skills and knowledge.

Midwives Alliance of North America. Similar to the ICM, MANA uses various resources that comprise its “essential documents.” (<http://www.mana.org/about-midwives/professional-standards>) It also refers to ICM resources. MANA’s Standards and Qualifications for the Art and Practice of Midwifery relates scope of practice to individual midwives’ competencies and personal choice. In other words, MANA believes that scope should vary with and be set by the individual.

National Association of Certified Professional Midwives. Likewise, the NACPM has a set of “essential documents,” whose scope includes:

“NACPM members offer expert care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. NACPM members work with women and families to identify their unique physical, social and emotional needs. They inform, educate and support women in making choices about their care through informed consent. NACPM members provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period. NACPM members are trained to recognize abnormal or dangerous conditions needing

² <http://cfmidwifery.org/mmoc/define.aspx>

³ <http://narm.org/wp-content/uploads/2012/05/State-Licensure-of-CPMs2012.pdf>

expert help outside their scope. NACPM members each have a plan for consultation and referral when these conditions arise. When needed, they provide emergency care and support for mothers and babies until additional assistance is available. NACPM members may practice and serve women in all settings and have particular expertise in out-of-hospital settings.”⁴

Although this scope does not mention newborns, one of the cornerstones of NACPM’s philosophy is the “inseparable and interdependent nature of the mother-baby pair.” From among the state regulations reviewed in the following section, Idaho and Wyoming use as scope the NACPM essential documents by reference, and each includes newborn care in its definition of the practice of midwifery.

⁴ <http://www.nacpm.org/Resources/nacpm-standards.pdf>