



Direct-Entry Midwifery Policy & Regulations Subcommittee Meeting

March 11, 2014

6:00-8:00 PM

Summary Notes

(FINAL - Approved as corrected 3/31/14.)

Subcommittee Members in Attendance: Jennifer Antonik, Consumer; Kristin Bennett, RN, DPH Nursing Director; State Rep. Paul Baumbach, Dr Garrett Colmorgen, Perinatologist; Patricia Gallagher, CPM; Ally Heiger, RN, Delawarean for Safe Births; Dr Richard Henderson, OB-GYN; Kathleen McCarthy, CNM, Birth Center of DE; Lindsay Robinson, CNM, Dedicated to Women; Jephtha J VanDunk, Consumer, Attorney; Karen Webster, NARM CPM.

Absent: Dr David Paul, Neonatologist (excused); Jodi Dampeer-Moore, RN; DSU Faculty; and Bonnie Perratto, Chief Nursing Officer, Bayhealth.

I. Welcome and Introductions

Co-Chair Garrett Colmorgen led meeting with support of Co-Chairs Jen Antonik and Pat Gallagher. Members introduced themselves to the public attendees.

II. Definition of Direct-Entry Midwives (Who are we actually discussing?)¹

(See Direct-entry/ non-nurse midwife definition in footnote.) Group agreed that focus for the purpose of committee work was on Nationally Certified Midwives - CPMs and CMs - as defined in current DE regulations:

“Nationally Certified Midwife” a direct entry midwife that has met national certification from North American Registry of Midwives (Certified Professional Midwife CPM) or American College of Nurse Midwives (Certified Midwife)

1. Current Delaware regulations (Title 16 HEALTH AND SOCIAL SERVICES, DELAWARE ADMINISTRATIVE CODE, 4100 Family Health Services, 4106 Practice of Non-Nurse Midwifery, see link below) include this definition: **“Direct Entry /non-nurse Midwife”** A midwife that has entered the profession directly through midwifery education and training and not through a prerequisite program of nursing and has met the qualifications and received a permit from the Delaware Division of Public health to practice midwifery in DE.
<http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Public%20Health/Family%20Health%20Services/4106.pdf>

III. Should We Recommend Establishment of a Board or Council to License Direct Entry Midwives?

Establishment of Board or Council

Groups supports establishment of a Midwifery Board or Council, but did not come to consensus on its placement.

Licensure Requirement

Group supports licensure requirements in keeping with most of Title 16 4106 4.1 in the current regulations, excerpted below. There was discussion about requirement of completion of an *accredited* program but no consensus to include.

Demonstration of completion of an accredited midwifery education program and is a Nationally Certified Midwife as demonstrated by possessing a valid certification of Certified Professional Midwives (CPM) from the North American Registry of Midwives or Certified Midwife (CM) from the American College of Nurse–Midwives Certification Council or an equivalent certification.

Group discussed need for revision of Section 4.2 (see below) in keeping with standards of Division of Professional Regulation. Per Governor’s Executive Order a Task Force has been established re: Criminal Background Checks. Legislation anticipated to be enacted for nurses and others – criminal background checks not only for new licensure (currently required) but also renewal, and possible child abuse registry checks.

Submits a sworn statement that he/she has not been convicted of a felony; been professionally penalized or convicted of substance addiction; had a professional midwifery license suspended or revoked in this or another state; been professionally penalized or convicted of fraud; and is physically and mentally capable of engaging in the practice of midwifery.

In addition there was discussion with regard to the fact that Certified Midwife (CM) education/training focused on facility vs home births. (Consideration if CM must become Certified Professional Midwife (CPM) but consensus better to be required by regulation to serve apprenticeship or period of supervised deliveries in home prior to independent home deliveries. (Noted academic requirement higher for CM than CPM. See comparison chart distributed at midwifery meetings.)

License Renewal/Maintenance of competence

Group discussed (in general) regulations (as per current regulations) which follow CPM and CM national certifying body (NARM or ACNM respectively) requirements.

Complaint/disciplinary process

Group discussed desire to use NARM or ACNM disciplinary process. Processes need further exploration.

NARM process found by attendee online during meeting – complaint needs to be made within 18 months.

<http://narm.org/accountability/how-to-file-a-complaint/>
<http://narm.org/accountability/greivance-mechanism/>

ACNM disciplinary process was not found during meeting but to be researched by KAB. (Subsequent to meeting Shannon Burdeshaw sent to KAB and added here for members' convenience.)

<http://www.amcbmidwife.org/docs/default-document-library/discipline-policy-procedures---updated-november-2012.pdf?sfvrsn=2>

Regulations: scope of practice/guidelines/record keeping

Pat Gallagher discussed current regulations and practice under them in regard to this topic. Group discussion focused on 4.3.2

4.3 Establishes a collaborative agreement with a Delaware licensed physician with obstetrical hospital privileges which includes at a minimum:

4.3.1 a minimum number of medical provider prenatal visits.

4.3.2 guidelines and protocols that must include access and use of oxygen, medications (including Intravenous medications), emergency protocols for labor, delivery, and postpartum for both mother and neonate.

Pat moved to documentation within EMR. Subsequent discussion on benefit and availability of basic no cost system. (Suggest contact: Kathleen McCarthy, BCD)

Group anticipated that appointed Council would set up standard guidelines and protocols.

Discussion ensued re: how might midwives be able to access/use medications without collaborative agreement and comply with code/regulations including DEA/Board of Pharmacy. Pat G. discussed medications currently used under her agreement – and ease to obtain. Karen Webster and Ally Heiger will look into formularies used by other states including Maine. Particular challenge is access to pain medication.

Informed consent

Discussion explored possible use of NARM informed consent materials/boiler plate which was shared with committee verbally/single hard copy (link and excerpts below). In addition, informed consent discussion included questioning if client truly understands relationship between midwife/client and MD/client and not Midwife/MD and that clarification need to be in statute.

<http://narm.org/accountability/informed-consent/>

Components of an Informed Consent/Informed Refusal

1. Explanation of treatments and procedures;
2. Explanation of both the risks and expected benefits;
3. Discussion of possible alternative procedures, including delaying or declining of testing or treatment, and their risks and benefits;
4. Documentation of any initial refusal by the client of any action, procedure, test or screening recommended by the midwife based on her clinical opinion or required by practice guidelines, standard of care, or law, and follow up plan;
5. Client and midwife signatures and date of signing for informed refusal of standard of care.

Components of an Informed Disclosure for Midwifery Care. The form should be entitled “Informed Disclosure for Midwifery Care,” and must include, at a minimum, the following:

1. A description of the midwife’s education, training, and experience in midwifery;
2. The midwife’s philosophy of practice;
3. Antepartum, intrapartum and postpartum conditions requiring consultation, transfer of care and transport to a hospital (this would reflect the midwife’s written practice guidelines) or availability of the midwife’s written guidelines as a separate document, if desired and requested by the client;
4. A medical consultation, transfer and transport plan;
5. The services provided to the client by the midwife;
6. The midwife’s current credentials and legal status;
7. NARM Accountability Process (including Community Peer Review, Complaint Review, Grievance Mechanism and how to file a complaint with NARM); and
8. HIPAA Privacy and Security Disclosures

IV. Vicarious liability

Group expressed the need for designation of vicarious liability to be codified. This is important for transition to new system of care. The fact that consultants don’t count needs to be explicit in liability. Some differences of opinion re: where liability starts and stops when transferred from home to hospital but discussion not pursued.

V. Potential legislative language (and related)

Group discussed potential numbers of midwives estimates varied 10-20 +.

Group discussed possible make-up of Council – preferably each with home birth experience

- Midwives CPM [or CM (?)] 3
- Consumers/Public 1
- Certified Nurse Midwife (CNM) 1
- MD OB or Pediatrician 1 (consult w other)

Chair Elected by Group / Chair breaks tie

Fact of little discussion re: role of person supporting infant. All agree need 2nd person available for mother and another for infant. Group in general did not see as being nurse. Some saw this as student (?) midwife.

Newborn Screening - DPH supports single standard of care – newborn screening: metabolic, hearing, cardiac.

Transfer issues including further discussion re: vicarious liability. Issue of 1% rule explained by Dr H. If primary defendant cannot pay if can find 1% fault in secondary defendant then can be held responsibility for 99%. This needs to be off the table as in California bill.

VI. Public Comment:

Two members of the public attendees elected to make public comment: Joan Greeley and Matthew Heiger. Mrs. Greeley noted positive change in meeting tone, spirit of camaraderie and group's movement forward. She also introduced young infant son Benjamin who was delivered at home – and noted - home birth after previous C-section. Matthew Heiger, Co-Chair of the Relationship-Standards Subcommittee made comments with regard to personal responsibility vs vicarious liability within informed consent.

Good discussion with committee followed including:

Dr Henderson reminded re: if outcome less than ideal, avenue taken - go to deep pockets.

Jeptha VanDunk, Esq., noted fleshing out continuity of care, respectful agreement on paper can't hurt, but won't prevent litigation – however could add clauses re: arbitration.

Kathleen McCarthy, CNM, emphasized need for all to see each other as team – all in this together – each respectful of others role and communicating this respect to client.

In addition to the formal public comment there was much thoughtful and respectful Q& A and discussion with the public attendees throughout the meeting

Public Attendance (elective sign-in): Shannon Burdeshaw, Robert Burdeshaw, Susan DiNatale, Chloé French, Joseph Fulgham, DE House Communications Officer, Minority Caucus; Andrew Greeley, Joan Greeley, Matthew Heiger, Delawarean for Safe Births, David Mangler, Director, Division of Professional Regulation; Wendy Mathews; Mandi O'Donnell., Yvonne Steele, Lobbyist, Andrew Wilson, Medical Society of Delaware.

VII. Adjournment/Next Meeting:

Members in attendance agreed that the next meeting will be held on March 31, 6-8 pm, at the same location, DPH Offices, Large Training Room, Edgehill Shopping Center, Dover. Meeting adjourned at approximately 8:15 p.m.