

Birth Assistant Sunrise Written Comments Received as of July 31, 2015

Overall comment: Why is this language embedded in the Licensed Midwife RCW? Certified Nurse Midwives (CNMs, licensed as ARNPs) and physicians (allopathic, osteopathic) might want to use birth assistants as well. Several Washington State CNMs practice in homes and birth centers, and there is no regulation that prohibits physicians from practicing in facilities or in homes where certified birth assistants might be needed.

Specific Comments for the language as it is currently proposed and embedded in Chapter 18.50 RCW:

Page 1, Section 1 (1)

Line 13: Should the phrase “licensed midwife” be used instead of just “midwife”?

Rationale: this addresses birth assistants for licensed midwives, right, not any type of midwife (i.e., lay midwife)? Later... I see further on that “midwife” is meant to refer to “licensed midwife”.

Page 1, Section 1 (2)

Lines 17-19: strike “~~by the manufacturer’s recommended route of administration, including by injection, orally, rectally, and intravenously.~~”

Rationale: evidence-based practice often is ahead of manufacturer monographs (package inserts) regarding indications, contraindications, and routes of administration. Sometimes manufacturers never change their monographs, regardless of new evidence or practice standards that incorporate new uses for medications, due to cost and/or liability considerations. This language written into law is problematic when a Licensed Midwife is practicing according to up-to-date research evidence, professional guidelines, and best practice, but the manufacturer and/or FDA is behind-the-times.

Another issue is that some medications can be given sublingually, buccally, ocularly, transdermally, nasally, vaginally, etc., so listing only 4 routes of administration makes the other routes seem to be against the law.

And, the –ly phrasing is awkward.

Page 2, Section 1 (4) (a)

Line 7: Should read “vital signs”, not “vitals”

Rationale: “vitals” is slang; “vital signs” is the correct phrase if you are talking about BP, pulse, respiratory rate, temperature, and pulse oximetry for the mother and fetal/newborn heart rate, respiratory rate, temperature, and pulse oximetry for the newborn.

Page 2, Section 1 (4) (a)

Line 7: “birth emergencies” should be expanded to say “labor, birth, postpartum, and newborn emergencies”

Rationale: “birth” is too narrow of a term, referring technically to the expulsion of the baby and the time immediately before and after this event. Some emergencies happened during labor, and others with only the newborn or the postpartum mother in the hours after the birth.

Page 2, Section 1 (4) (a)

Line 8: “practical skills” is a term open for interpretation and confusion. Is there a better phrase? I don’t recommend necessarily a list of skills (which then makes the law too restrictive when practices change over time), but how far does this go? Is there language, maybe from LPN or RN law, that describes this more purposefully?

Later...Or would the Skills Checklist as approved by the Secretary discussed in (4) (b) later in this section provide the clarification?

Page 2, Section 1 (4) (a)

Educational requirements not mentioned in this section but should be:

- blood-borne pathogens & standard precautions (7 hours);
- ethics (basic), confidentiality, & HIPAA;
- working with interpreters

Rationale: All persons touching the body fluids of another in a medical situation should have standard precautions training; all persons who have access to medical records should have ethics, confidentiality, and HIPAA training to protect the patient(s); all persons who have a health care role may need to communicate with a patient or her family during labor, birth, or postpartum and should therefore receive basic training on how to work with interpreters.

Page 2, Section 1 (4) (b)

Line 17: “signed by a midwife” should be changed to “signed by a Licensed Midwife or Certified Nurse-Midwife in Washington State”

Rationale: Either type of midwife in Washington State could sign off on births during the training of a birth assistant. Conceivably, the training could be done by a physician or L&D RN, too – with the right kind of site-specific experience (i.e., out-of-hospital labor/birth for the birth assistant who would be working in homes or birth centers).

If the birth assistant training in other states (to reach the minimum of 10) would be acceptable, then the language would need to be broader to also include Certified Midwives and Certified Professional Midwives which are how some states license midwifery practitioners. However, since the certified birth assistant will be assisting midwives in Washington State, it seems reasonable to make sure they have at least 10 births in WA to learn the scope of practice, even if they have experience from another state, territory, or country.

Page 2, Section 1 (4) (c)

Line 20-21: Could this be deleted if the 7 hours of training was stated in Section (4) (a) above?

Rationale: Standard precautions and blood-borne pathogens include HIV. However, if the old language in WA State law says “acquired immune deficiency syndrome”, then the birth assistant language should be the same as for every other health care provider. (But the education should be more than just AIDS, and it’s more about HIV than AIDS anyway!)

Page 2, Section 1 (4) (d)

Line 22: Replace “cardiopulmonary resuscitation” with “basic life support”

Rationale: I think the proper term is BLS, or basic life support. See:

https://www.heart.org/HEARTORG/CPRAndECC/HealthcareProviders/BasicLifeSupportBLS/Basic-Life-Support-BLS_UCM_001281_SubHomePage.jsp

Karen Hays, DNP, CNM, ARNP

In regards to the proposed Certification of Birth Assistants I have the following concerns:

1. For midwives living in isolated or rural areas, it's hard to find a birth assistant (BA) or even a student unless you have a busy practice. The hours are awful and so is the pay. I'm wondering as a rural and isolated midwife, who I can recruit to travel for certification, pay for the training and for the annual costs involved in certifying on top of other obstacles. Rural midwifery is a great help to the public but it's

becoming more and more difficult to practice when laws are written without considering those who practice in this unique setting. This increases costs and limits availability for us. It's a roadblock.

2. The alternative is to use a BA not certified, but they cannot administer meds, etc. so how safe is that and how does that contribute to public safety?

3. As I read it, it states that other professionals (RNs, etc.) can challenge the exam and pay the fee before being able to administer meds, this conflicts with earlier law that says MWs can direct RNs.

4. Because there are new costs involved in training and certification for BAs, their fees will likely go up. I don't see anything in the law saying they would need to be covered by insurance. So who pays for this cost?

5. Finally, a much simpler solution seems to add BAs to liability coverage. My liability insurance company covers any employees, students, and those contracted (1099) working under my direction. My BAs are named and listed under my coverage. Why not work on it from this angle?

I can't support this. I don't see it as an issue and should it pass, see issues stemming from this.

Crystal Ogle LM, CPM
Assist In A Miracle LLC

What is the true purpose of the bill? Why is it relevant?

Concerns I have with the bill:

1. Limits options rural midwives have for a second set of skilled hands at a birth
2. Charging certificate fees benefits the state not the assistant, midwife or the public
3. Stating they have to attend a state approved course without having one set up takes time or allows for the possibility of a monopoly occurring with schools trying to make more money. This only inhibits birth assistants from being available when needed. Any WA licensed midwife should be able to teach the skills needed for a birth assistant to assist her. This should not be an added expense for a birth attendant.
4. Safety level for the public or midwives is not improved with proposed legislation
5. Insurance companies are not required to cover any of the cost to have a birth assist in attendance.
6. The balance of the MAC is disproportionate against the midwives it supposedly serves. If a birth assistant is add to the MAC than one of the doctor slots should be converted to another licensed midwife. Midwives should be the majority of the MAC not the minority. It creates a disparity against midwives and the women they serve. Actually for the MAC to best serve the midwives of WA it should be only midwives (CNM, LM, traditional with representation from both midwifery organizations).
7. Sec 11 should state "A licensed midwife may delegate to a registered nurse or anyone with a lessor license or one who has been trained by a midwife for the elected acts, tasks, or procedures that constitute the practice of midwifery but do not exceed the education of the nurse." Thus making the language inclusive instead of exclusionary as it is now written. This wording would eliminate the need for any additional legislation of birth assistants.

8. A grandfather clause should be added for anyone who has currently been an active birth assistant. If they have attended 15 births in that capacity no additional educational requirement will be required to become certified.

Eudine Stevens

I would very much appreciate receiving updates during this process.

Our state midwifery association, WARM, would also appreciate being extensively consulted (now and in the future) during any process which involves our profession.

I have read over the Review Application, draft bill, and Follow-Up, and have some concerns about this proposal. The last one is by far the most serious.

From sections in the Application:

(1)(a) I am not convinced that there is a problem, or that regulation is necessary. The comments supporting these ideas are vague and unconvincing, and not supported by any facts in evidence. Please quantify and qualify any and all such incidents of harm to the public from lack of regulation of birth assistants, so this critical element can be discussed. Simply theorizing that such harm might potentially happen is inadequate to require expensive and burdensome regulation.

(1)(b) No safety is "ensured" by this bill, especially since birth assistants would be trained by other birth assistants (qualified by only 3 days of classroom study, and 10 births), not by midwives (qualified by a minimum of 3 years of classroom study and 100 births). Rather than provide midwives with a pool of qualified assistants, it would further limit the available and affordable birth assistants in rural underserved areas.

(4)(a) Please identify these alleged complaints; who filed them, and what merit were they found to have? Over-reacting to nuisance complaints (where no harm was actually done) is not in the best interest of anyone.

(4)(b) In no way does paying money and taking a super-easy test "assure" the public of any quality, competence, or supervisory adequacy. All it does is impart to the public the appearance of competency.

(4)(c)(i) We do not even have license fee reform yet, so why would we agree to pool fees (and costs for investigating complaints) with a group which is not even required to be trained by midwives, and has such miniscule training requirements?

(4)(c)(ii) With no grandfather clause, there is not adequate and specific description of what would be or would not be permitted to be done by non-certified birth assistants. The bill is vague in Sec.1(2) except for administration of medications. This indicates that the scope of practice for professions such as RNs would actually be limited by this bill, as would the authority granted to midwives to give directives to RNs - that authority would now be partially withdrawn, in conflict with existing law.

(4)(c)(iii) If no one regulates birth assistants anywhere, but some Canadian provinces have policies for birth assistants already established and working well, why not save everyone a lot of trouble and adopt those policies instead of create another expensive bureaucracy?

(4)(c)(iv) A three day course? Is that really worth a regulatory certification?

(4)(c)(v) Incorrect information is provided here. "They would just need to meet the requirements" is misleading, because the bill states that the 3-day course would have to be approved and accredited by the state. At what cost?

(4)(d)(ii) What are the estimated fees to the state for certification?

(5)(a)(ii) The standards are in fact too low to justify the restrictive effects of an expensive certification process and fees.

This will result in harm to the public in underserved and financially depressed areas. Again, over-qualified birth assistants (RNs, etc.) will still have to pay state fees, and if they do not pay to certify then it is still unclear what duties they may legally perform. It is also not clear what would be the costs of challenging the course and taking a test, then paying the state fees for certification, if such an option is even provided in the bill.

(5)(c) Why were LPNs not included in Sec.1(4)(a)? They are more qualified than someone who took a 3-day class. And the proposal indicates that all professions will be required to take the course, which for many will be adding the insult of wasting their time to the injury of taking their money.

(8) Costs will absolutely not be passed on to insurance companies (pure misleading fantasy), because insurance will not pay for them. It would take harsh legislation aimed directly at insurance policies in Washington before any kind of insurance reimbursement would ever be paid for birth assistants, and it would never be enough to cover the actual costs. These expenses will be borne by the midwives, CBAs, and already-stressed consumers. In most of the state, no one can afford these expenses; this is an example of unrealistic urban privilege making rules for a public which cannot support them.

The Worst Problem:

All of the above issues are barely worth mentioning in comparison to the unbelievable proposal to add a CBA member to the Midwifery Advisory Committee, and without also adding at least 2 more LMs! Licensed Midwives are already greatly outnumbered on their own advisory committee, and adding another member whose qualifications are a 3-day course (not even taught by midwives) will make our professional input to the MAC insignificant at best. The non-midwives would outnumber the midwives by about double, far more when the defacto members in the DOH are considered. This is unspeakably unacceptable, as it would be in any other profession. If we are opening up the wording for the makeup of the MAC membership, then we should require that Licensed Midwives be >50% represented by seats on the MAC at all times, otherwise we will be forced to create a regular state Board of Midwifery, run by midwives.

Thank you,
Lorri Carr, LM CPM LDM
WARM Board of Directors

I have just today been notified of the hearing occurring today regarding birth assistants.

I would like to take this opportunity to comment, though comment time closed two days ago; I received no notification. I see no comment by the Wa State ob/gyn society. Were they notified of this hearing? This seems that the group who has the most amount of training should be asked to comment about this issue. We who are trained to evaluate and care for the worst of circumstances in ob/gyn are likely to have

the most valuable comments. I kindly urge you to contact the WA State Ob/gyn Association for their highly valuable input.

From my standpoint, health care providers should have more, not less training. Are midwives and these assistants going to take Suicide prevention and HIV training? Yes, there are costs associated with good care. The argument that we should not have good education for rural patients due to travel and cost does not hold water. Education does count. If educated, qualified care givers are not available, patients should not receive sub-standard care. It seems, by reading the midwife comments, that they feel they should not be included in the fray of health care providers in terms of credentialed education. I must strongly disagree with their point. Education, again, counts. Education makes safer health care for women.

Thank you kindly,
Katharine Barrett-Avendano, DO, FACOOG
Director, The Women's Center,pllc

I would like to comment on the Birth Assistant Sunrise currently under review. Specifically the following language in section 1, 4.a.:

“In lieu of the education 11 program required by this subsection, the applicant may provide evidence of certification as a professional midwife or licensure, registration, or certification as a registered nurse under chapter 18.79 RCW, **physician assistant under chapter 18.71A or 18.57A RCW**, or medical assistant under chapter 18.360 RCW;”

Physician Assistants, by definition and law, practice with *physician* collaboration/supervision. We are licensed under the osteopathic and allopathic *medical boards*, not under the nursing board. Our training allows us to perform the same duties that a nurse midwife performs during labor, delivery, and post-partum care if we are working with a physician who does obstetrics.

It is inappropriate to list Physician Assistants as being a “birth assistant” so please remove our profession from this bill. Certainly if a physician assistant wanted to retire from the PA profession and become a birth assistant, they may do so, but must refrain from using the title “physician assistant” and become the “birth assistant” as laid out in this bill.

Sincerely,
Linda M. Dale, D.H.Ed., PA-C
Chair, Legislative and Health Policy Committee
Washington Academy of Physician Assistants



July 23, 2015

Department of Health
Ms. Sherry Thomas
PO Box 47850
Olympia, WA 98504-7850

Subject: Birth Assistant Certification

Submission of written comment from: PeaceHealth Washington State hospitals (Southwest Medical Center, St. John Medical Center, St. Joseph Medical Center) and Oregon and Alaska hospitals.

PeaceHealth opposes the Birth Assistant Certification proposal as written. We believe that the proposal as written is too vague and unclear in multiple areas. Here are some of the concerns that PeaceHealth has relating to the proposal as it is written:

- The proposed Certified Birth Assistants scope of practice is not well defined. We have a concern with this language in the proposed new section Sec. 1. (2): "A certified birth assistant may perform **any** duties delegated by and under the close supervision of a midwife that **do not exceed the midwife's scope of practice**" If that is the case, then what is the difference between scope of practice of a midwife and a certified birth assistant?
- What are the scope limitations and education for the content listed in Sec. 1. (4) (a)
 - Specific Scopes of Practice and education for:
 - "birth emergencies"
 - "role of birth assistants"
 - "practical skills"
 - "medication use in midwifery care"
- Is the Certified Birth Assistant scope limited to community/home settings or will scope of practice cross over into hospital settings?
- There is a considerable difference in scopes of practice between Licensed Midwife, Certified Nurse Midwife and Physicians. Is there any scope of practice limitation of the "Birth Assistant" based on provider type they are working under?
- What is the process for a midwife or other licensed birth provider to apply for and be granted approval to proctor and provide performance evaluations of Certified Birth Assistant candidates?
- What are the criteria for "satisfactory skill performance"?
- Certification renewal does not require specific number of births attended and/or continuing birth assistant education. Paying a fee and maintaining NRP and CPR certifications does not ensure maintenance of satisfactory birth assistant performance.

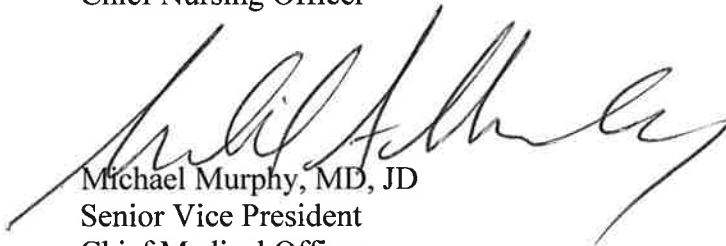
- What is the educational or certification requirement for a birth assistant educator?
- What is in place to keep a non-certified birth assistant from performing the skills in section 1 (2) of the draft bill?
- What is in place to keep a midwife or other licensed birth provider from using and delegating tasks to a non-certified birth assistant?
- What are the repercussions of a noncertified birth assistant who performs the duties of a certified birth assistant?

As outlined, there are many aspects of the Birth Assistant Certification proposal that PeaceHealth would like to see addressed. Until these elements and likely others are addressed, PeaceHealth does not support the Birth Assistant Certification bill as it is written.

Thank you for accepting our testimony on this proposal.



Victoria King, MHA, MSN, RN, CNOR, NEABC
Senior Vice President
Chief Nursing Officer



Michael Murphy, MD, JD
Senior Vice President
Chief Medical Officer

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