MIDWIVES ADVISORY COMMITTEE
Professional & Vocational Licensing Division
Department of Commerce & Consumer Affairs
State of Hawaii

MINUTES OF MIDWIVES ADVISORY COMMITTEE MEETING

The agenda for this meeting was filed with the Office of the Lieutenant Governor as required by section 92-7(b), Hawaii Revised Statutes.

Date: Monday, October 30, 2023

Time: 9:00 a.m.

In-Person Meeting Location: Queen Liliuokalani Conference Room, 1st Floor
HRH King Kalakaua Building
335 Merchant Street
Honolulu, Hawaii 96813

Virtual: Virtual Videoconference Meeting – Zoom Webinar (use link below)
https://dcca-hawaii-gov.zoom.us/j/86061855751

Zoom Phone Number: (669) 900 6833
Meeting ID: 860 6185 5751

Zoom Recording Link: https://youtu.be/Uyi_N6K3VT4

Virtual Meeting Instructions: The Executive Officer asked Ms. Duarte to read the information on internet and phone access for today's virtual meeting and a short video regarding virtual meetings was played for attendees.

For purposes of this virtual meeting, the EO will take roll call of the Committee members to establish quorum and for motions that require a vote of the Committee members.

Members Present: Sky Connelly (Reyly), CPM
Sheena Kristie Duarte, Public Member
Leah Hatcher, CPM
Rachel Lea Curnel Struempf, CPM
Pua O Eleili Pinto, Public Member
Lea T. Minton, CNM

Staff Present: Lee Ann Teshima, Executive Officer ("EO")
Marc Yoshimura, Secretary

Attendees:

Pahnelopi Mckenzie
Whitney Herrelson
Pi'ilani Schneider-Furuya
Jmelee Lewis
Kiana Rowley
Yvonne Gray
Alexandrine
Daniela Martinez
Dr. Lori Kimata
Melissa Danielle
Margaret Ragen
Ki'inaniokalani Kaho'ohanohano
Michelle Palmer
Leah Hatcher
Merciful Ananda
CC
JuliaRL
Rethabile Molapo
Laura Acasio
Roxanne Estes
Kari Wheeling
Jasmine Merritt
Tara Compehos
Tanya Smith-Johnson
Amber Ward
A. Ezinne Dawson
Brady
Mieko
Trinisha Williams
Piper Lovermore

Call to Order: The agenda for this meeting was filed with the Office of the Lieutenant Governor, as required by section 92-7(b), Hawaii Revised Statutes ("HRS").

The EO took roll call and asked the Committee members if they were alone in a non-public location. The meeting was called to order at 9:25 a.m.

Approval of Minutes: **Approval of the Minutes of the November 16, 2022 Meeting**

The EO asked if there were any corrections to the minutes of the November 16, 2022 meeting besides a correction to Ms. Duarte's name and the time the meeting was adjourned.

Upon a motion by Ms. Curnel Struempf, seconded by Ms. Reyly, it was voted on and unanimously carried to approve the minutes with the corrections indicated (as amended).

Review and Discussion of Proposed Rules: **Review and Discussion of Proposed Rules for License Midwives' Scope of Practice**

The EO went over the following distribution material that was distributed to the Committee members for discussion:

- Draft #1 – Based on Senate Bill 1033, 2019 Legislative Session
- Draft 10.16.17 – Sky Connelly (Reyly) as discussed at the November 16, 2022 meeting
- Oregon Health Authority – Board of Direct Entry Midwifery – Oregon Revised Statutes (2021, Unofficial Version) and Chapter 332, Division 25 - Practice Standards
- Utah Code, Chapter 77 Direct-Entry Midwife Act
- Te Wahtu Ora Health New Zealand – Midwifery
- Code of Virginia – Regulation of the practice of midwifery

The EO called on each member for their recommendations on the previously mentioned distribution to see if they had a preference of other midwifery regulations they would like to see adopted in Hawaii's scope of practice for midwives.

Ms. Curnel Struempf stated that Virginia had done some revisions to their laws recently and that in her opinion, includes scope of practice language that is well defined using the National American Registry of Midwives (NARM), Midwives Alliance of North American (MANA) and the National Association of Certified Professional Midwives (NACPM) practice guidelines and recommendations for the profession and believes that it is better than Oregon's language.

Ms. Curnel Struempf further clarified the sections in the Virginia practice act as the sections regarding the scope of practice of midwives as 54.1-2957.8 – 54.1-2957.13.

The EO called on Ms. Duarte.

Ms. Duarte stated that there was testimony from Kim Pekin of NARM who is a licensed Virginia Midwife and Chair of the Board of Directors and that she refers to the Virginia regulations in her testimony.

The EO interjected and ask that the Committee members not "testify" on behalf of another organization and that the Committee will take and review testimony after the Committee members have had an opportunity to discuss first.

Ms. Duarte stated that she reviewed the "draft" of the rules that was distributed and liked it and that she would like to see language that is in the Utah law on page 3 of the distribution, 58-77-304, language relating to parent's rights that she would like to see included in the Hawaii practice act for midwives.

The EO called on Ms. Reyly.

Ms. Reyly had questions regarding the "draft" as to why certain definitions were striked through as if to be deleted.

The EO explained that if the definition already exists in the statute (law), then there is no need to reiterate in the rules.

Ms. Reyly said her main question is that reading the draft, it appears that certified midwives are "grouped" in with certified professional midwives even though their scope of practice by definition through ACNM is more like a CNM and wondered if that was going to be addressed.

The EO called on Ms. Hatcher.

Ms. Hatcher thought the meeting was cancelled with the email that went out and therefore did not review the information that was distributed.

The EO asked Ms. Hatcher that prior to this meeting, did she have any preferences for language in regard to the scope of practice for midwives from other states/jurisdictions.

Ms. Hatcher said that other states have laws that we could amalgamate into our State laws.

The EO called on Ms. Pinto.

Ms. Pinto stated that she doesn't have any comments at this time but that the "draft" looks good.

The EO called on Ms. Minton.

Ms. Minton wanted clarification on certified midwives in the "draft" that is based on the SB 1033 the scope of practice including prescriptive authority is crossed out but it does give prescriptive authority to certified midwives so that one of her questions is the Director of DCCA able to give prescriptive authority privileges to certified midwives if it is not in the statute.

The EO said no.

Ms. Minton stated then one of her recommendations is that this should be considered by this committee for future legislation. She also stated that section 16 would then have to be deleted and that her concern at this time are the administrative rules in that we will be relegating certified midwives to essentially the same as certified professional midwives, which they are not and that they do have the same training and scope of practice as defined by the American College of Nurse Midwives for certified midwives. She further clarified that the American College of Nurse Midwives provides the scope of practice for both certified nurse midwives and certified midwives and the American Certified Midwifery Board certifies the same and that's why in the original SB 1033 prescriptive authority given and different scope of practice for certified midwives than a certified professional midwife. So as a Committee, when establishing administrative rules, we should be cognizant of how we are laying that out and what we have the authority to do so based on the statute and what recommendations we would make moving forward for improvements to the law to ensure that both professionals are able to practice within their scope of practice because currently certified midwives are not able to practice in the way that they have been trained.

Ms. Minton further stated that she did review the testimonies that were submitted and did see that certified professional midwives be based on NARM job analysis that is in draft 1 based on SB 1033 and also saw recommendations for professional standards and competencies, the National Association for Certified Professional Midwives and have concerns around that. Number one, according to the NACPM's website, it says that they have not yet adopted a standard of competencies specific to CPMs so we don't want to reference an organization that has no competency set out for CPMs.

The EO reiterated that the Committee will be discussing the testimonies that were submitted after the Committee members have provided their recommendations.

Ms. Minton wanted to point out that based on the distribution, for example Oregon regulations have a lot of listed scope of practice individualized lines, the reason being that certified professional midwives do not have a defined scope of practice that is different from what people are used to with other professions and that's why for certified midwives, we would be referencing the scope of practice by the ACNM but for CPMs, there is no place to reference the scope of practice because it's not defined. She further stated that each certified professional midwife individual defines their own scope of practice for themselves and that they can also change that which each individual client and so as long as they are willing to do what is listed in the informed consent with their client, then that is the form that actually defines the certified professional midwife scope of practice with each individual client and that is why historically many states have very long administrative rules because otherwise there are no rules.

She stated that she wants to be very clear that when people say we should be referencing for example SB 1033 does not specifically reference any CPM and that historically that was intentional because NACPM only represents members of NACPM rather than all CPMs and that means they have no jurisdiction over CPMs who are not actually members of NACPM. She further stated that with SB 1033, she does agree that the reference to job analysis that there are things in there, specifically for example actually references ACNMs home birth practice guidelines and the reason why even though CPMs do not fall under the ACNM, she agrees with it being referenced because CPMs have no practice guidelines for home birth and within that document for ACNMs practice guidelines, it at least lists out what is considered higher risks and when those are recommended for transfer so at least there are some guidelines for what would be considered reasonable and prudent for a professional. It does not require those transfers of care but it does actually define what those levels of risks are and that in her opinion, that is important because otherwise there is no actual regulation.

Ms. Minton stated that she wanted to bring up these important points in case it was missed or misunderstood as to why many states do have it highly listed out, though she doesn't think we have to do that and agree that the way it is listed in SB 1033 is written and at the same time we will be limiting the certified midwife work at this time. She stated that the last thing she wanted to say is that it is important for us to ensure that there are continuing education licensing requirements because at this time there are none and so within the admin rules of SB 1033 draft, she does agree that there be continuing education requirements as well as peer review especially understanding that peer review does happen inside of facilities but is not required to happen if you have community births and it is required for CPM renewal of their certification but that there are no true parameters around that so of us having that requirement is important but that we do need to consider how that would ensure that peer review would be protected because there are no protections in this draft to allow for that and ensure confidentiality within peer review for licensed midwives that is critical in order to ensure that we can move the profession forward.

Mr. Yoshimura stated that Ms. Reyly had her hand raised.

Ms. Reyly stated that her understanding of what is happening with NACPM is that it is in the works to come up with scope of practice and that in the future, it may be a workable reference. She added that there were things in the Oregon law that she agreed with but feel that could be incorporated that was more around the informed consent, the way that it was very specific she felt was important to a certain extent that is included in the CPM credential and also included in the CM credential, however, as Ms. Minton pointed out, she doesn't feel it is specific enough and tends to be "loosey goosey" on the CPM side and that she liked that there was specific criteria for both informed consent and consultation specifically. She doesn't agree with having huge long rules that spell out things specifically

because overtime, scopes may change and what people are learning will change and especially if we put in what exactly, for example birth control or medication that someone can use, that may change over time. She would like the rules to be flexible so that we can allow for those changes over time and it is important to define things such as what is informed consent and choice and what is being told to people in those documents. As CPMs, they write their own consent so it doesn't come across as uniform therefore a big disservice to their client and consumers. She also thinks that laying out the ability and time to consult with other health care providers will go a long way to building bridges that don't exist right now, especially on Maui. For example if required by law that she needs to consult when someone has 2 cesareans before they have a home birth like in the Oregon law where the midwife has to talk to someone if a client had a cesarean, so you have to talk/consult with an OB and that in Hawaii, or at least on Maui, they are not available, they won't talk to CPMs. She feels that by putting in the law, we are trying to build bridges, wanting to integrate our professions and create a better system that will be, at the end, safer and create better outcomes for everyone. Research shows that the more integration you have, the better the outcomes, so she likes the idea of including requirements for consultation although some people may see that as a big barrier, but in the long run, it will start to build some bridges, including other midwives. She stated that this is a community thing and that we should be integrating these systems so that there can be better transports and relationships.

The EO stated that the Committee will now receive testimony on this agenda item. Testifiers have 5 minutes and if the testifier is unable, she will read/summarize their written testimony. She called on the first testifier who was Daniella Martinez Guzman.

Ms. Guzman was promoted to panelist and wanted to make 2 main points in her testimony, one referring to the Virginia law as a great model and that the 2 main points on that model for regulations is that they do refer to the NACPM and NARM for scope guidelines but in addition to that there aren't paper specific guidelines for CPMs and part of that is intentional because CPMs do have different training for example one may be trained for twin births and another not so it shouldn't be a very general guideline that all midwives can do that so it is and it is a personalized thing and NARM allows for that individuality but in order to address and specific guidelines, the Virginia law does offer a specific way of addressing high risks situations and that the way is to make sure that everyone is informed about those risks and signed informed consents.

The EO called on the next testifier, Michelle Palmer, Board Representative of the American College of Nurse Midwives.

Ms. Palmer was promoted to panelist and stated that they have certified nurse midwives, certified midwives and certified professional midwives in Rhode Island

where she is licensed and perhaps would like to look at the regulations as well. She stated that the Rhode Island regs seem to be working well and referred to what Ms. Ryley in reference to bridging and improving outcomes by providing seamless provision of care. She stated that the Committee should reconsider so that CMs can function to their full scope of their practice and realize that there may not be room for putting in prescriptive privileges per se but one of the way that other states have worked around this to allow CMs to full practice is to add in the wording "furnish", that the certified midwife may "furnish" medications as delineated in their scope of practice and stated that she included Rhode Islands regulations with her testimony.

The EO called on the next testifier, Karen Kelly, who was not present but did submit the following written testimony which was read into the record:

"My name is Karen Kelly and I am an American Midwifery Certification Board, Certified Midwife of twelve years. I am writing to address the issue of licensure and regulation of Certified Midwives in Hawaii.

Certified Midwives are in education, certification and practice the same "type" of midwife as Certified Nurse-Midwives. Safety of practice is assured by the fact that CNMs and CMs graduate from a midwifery program with identical curricula and must pass the same board exam in order to be certified Our scope of practice as defined by the American College of Nurse-Midwives and recognized and affirmed by the American College of Obstetrics and Gynecology is identical to Certified Nurse-Midwives.

Midwifery as practiced by CNMs and CMs: encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. Midwives provide care for all individuals who seek midwifery care, inclusive of all gender identities and sexual orientations. CM/CNMs exist in a community of all midwives, and we respect and elevate the importance of having midwifery care available for all people who want it.

Growing the midwifery workforce capacity by licensing CMs in Hawaii makes it imperative that the law reflects the actual scope of the professional. The CM allows those who have a desire to serve the public in the role of an advanced practice midwife to do so without the economic impact on society or the individual of getting an entirely separate undergraduate degree in nursing first.

In Virginia, where I live, the certified midwife scope is consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives governing the practice of midwifery. Notwithstanding any provision of law

or regulation to the contrary, a licensed certified midwife may prescribe Schedules II through VI controlled substances in accordance with regulations. I live near the boarder on Maryland and Washington DC, two additional states that have passed legislation in recent years for full-scope, independent practice of Certified Midwives that is identical to Certified Nurse-Midwives.

There is also a strong economic incentive for both the individual and the public to recognize the CM credential. It means potential midwives do not face double tuition. There is no good reason to require an undergraduate degree specifically in nursing in order to utilize one's graduate degree of midwifery. Midwives on the whole have been shown to be more cost-effective than physician care and, for low risk people, equally safe and effective with high rates of satisfaction. Without full recognition I am concerned CMs will not be able to adequately work in Hawaii to address the healthcare shortages for women and reproductive health and wellness needs. Please note, I would be happy to be available to provide any further information. My email is KarenKellyCM@gmail.com"

Thank you for your consideration as you review HRS Section 92-7

Karen Kelly, CM, FACNM
President-Virginia Affiliate of The American College of Nurse-Midwives

The EO called on the next testifier, Nasima Pfaffl, NACPM Chapter Program. Ms. Pfaffl was not present but submitted testimony on behalf of Cassaundra Jah, Executive Director of the National Association of Certified Professional Midwives who also was not present and the following written testimony was read into the record:

"Dear Midwives Advisory Committee,

The National Association of Certified Professional Midwives provides the following testimony to your October 30, 2023 Agenda, Item #3: "Review and Discussion of Proposed Rules for License Midwives 'Scope of Practice."

The National Association of Certified Professional Midwives '(NACPM)purpose is to be a powerful, collective voice for Certified Professional Midwives (CPMs). We strengthen and support excellence in the profession and influence birth health policy to ensure that all childbearing people and babies have a healthy start. We work to ensure safe, high-quality, respectful care for all women and childbearing people that improves outcomes, avoids unnecessary medical interventions and locates power over the birth experience with the woman or person giving birth. We are committed to investing in a strong, racially, ethnically and socially representative CPM workforce to meet the urgent needs of childbearing people.

NACPMs Briefing Papers lay out the history, regulatory structure and vision for the CPM profession. Our paper, Education and Accreditation, lays out the educational foundation for practice. The Midwifery Education and Accreditation Council's (MEAC) is the Department of Education (DoE) recognized accrediting body for CPMs. MEAC's education standards, which include the Curriculum Checklist of Essential Competencies, are based on the International Confederation of Midwives 'Essential Competencies, the NARM Knowledge and Skills List, and the MANA Core Competencies, that prepares students for competent practice as CPMs. Students must also pass the NARM exam to receive their CPM credential. The NACPM paper Certification and a National Credential provides deeper information on the CPM credential. As the national association for certified professional midwives, NACPM's Essential Documents provide statements on Philosophy and Principles of Practice, Standards of Practice, and Scope of Practice.

CPMs are the recognized experts in out-of-hospital birth. The CPM credential is the only midwifery credential to train students in knowledge, skills, and abilities for community birth and determine competency in out-of-hospital settings. Only one state out of 36 states that license CPMs reference ACNM's scope of practice document in rule or law. This state, Florida, PO Box #1448 Williston, VT 05495 T: 802-556-1522 W: nacpm.org E: info@nacpm.org achieved licensure in 1995 before CPMs had established the credential's three internationally recognized professional midwifery organizations. Hence, it is critical that our CPM professional associations 'standards and scope be utilized in rule making for CPMs.

The American College of Nurse-Midwives (ACNM) establishes standards and delineates the scope for Certified Nurse Midwives (CNMs) and Certified Midwives (CMs). Analogously, it is the prerogative of the National Association of Certified Professional Midwives (NACPM) to define the standards and scope for Certified Professional Midwives (CPMs). Similarly, while the Accreditation Commission for Midwifery Education (ACME) oversees the accreditation standards for CNM/CM training programs, Midwifery Education Accreditation Council (MEAC) is charged with establishing the accreditation standards for CPM education programs. Furthermore, while the American Midwifery Certification Board (AMCB) dictates certification standards for CNM/CMs, it is within the jurisdiction of the North American Registry of Midwives (NARM) to determine standards for the CPM credential.

While we all identify under the banner of midwifery, it's paramount to recognize that we are discrete professions. Each has meticulously crafted regulatory frameworks for education, credentialing, and professional standards and scopes.

In your rule making on CPM scope and standards, we encourage the committee to only refer to, or include, NACPM's Scope of Practice statements found in our Essential Documents and NARM's latest Job Analysis.

Sincerely,
Cassaundra Jah,CPM,PhD Executive Director National Association of Certified Professional Midwives"

The EO called on the next testifier, Kim Pekin, NARM Board of Directors Chairperson and because Ms. Pekin was not present, asked Ms. Duarte to read her testimony into the record:

"Dear Midwives Advisory Committee:

As a Virginia Licensed Midwife and Chair of the Board of Directors of the North American Registry of Midwives, I am writing to you in advance of your meeting on Monday October 30, 2023. It is my understanding that your Midwives Advisory Committee will be meeting to review and discuss proposed rules for the practice of Licensed Midwives in your state. I am hopeful that sharing my perspective as a Virginia Licensed Midwife will be helpful to you as you consider how the midwives in Hawaii should be regulated.

In Virginia, the law dictates the alignment of Licensed Midwives' regulations to their scope of practice as determined by the NARM Job Analysis and the NACPM Standards of Practice. Licensed Midwives are also required to provide evidence-based informed consent for clients planning vaginal birth after cesarean (VBAC), twins, breech or a high-risk birth in the community setting. Midwives in Virginia are regulated by the Board of Medicine, with the assistance of the Midwifery Advisory Board.

Virginia's Midwifery Advisory Board is composed of three Licensed Midwives, a public member who has used out-of-hospital midwifery services, and one doctor or Certified Nurse-Midwife with experience in out-of-hospital settings. This composition has allowed for the regulation of Licensed Midwives by people who would have the greatest understanding of the profession. As the former Chair of the Virginia Midwifery Advisory Board for 8 years, I can tell you that this regulatory framework has worked well to create a thriving and autonomous midwifery workforce that safely serves the residents of the state. Virginia legislators and Midwifery Advisory Board have wisely avoided imposing any regulations that would limit Licensed Midwives' ability to practice within their scope, knowing that adding restrictions would not increase public safety, but would instead largely result in families seeking care from unlicensed providers.

The North American Registry of Midwives supports regulations that are aligned with the NARM Job Analysis and the NACPM Standards of Practice. Certified Professional Midwives are highly skilled professionals, uniquely trained to serve families planning community births. They are an essential part of the maternity provider workforce in Virginia, addressing the problems of maternity care deserts

and the need for culturally congruent care. The Virginia regulatory framework is a model that could be successfully adapted to meet the needs of Hawaiians. I encourage you to consider the Virginia model when discussing how Licensed Midwives should be regulated in Hawaii.
Sincerely,
Kim Pekin, CPM
Chairperson, Board of Directors"

The EO called on the next testifier, Margaret Ragen, who in addition to her written testimony provided the following, CNM-CM-CPMs Comparison Chart; Definition of Midwifery Scope of Practice 2021 from the American College of Nurse Midwives, and provided oral testimony as follows:

Ms. Ragen thanked the Committee for allowing her to testify on the CM definition and scope of practice and that she lives and works on the island of Hawaii and is the only certified midwife practicing in this State. She stated that she was also licensed in New York and currently serves as the Secretary for the Hawaii affiliate of the American College of Nurse Midwives also known as HAA and since 2017 has been a member of CMAC, the ACNM committee on midwives advocates for the certified midwives and have benefited greatly with their support and analysis and draft of the HAR document that was emailed yesterday to the EO. She also wanted to express her gratitude to the non-profit Health Mothers/Healthy Babies Coalition for Hawaii for offering her employment.

She stated that this oral testimony is supplementary to the Hawaii Administrative Rules draft that she shared and will be happy to discuss any questions. There are rules and regulations for the CM credential that could stand as precedent for HAR and seven other states for the practice of midwifery and the scope reflects standards of the ACNM in the draft she has prepared. We have chosen to utilize existing HAR administrative rules that regulate CNMs under the Board of Nursing. It is interdepartmental and in its use represents the equivalency of the CMs and CPMs in this regard. In this draft they have endeavored to address 457J to address the full extent of the CM education, clinical training, certification and experience according to the records shared by the EO, the original draft of SB 1033 included scope of practice but was taken out by the Legislators and later brought into HAR. This is the source of the scope of practice for the CM subchapter that they included in the draft presented to the Committee. We also utilized regulations as noted in the licensing application for midwives as it relates to CMs and CPMs. In any section of the draft she presented where CPMs is specifically addressed, it is a direct quote from one of the 3 documents so the CPM's scope of practice has been left blank because it is not within the ACNM's purview to comment.

In response to Ms. Minton's comment regarding the CMs credentials of it being limited, in the statute, she would like to address broader thinking in light of Ms.

Reyly's note on practice changes and that she is in full support of that and would recommend utilizing any definitions and scope of practice that are broad or as broad as possible as to benefit all of the midwives.

Ms. Ragen stated that there are a few aspects to be noted, including the term "furnish", a fellow CNM noted this, Michelle Palmer, this is based on a creative solution that CNMs coined in California. For California CNMs, the law omitted prescriptive privileges, the term "furnish" was introduced and passed and utilized in the rules and now CNMs in California can practice full scope. Kaiser has also gone so far to find a way for CNMs can practice in both Hawaii and California. So with creative thinking there are solutions and deeply urge the Advisory Board (Committee) to look for these solutions instead of setting limitations. On the section of furnishing authority drawn from Hawaii Administrative Rules regarding CNMs including Exhibit "A", the Exclusionary Formulary.

The second important aspect involves the controlled substances which is also copied from the same HAR applied to CNMs, as was stated in the original draft of SB 1033, prescriptive rights and the ability to prescribe controlled substances was a part of the CM credential, it was recognized. According to ACNM definitions, DEA number is a right of a CM credential which is different from NPI numbers.

Ms. Ragen stated that the HAR draft states that CMs are trained and credentialed to attend births in all birth settings so they are requesting that the final HAR draft acknowledges these distinctions of the CM credential. There are a few documents that were provided to the Advisory Board (Committee) that include a comparison chart for CNM-CM-CPM from the ACNM, the position statement on the definition of scope of practice for CNMs and CMs. She stated that she can provide state precedence if that is the direction they would like to go as there are 7 states where regulations have been written that reflect ACNM standards that include Maine, Maryland, New Jersey, New York, Rhode Island, Virginia, Washington DC with Colorado joining this group as their statute have recently passed. The American Midwifery Certification Board noted that there are currently 131 CMs working in U.S. territories. She stated that she is one of the 131 that works in Hawaii with the other 130 work primarily in the other 7 states. ACNM legislative leadership is convinced that with rules and regulations that reflect the potential for Hawaii numbers to grow and that she is also convinced and can see the benefits of the CM credential for the Hawaii community and for future CM student midwives to have a more efficient and affordable path to complete a masters program and return to Hawaii to serve. She stated that she is happy to speak on CM programs if the Committee had any questions.

She had one final question for the Committee, stating she appreciates the CNM presence on the Board (Committee) but a CNM is not a CM and they are the ones who will be regulated by this Board (Committee) so she has to speak to that short sightedness and that there is no ACNM member on the Board (Committee), so in

the final discussion of the draft, she would request that either a CNM or a member of the ACNM be a part of the final discussion and to speak with work environments…

The EO apologized and informed Ms. Ragen that her time is up and that she has to call on the next testifier to provide everyone who is attending, an opportunity to testify.

The EO called on the next testifier as Annette Manant, President of the Hawai'i Affiliate of the American College of Nurse Midwives (HAA) who was not present and Ms. Duarte read her testimony into the record as follows:

"Thank you for this opportunity to contribute to the discussion regarding Hawai'i Administrative Rules (HAR) draft as it applies to licensed Certified Midwives (CMs) practicing in the State of Hawai'i. Our purpose here, as the Hawai'i Affiliate of the American College of Nurse Midwives (HAA), is to comment solely on the section related to the CM credential. To comment on the CPM credential is not within our scope, though we do aim to differentiate between the two. The executive board of HAA has reviewed HRS 457j. We have also reviewed HAR related to CNMs in the State of Hawai'i and support its use as a precedent in defining scope of practice for CMs as relates to the practice of midwifery. The board has also invited HAA members and working CNMs and CMs to provide testimony to the Advisory Committee members on this HAR draft discussion.

Regarding the distinction and definition of the practice of midwifery as a CM we wish to resubmit a statement from the previous HAA board in January of 2019. In written testimony, it was stated that MIDWIVES is a generic term. It applies to different types of midwives with different education, training, and scope. The definition, education, certification, scope of practice, location of practice, continuing education, prescriptive authority, and authority to use legend drugs are not the same for CMs and CPMs. Board members have provided documents to the Executive Officer for disbursement to the Advisory Board January of this year, to clarify the distinction of these licensed midwife credentials and to define the practice of midwifery for CNMs and CMs. These documents are here attached for review. As the HAR for the Midwives Program will regulate both CMs and CPMs, we recommend review of these documents by the Advisory Board to inform any HAR draft.

We support CM regulation that includes scope of practice compliant with ACNM's definitions, as described in their document, "Definition of Midwifery and Scope of Practice of CNMs and CMs." Examples of states that have passed legislation and regulation regarding the CM credential reflective of ACNM definitions include: Colorado, DC, Maine, Maryland, New Jersey, New York, Rhode Island, and Virginia. In these states, CMs practice side-by-side with CNMs in the role of delivery of ACNM's definition of midwifery care. It is our aim that CMs can be

brought into the same midwifery practice work environments as CNMs in the State of Hawai'i. These state precedent documents can also be furnished to the board, upon request.

Sincerely,
HAA Executive Board
Annette Manant, President
Connie Connover, Vice President
Sharon Offley, Treasurer
Margaret Ragen, Secretary"

The EO called on the next testifier as Ida Darragh, Executive Director, North American Registry of Midwives who was not present but her written testimony was read into the record by Ms. Duarte as follows:

"Dear Midwives Advisory Committee,

It has come to our attention that the Midwives Advisory Committee will meet on Monday, Oct 30, 2023, as part of an ongoing discussion of issues related to the licensure of Certified Professional Midwives. This letter is supportive testimony for that discussion.

The North American Registry of Midwives maintains the accreditation status of the Certified Professional Midwife, consistent with the Institute for Credentialing Excellence and the National Commission for Certifying Agencies. This assures that the certification program follows the highest standards in identifying the knowledge and skills critical for midwives practicing in homes and birth centers, and maintains the appropriate assessment instruments for determining readiness for practice.

When evaluating the scope of practice for licensed midwives via the Certified Professional Midwife credential, NARM supports keeping the state scope consistent with the NARM Job Analysis and Test Specifications, and the Professional Standards and Competencies from the National Association of Certified Professional Midwives. These documents may be found on their websites: www.narm.org and www.nacpm.org. The most effective regulation is that which is consistent with the education, assessment, and professional standards of the profession being regulated.

Sincerely,
Ida Darragh, Executive Director
North American Registry of Midwives"

The EO asked if there was anyone else wishing to testify on this agenda item.

Ms. Dawson, who was attending in-person stated she is a licensed certified professional midwife practicing on Oahu testifying in regard to the scope of practice of CPMs. For those of midwives practicing in this State, that we look at Virginia and Utah who use practice guidelines that are set forth in standards shown through MEAC, PEP and NARM, they are very clear and require informed consent and as long as we are requiring informed consent, the midwife can safely practice to their comfort level and clients seeking these midwives can feel confident with their practitioner with that expressed information.

As a practicing midwife in home birth setting and working alongside other practicing home birth practitioners, naturopathic licensed practitioners and other licensed CPMs. She stated that specifically, Virginia does give mothers the most bodily autonomy and does not dictate the licensed midwife may treat someone as long as they are provided with informed consent. She further stated that our mothers are the people we should be looking out for and that bodily autonomy is absolutely a prerequisite and requirement that needs to be honored. Lastly, she wanted to note that forced doctor consultation should not be required in certain high-risk situations and not a good idea. She stated that she agrees that we have to work on communication and integration and bridges, forcing it would lead to negatively impact for mothers. Consults are a good idea, but forcing them is not and the last thing we need is a forced medical consultation that is not going to build bridges and that we need to build bridges, but need to do it appropriately.

Mr. Yoshimura stated that Ms. Whitney Herrelson has raised her hand.

Ms. Herrelson was promoted to panelist and stated that she is a practicing midwife on Maui in home birth setting and disagrees with the OB consult requirement and that where she works, she has collaborative relationships with every midwife on the island but do not have access to OB-GYN and so that requirement would prohibit her from practicing. She stated that she does have a telemedicine consulting relationship that she paid for and that it is so restrictive on Maui that it will be detrimental to their patients. She also stated that it would be unnecessarily burdensome and adding that restriction would improve outcomes.

Ms. Herrelson stated that she agrees with Ms. Ragen's testimony on the CM credential and that their scope is being restricted and that they should have a full scope of practice within ACM's definitions and wondered why they are included with the CPMs because they have completely different training and scope of practice and that we should strive to ensure that all practitioners have the ability to practice under their full scope of practice because we are in a health care desert.

She stated that she has trained in both Oregon and Utah and have experienced working under those states' regulations. She supports utilizing Virginia's legislation as a template for Hawaii midwifery regulation as it allows the largest scope of practice.

The next testifier was Charlene Kiana Rowley, Interim Executive Director of the Pacific Birth Collective and is in attendance to witness the discussion and is in support of a full scope of practice and having CM representation on the Committee, allowing a stepping stone for currently licensed midwives to advance their scope of practice through additional training which would be a positive step forward in terms of integrating midwifery care into the current medical system and being able to expand access in our rural communities that are extremely limited, including Maui county.

The EO asked the members if they wanted her to clean up draft #1 for the next meeting.

Ms. Minton stated that it is her assumption that draft #1 may already include the Virginia law and does not list out all the specifics like the Oregon law though it does reference the NARM job analysis comprehensive skills knowledge and abilities essential for the competent midwifery practice by NARM or successor organization, referencing their education and training which would allow "permissive" practice and that perhaps a comparison of the Virginia law to highlight the differences.

She also stated that the statute does stipulate that the advisory committee would comprise of 3 licensed midwives that can include certified professional midwives or certified midwives so it allows for a certified midwife to be included. Secondly, the statutes do not require CMs or CPMs to be members of national organizations because that is not indicative of their knowledge of their scope of practice.

Ms. Minton added one more comment that there seems to be some confusion as to why certified midwives were included in the licensed midwife statutes and that the statutes license the practice of midwifery and midwives and that is why certified midwives are included even though they have a different scope of practice.

Ms. Curnel Struempf wanted to address the members of the committee and stated that the physician's advisory committee and the board of nursing advisory committee that has six RNs, one APRN, one LPN and two public members.

The EO interjected that the Board of Nursing is not an advisory committee.

Ms. Curnel Struempf said that it still has all nurses and that for the physician's board, they have seven physicians or surgeons, two osteopathic physicians and two public members and that no where on there is there a nurse on the doctor's board or a CPM on the nursing board. It doesn't make sense that there is a CNM on CPM CM board. The CM credential is the equivalency of the non-nurse equivalency of the certified midwife, the certified midwife is like the non-nurse

equivalency so it would make sense that the seat on the advisory board that is taken up by the advanced practice person would be a CM with three CPMs and not a CNM.

Secondly, Ms. Curnel Struempf had questions on the following section of the draft:

§ -3 Care provided by licensed midwives; requirements. (a) Licensed midwives shall continually assess the appropriateness of the planned location of birth, and shall refer to the American College of Nurse-Midwives Clinical Bulletin: Midwifery Provision of Home Birth Services (November 2015), or succeeding document, for guidance, taking into account the health and condition of the mother and baby.

She stated that this section is great for the CMs but not applicable for the CPMs.

The EO stated that based on all the information that was distributed and the additional testimony, it was a lot of information and that she will compile a chart that compares draft #1 with the Virginia law and allows the members to "add" language as well in regard to the scope of practice.

The EO also explained how the advisory members were appointed and will be discussing term of members with the Director.

After some discussion, it was determined that the next meeting will be in December.

Ms. Minton wanted to comment on why there was no certified midwife on the committee, at that time when the legislation was going through, there was no certified midwife practicing in this State and that is why a certified nurse midwife who has the exact same training and scope of practice of a certified midwife was included.

Mr. Yoshimura said that Ki'inaniokalani Kaho'ohanohano raised her hand.

Ms. Ki'inaniokalani stated that while there is still representation from folks who are not practicing, that is a problem as opposed to someone who is practicing, she sees that the person practicing has a deeper understanding what a practicing midwife in Maui means, including the issues that they have to deal with and wanted to add her mana'o on that. See added that another thing that is problematic is that there is no space for traditional seat although they are not allowed to practice and that she is glad to see Ms. Pinto on the committee, who is kamaka maol,i and who can bring perspective and history and depth.

The EO asked if anyone else wanted to speak.

Ms. Curnel Struempf wanted to know if she was the only one committee member practicing midwifery.

Ms. Minton stated that she practices midwifery.

Ms. Ryley stated that she is not currently practicing.

Next Meeting: Monday, December 11, 2023
9:00 a.m. - 10:00 a.m.

Ms. Ryley stated that she will be stepping down from the committee because she will be moving out of state.

Adjournment: The meeting was adjourned at 10:47 a.m.

Taken by:

_/s/ Lee Ann Teshima_____
Lee Ann Teshima
Executive Officer

LAT

11/30/23

[X] Minutes approved as is.

[ ] Minutes approved with changes; see minutes of