The Honorable Eileen Cody
303 John L. O'Brien Building
Olympia, WA 98504

May 13, 2021

The Honorable Umair Shah, MD, MPH
Washington State Secretary of Health
Washington State Department of Health
PO Box 47890
Olympia, WA 98504-7890

Dear Secretary Shah:

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would change the scope of practice for licensed midwives, namely giving this profession the limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with appropriate training.

A copy of the proposal is attached (H-1639.1). The House Health Care & 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

Representative Eileen Cody, RN
Chair, House Health Care & Wellness Committee
34th Legislative District

Cc: Kelly Cooper, Washington State Department of Health
Ryan Black, Washington State Department of Health
Christie Spice, Washington State Department of Health
Amber Ulvenes, Midwives Association of Washington State
Chris Blake, Washington State House of Representatives Office of Program Research

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-1639.1/21

ATTY/TYPIST: MW:akl

BRIEF DESCRIPTION: Concerning the practice of midwifery.

AN ACT Relating to the practice of midwifery; and amending RCW 18.50.010, 18.50.040, 18.50.108, and 18.50.115.

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

Sec. 1. RCW 18.50.010 and 2014 c 187 s 1 are each amended 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~~)) individuals during prenatal, intrapartum, and postpartum stages or to ((~~her~~)) their newborn up to two weeks of age 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~~)) gestational parent or the newborn.

Sec. 2. RCW 18.50.040 and 1994 sp.s. c 9 s 705 are each amended to read as follows:

(1) Any person seeking to be examined shall present to the secretary, at least forty-five days before the commencement of the examination, a written application on a form or forms provided by the secretary setting forth under affidavit such information as the

secretary may require and proof the candidate has received a high school degree or its equivalent; that the candidate is twenty-one years of age or older; that the candidate has received a certificate or diploma from a midwifery program accredited by the secretary and licensed under chapter 28C.10 RCW, when applicable, or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued. The diploma must bear the seal of the institution from which the applicant ((~~was~~)) graduated. Foreign candidates must present with the application a translation of the foreign certificate or diploma ((~~made by and under the seal of the consulate of the country in which the certificate or diploma was issued~~)).

(2) The candidate shall meet the following conditions:

(a) Obtaining a minimum period of midwifery training for at least three years including the study of the basic nursing skills that the department shall prescribe by rule. However, if the applicant is a registered nurse or licensed practical nurse under chapter 18.79 RCW, or has had previous nursing education or practical midwifery experience, the required period of training may be reduced depending upon the extent of the candidate's qualifications as determined under rules adopted by the department. In no case shall the training be reduced to a period of less than two years.

(b) Meeting minimum educational requirements which shall include studying midwifery; 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; ((~~breastfeeding~~)) lactation; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule.

(c) For a student midwife during training, undertaking the care of not less than fifty ((~~women~~)) individuals in each of the prenatal, intrapartum, and early postpartum periods, but the same ((~~women~~)) individuals need not be seen through all three periods. A student midwife may be issued a permit upon the satisfactory completion of the requirements in (a), (b), and (c) of this subsection and the satisfactory completion of the licensure examination required by RCW

18.50.060. The permit permits the student midwife to practice under the supervision of a midwife licensed under this chapter, a physician or a certified nurse-midwife licensed under the authority of chapter 18.79 RCW. The permit shall expire within one year of issuance and may be extended as provided by rule.

(d) Observing an additional fifty ((~~women~~)) individuals in the intrapartum period before the candidate qualifies for a license.

(e) For those candidates seeking a limited prescriptive license extension, additional study and training is required, as prescribed by the department by rule.

(3) Notwithstanding subsections (1) and (2) of this section, the department shall adopt rules to provide credit toward the educational requirements for licensure before July 1, 1988, of ((~~nonlicensed~~)) midwives who are not licensed in Washington, including rules to provide:

(a) Credit toward licensure for documented deliveries;

(b) The substitution of relevant experience for classroom time; and

(c) That experienced ((~~lay~~)) midwives may sit for the licensing examination without completing the required coursework.

The training required under this section shall include training in ((~~either hospitals or alternative birth settings or both~~)) any birth setting with particular emphasis on learning the ability to differentiate between low-risk and high-risk pregnancies.

Sec. 3. RCW 18.50.108 and 1981 c 53 s 14 are each amended to read as follows:

Every licensed midwife shall develop a written plan for consultation with other health care providers, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive care nursery, and transport of ((~~a woman~~)) an individual to an appropriate obstetrical department or patient care area. The written plan shall be submitted annually together with the license renewal fee to the department.

Sec. 4. RCW 18.50.115 and 2019 c 55 s 1 are each amended to read as follows:

A midwife licensed under this chapter may obtain and administer prophylactic ophthalmic medication, postpartum oxytocic, vitamin K, Rho immune globulin (human), and local anesthetic and may administer

such other drugs or medications as prescribed by a physician. A pharmacist who dispenses such drugs to a licensed midwife shall not be liable for any adverse reactions caused by any method of use by the midwife. A midwife licensed under this chapter who has been granted a limited prescriptive license extension by the secretary may prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal and nonhormonal family planning methods, as prescribed in rule.

The secretary, after consultation with representatives of the midwife advisory committee, the pharmacy quality assurance commission, and the Washington medical commission, may adopt rules that authorize licensed midwives to ((~~purchase and use~~)) prescribe, obtain, and administer legend drugs and devices in addition to the drugs authorized in this chapter.

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COVER SHEET

Licensed Midwives Scope of Practice
Sunrise Applicant Report

June 2021

1. **Legislative proposal being reviewed under the sunrise process (include bill number if available):**
    - Please see bill draft
    - Increasing health equity and improving health outcomes by authorizing qualified Licensed Midwives to prescribe all contraceptive options and medications/therapies needed for the prevention and treatment of common prenatal and postpartum conditions.

2. **Name and title of profession for which the applicant seeks to change scope of practice:**
    - Licensed Midwifery

3. **Approximate number of individuals practicing in Washington**: 200

4. **Information about applicant's organization:**
    - Organization name: Midwives' Association of Washington State
    - Contact person: Jennifer Segadelli, JD, MSM, CPM
    - Address: 16904 Juanita Drive NE #203, Kenmore, WA 98028
    - Telephone number: (206) 200-7153
    - Email address: jennifer.segadelli@gmail.com

5. **Number of members in the organization:**
    - Professional Members: 144, with representation in all regions in Washington
    - Student Members: 17
    - Friends of MAWS Members: 12
    - Birth Center Members: 14

6. **Name(s) and address(es) of national organization(s) with which the state organization is affiliated and number of members in the organization:**
    - None

7. Name(s) of other state or national organizations representing the profession:

- Washington Alliance for Responsible Midwifery (WARM)
- National Association of Certified Professional Midwives (NACPM)

8. List states where this profession includes this expanded scope of practice:

The profession of Licensed Midwifery is known by several other names throughout the United States and the District of Columbia. In the other states where they are licensed, direct-entry midwives, provide many sexual and reproductive health (SRH) care services during pregnancy, birth, the postpartum period, and in some states during the interconception and pre/post-childbearing period as well (Zell, 2021). They perform cervical cancer screening; health education; testing for urogenital, breast, and sexually transmitted infections; clinical breast exams; and counseling about family planning and contraceptive options. Their access to medications and devices varies significantly based on state statutes and/or regulations, from being able to offer all medications and devices relevant to their scope of practice and training, to having access to a limited list of sanctioned medications, to requiring a physician prescription for each medication they administer (Effland et al., 2021; Zell, 2021).

Licensed direct-entry midwives in WA currently are not permitted to prescribe the majority of contraceptives or infection treatments, despite the fact that testing and educational counseling related to these conditions, medications, and devices is within their scope of practice in most instances (ACNM Government Affairs, 2019; Goldstein & Weeks, 2013; Marzalik et al., 2018; Zell, 2021). Washington is among the 19 states that permit administration of intrapartum antibiotic treatment for rectovaginal Group B streptococcus colonization and among the five that authorize prescription of cervical caps and diaphragms, generally only in the postpartum period[1].

Licensed or certified direct-entry midwives (excluding Certified Midwives (CMs)) are already explicitly permitted by statute or regulation to provide SRH care outside of the childbearing cycle in five states: California, Hawaii, New Mexico, Rhode Island, and Utah (California Business and Professions Code § 2507; Hawaii HRS 0457J; New Mexico Administrative Code 16.11.3.12; Rhode Island Code of Regulations 216-40-05-23; UT Code § 58-77-102; Zell, 2021).

[1] Alaska Administrative Code 12.14.570; Arkansas Administrative Code 007.13.92-300; California Business and Professions Code § 2507; 24 Delaware Administrative Code 1795-4.4; D.C. Code § 3-1201.02; Hawaii HRS 0457J Idaho Administrative Code 24.26.01-351; Kentucky Administrative Rule 201.20:650-3; Louisiana Administrative Code 46:XLV.5325; Code of Maryland 10.64.07; Michigan Administrative Rule 338.17137; Minnesota Statute § 147D.09; New Hampshire Rule Mid 502; New Mexico Administrative Code 16.11.3.12; Oregon Administrative Rule 332-026; Rhode Island Code of Regulations 216-40-05-23.10; South Dakota Rule 20:86:03:11; Vermont Administrative Rules for Midwives 3.16; Washington AC 246-834-250; Wyoming Code 036.0001.10; Zell, 2021

In California, the law states that “the license to practice midwifery authorizes the holder to attend cases of normal pregnancy and childbirth…and to provide prenatal, intrapartum, and postpartum care, including family-planning care” (BPC Article 24, sec. 2507 as cited in Segadelli, 2016). Licensed midwives in California also have a process by which clinical scope of practice may be expanded (Segadelli, 2021).

New Mexico regulations allow the state midwifery association to update their formulary to reflect the evidence base and evolving expert recommendations (New Mexico Administrative Code 16.11.3 as cited in Effland et al., in press). This level of professional association control is consistent with the model structure advised by the International Confederation of Midwives and multiple national-level stakeholders in the United States (Kennedy et al., 2018 as cited in Effland et al., in press). Rather than outlining a list of medications and devices in rule, the New Mexico midwifery regulatory authorities refer to “the definition and scope of practice established by the professional midwifery associations and the national certifying bodies” to define the scope of practice of midwives (Kennedy et al., 2018, p. 657 as cited in Effland et al., in press).

The Certified Nurse Midwife (CNM)/Certified Midwife (CM) scope of practice includes well-person SRH care throughout the lifespan including pregnancy and birth (Marzalik et al., 2018; Zell, 2021). CNMs have prescriptive authority in all 50 states, American Samoa, Guam, Puerto Rico, the U.S. Virgin Islands, and the District of Columbia, although their independence in practice varies from state to state (ACNM, 2019; Osborne, 2015; Zell, 2021). In some states, CMs have equivalent prescriptive authority to that of CNMs, while in others it is regulated independently (Osborne, 2015; Zell, 2021).

Factors to Address

Address the following (refer to RCW 18.120.030 for more details):

Executive Summary

Access to sexual and reproductive health (SRH) care is instrumental in improving public health outcomes and maintaining reproductive autonomy. The 14 major U.S. professional organizations related to family planning, reproductive medicine, obstetrics, and nurse-midwifery are in agreement that adequate access to full-spectrum SRH care is vital to individual and population health (American College of Nurse-Midwives [ACNM], 2016; Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2017; Espey et al., 2019; Zell, 2021). In individual and joint statements, they acknowledge significant disparities and barriers, and support improving access to all SRH services (ACNM, 2016; American College of Obstetricians and Gynecologists [ACOG], 2018b, 2019a; AWHONN, 2017; Espey et al., 2019; Zell, 2021). Currently, access to such care in the U.S. is inadequate, as evidenced by the fact that more than 35 percent of U.S. pregnancies are unintended; syphilis, gonorrhea, and chlamydia rates are higher than they have ever been; and breast and cervical cancer mortality, which is reduced by adequate screening, accounts for the greatest number of cancer-related deaths among those aged 20-39 (Bowen et al., 2019; Centers for Disease Control and Prevention, 2019; Curry et al., 2018; Finer & Zolna, 2016; Myers et al., 2015; Peirson et al., 2013; Siegel et al., 2016; Zell, 2021). Significant population-based disparities exist, with care utilization often lowest and associated outcomes worst among Blacks, Latinxs, Native Americans, low-income individuals, and other historically underserved groups (Blackwell et al., 2008; Finer & Zolna, 2011, 2016; Kavanaugh & Jerman, 2018; Siegel et al., 2016; Zell, 2021).

Access to healthcare impacts outcomes (Zell, 2021). Timely diagnosis and appropriate treatment of sexually transmitted, urogenital, and breast infections reduce their associated morbidities (Angelopoulou et al., 2018; Workowski & Bolan, 2015; Zell, 2021). Provision of effective contraception decreases the personal and societal burden of unintended pregnancy and short interpregnancy intervals, while screening for cervical and breast cancers reduce their incidence and high mortality rates (Curry et al., 2018; Huynh et al., 2013; Myers et al., 2015; Zell, 2021). Additionally, health education by providers improves use of contraception, compliance with preventive care, and duration of lactation (Lopez et al., 2016; Zell, 2021).

One method of increasing access to healthcare is increasing the number of qualified providers (U.S. Department of Health and Human Services, 2019; Zell, 2021). LMs are one eligible profession that is well-suited to provide more SRH care than the current law allows. LMs provide continuity-model primary care during pregnancy, childbirth, and the postpartum period (North American Registry of Midwives, 2019b; Zell, 2021). Despite providing preventive services including pelvic exams, diagnosing infections, and educating clients about treatments, LMs are

not able to offer treatments for those same infections or prescribe and manage contraception (Marzalik et al., 2018; Zell, 2021). Similar restrictions to autonomy and full-scope care in other analogous U.S. health professions decreases utilization of their services, worsens health outcomes, and affects the number of providers by disincentivizing moving to these states to practice and even motivating providers from these restrictive jurisdictions to relocate to other states with fewer restrictions (Markowitz et al., 2017; Neff et al., 2018; Perry, 2012; Ranchoff & Declercq, 2020; Yang et al., 2016; Zell, 2021). The inability to provide comprehensive care to their clients prevents midwives from utilizing the strengths of their high-satisfaction, continuity-focused care to improve reproductive health outcomes (Scrimshaw & Backes, 2020; Zell, 2021).

Midwives in other high-income countries often have broader scopes of practice than LMs and/or have mechanisms by which to expand autonomy and access to medications and contraceptives (Australian College of Midwives, 2016; New Zealand College of Midwives, 2014; Ordre des Sage-Femmes, 2017; Stewart et al., 2012; Wilson et al., 2018; Zell, 2021). Either sufficient pre-service training or post-registration continuing education is utilized to ensure competency.

Apart from practice authority, integration of midwives into the healthcare system has implications for public health and the midwifery profession (Zell, 2021). Indicators of integration include regulatory and statutory barriers to practice for all types of midwives, autonomy, public insurance coverage, and inclusion of community birth settings into quality improvement processes, among others (Vedam et al., 2018; Zell, 2021). Greater state-level integration is associated not only with increased access to perinatal care and numbers of midwives, but also decreased neonatal deaths, cesareans, and preterm deliveries and higher rates of breast/chestfeeding (Vedam et al., 2018; Zell, 2021).

Based on these findings, it is clear that increasing autonomy and decreasing barriers to full-scope practice for LMs is a logical way to increase access to perinatal and SRH care across the population (Balasa, 2017; Neff et al., 2018; Zell, 2021). As a 2020 National Academies report asserted, “The wide variation in regulation, certification, and licensing for nonphysician providers across the United States impedes access to high-quality” perinatal care (Scrimshaw & Backes, 2020, p. 136 as cited in Zell, 2021). Decreasing barriers to practice and increasing autonomy for midwives in individual states sets a precedent for other states to follow suit (Zell, 2021). If LM practice authority was expanded, midwives may be more attracted to work in states with broader scope and better able to address disparities in access to both perinatal and SRH care (Scrimshaw & Backes, 2020; Zell, 2021). In the long term, a more viable profession may attract greater numbers and diversity of individuals to become LMs, in turn conferring the benefits of community-based midwifery care to a greater proportion of the population (Zell, 2021).

1. Define the problem and why the change in regulation is necessary (refer to RCW 18.120.030(1)).

A. Why midwives need to provide contraception

The literature below addresses the following problems:

- The rates, problems, and sequelae associated with unintended pregnancy, and unintended pregnancy as a result of inconsistent or non-use of contraceptives;
- The rates, problems, and sequelae associated with commonly occurring prenatal and postpartum conditions if left untreated;
- The costs, both economic and personal, of both;
- The provider shortage gap, both current and anticipated for sexual and reproductive health (SRH); and
- How the restriction of scope on licensed midwives (LMs) prevents LMs from providing the aforementioned care and services even though they already offer related services to childbearing persons in every county in WA state.

The literature below also outlines why the change in regulation is needed, namely how it promotes

- Optimal health outcomes for childbearing persons in Washington State, especially those in rural and marginalized communities.

Unplanned Pregnancy is Preventable with Improved Access to Preferred & Effective Contraception Through a Chosen Provider

Nearly 35% of all pregnancies in the U.S. are unintended, meaning pregnancies that are either mistimed, unwanted, or unplanned at the time of conception (Segadelli, 2016; Zell, 2021). In Washington State, more than one-third of all births result from unintended pregnancies (Cawthon, 2015; Segadelli, 2016). While the rate has declined slowly, in 2014, over 21,000 births to women receiving Medicaid in Washington State occurred following an unintended pregnancy, just over half of the total of the state's Medicaid births (41,809) (Cawthon, 2015; Segadelli, 2016). Nearly half of all unintended pregnancies occur in pregnant people who are currently not using contraception, despite an expressed or implied desire to avoid pregnancy (Blumenthal et al., 2010; Segadelli, 2016).

Unintended pregnancies have significant health implications for pregnant people and children, and have been correlated with a higher risk of maternal mortality and morbidity, higher rates of perinatal mood disorders, increased adverse health behaviors, increased intimate partner violence, higher rates of preterm birth and low birth weight infants, inadequate or

untimely prenatal care, decreased rates of breastfeeding initiation and duration, and adverse mental and physical health impacts in children (Abajobir et al., 2016; Blumenthal et al., 2010; Gipson et al., 2008; Guttmacher Institute, 2015a; Segadelli 2016; Zell, 2021). The overwhelming consensus of reproductive literature and public health initiatives supports that increased contraceptive uptake and continued, consistent use of contraception decreases the rates of unintended pregnancies and its sequelae (Segadelli, 2016; Sundaram et al., 2017; Zell, 2021). Contraceptive use, particularly that of long-acting reversible contraception (LARC), is a key metric of access to care (Zell, 2021). Currently, contraceptive use in the United States falls behind the need, with especially low rates for teens and those under age 25, Blacks and Latinxs, low-income individuals, and people with inconsistent insurance coverage (Frederiksen et al., 2017; Zell, 2021). Estimates of overall use rates are between 60-65%, are lower among teens, Blacks and Latinxs, and have not increased in the past ten years (Daniels & Abma, 2018; Kavanaugh & Jerman, 2018; Zell, 2021).

One effect of inadequate contraceptive services and uptake includes the choice to seek an induced abortion when an unintended pregnancy occurs, which can have negative health impacts in places where skilled providers are scarce (Blumenthal et al., 2010; Segadelli, 2016). In Washington State, 64% of counties do not have an abortion provider (Guttmacher Institute, 2014; Segadelli, 2016). For individuals living in these areas, access to timely, effective contraceptive services may be the only strategy in planning and spacing their pregnancies (Segadelli, 2016). Efforts to reduce the incidence of induced abortion while optimizing health are worthy of consideration; more access to modern contraceptive methods is one (and perhaps the most important and efficacious) legal and scientifically valid way to achieve the goal of fewer abortions (Segadelli, 2016).

The interval between a previous delivery and the following pregnancy is referred to as the interpregnancy interval (IPI); short IPIs are associated with unintended pregnancy (Ahrens et al., 2018; Zell, 2021). More than 75% of U.S. pregnancies occurring within one year of the most recent birth are unintended (White et al., 2015; Zell, 2021). IPIs less than 6 months are associated with increased rates of preterm birth, small for gestational age, and infant mortality; while IPIs less than 12 months show increased risk of autism, developmental delays, and cerebral palsy in the offspring (Ahrens et al., 2019; Conde-Agudelo et al., 2016; Zell, 2021).

Unplanned pregnancies and the resulting births also present significant costs to taxpayers. More than double the percentage of unintended versus planned births are funded by public insurance, and estimates of annual taxpayer costs per year are in the range of $11 billion (Monea & Thomas, 2011; Sonfi et al., 2011; Zell, 2021). Unintended births have been identified as one of the primary contributors to the high costs of pregnancy in the U.S. healthcare system (Huynh et al., 2013; Zell, 2021).

The U.S. census (2014) projects that nearly 44 million more people of childbearing age will require healthcare by the year 2060. The majority of childbearing people in America currently receive their preventative and reproductive healthcare from obstetricians/gynecologists (ob/gyns), but the ob/gyn workforce is aging and ob/gyns are working fewer hours than in the past (ACNM, n.d.; Segadelli, 2016). In addition, the number of medical graduates entering ob/gyn residencies has remained largely stagnant and unchanged for nearly three decades, thus not increasing concurrently with the increasing needs of reproductive-aged individuals (Rayburn & Tracy, 2016; Segadelli, 2016). Of medical graduates entering ob/gyn residencies, the number choosing subspecialties out of the realm of general SRH (such as female pelvic medicine and reconstructive surgery, or reproductive endocrinology and infertility) is increasing; in 2000, only 7 percent of ob/gyn residents entered subspecialties, but that number jumped to nearly 20 percent in 2012 (Rayburn, 2011; Rayburn et al., 2012; Segadelli, 2016). Many of these subspecialties may cease providing "traditional" obstetrical and gynecological care, including antepartum and postpartum care, and contraceptive services. Combined with the already-projected shortage of primary care providers, this trend makes a clear case for reevaluating the delivery of essential, basic SRH services in the United States. Licensed midwives can be part of the solution to the reproductive healthcare workforce crisis.

Limited access to physicians and limitations on the type of providers who can administer contraceptive services and prevent and treat common perinatal and postpartum conditions, as well as delays in access to care, are widely recognized as reasons for low usage of contraceptives and adverse health outcomes (Segadelli, 2016). In 2004, the percentage of access to physicians with same-day appointments in the United States was 33%, behind the UK (41%), Australia (54%), and New Zealand (60%) (Blumenthal et al., 2011; Guilbert et al., 2011; Segadelli, 2016). This results in an over-reliance on emergency departments, which is both inefficient and costly.

The reasons for contraceptive use or lack of use are numerous and complex, but satisfaction with care providers and consistent contact with a single care provider appear to have a significant impact on continued contraceptive use (Guttmacher Institute, 2008; Segadelli, 2016). The Midwives' Model of Care™ is client-centered and promotes elements central to public and personal health that may be critical to effective family planning services initiation and maintenance (ACNM, 2012; Collins et al., 2015; MEAC, 2014; Segadelli, 2016). Despite this, LMs remain underutilized in the delivery of contraceptive services in Washington State.

According to RCW 18.50.040, candidates for midwifery licensure in Washington must have a minimum period of three years of midwifery training that includes "basic nursing skills" and education in obstetrical pharmacology, family planning and gynecology. Moreover, the WAC Legend Drug and Devices for Licensed Midwives states that "Pharmacies may issue…diaphragms and cervical caps ordered by licensed midwives" (WAC 246-834-250(2) as cited in Segadelli, 2016). It may be concluded from the aforementioned that contraceptive services have, at least in part, been contemplated as appropriately placed within the licensed midwife's scope of

practice. Of note, the language regarding diaphragms and cervical caps was written in 1991, at a time when these contraceptive devices were far more popular than they are today; the law was also changed in 2004 to remove language that limited the provision of diaphragms and cervical caps to postpartum people (Segadelli, 2016; WSR 04-24-086x). Advances in more effective and acceptable contraceptives have resulted in these barrier methods losing popularity with individuals; in 1960, nearly 25 percent of women used the diaphragm, but by 2002, it's prevalence, along with other female-controlled barrier methods, had decreased to less than 1 percent (Corson et al., 1994; Guttmacher Institute, 2015b; Mosher et al., 2004; Segadelli, 2016). If the original contemplation of this regulation was to accommodate the contraceptive needs of individuals, and the role midwives may play in addressing those needs, then it is appropriate that the language be revised to reflect advances in contraceptive technology and changes in preferred contraceptive methods.

B. Why Midwives Need to be Able to Treat Common Conditions

Requiring Additional Visits for the Treatment of Common Pregnancy and Postpartum Conditions is Costly, Inefficient and Risks Loss to Follow-up

In the low-risk childbearing population that midwives autonomously and effectively serve, immunosuppression and its impacts are common and should be treated and managed as such in a timely, cost-effective, and patient-centered way. The following are examples of common perinatal conditions and infections that may be routinely found in a low-risk population of childbearing persons:

- Common infections treatable with antibiotics: The pregnant and postpartum body is particularly susceptible to viral and gram-negative bacterial infections (such as gonorrhea, chlamydia, and urinary tract infections). Breast infections in the postpartum period are also fairly common and readily treatable.
- UTIs treatable with antibiotics: Increased estrogen and progesterone can also lead to an immunosuppressive state, particularly in the urinary tract.
- Urogenital infections treatable with antifungals or antibiotics: Progesterone increase in pregnancy can lead to increased alkalinity of the vagina, which can cause an overgrowth of normally harmless bacteria that takes on more clinical significance in the pregnant state. Similarly, the increased alkalinity of the vagina also leads to a decrease in vaginal flora diversity, making the vagina more prone to infections.

Sexually Transmitted Infections Treatable with Antibiotics

According to CDC data, rates of sexually transmitted infections (STIs) are rising in the United States, and the number of cases of syphilis, gonorrhea, and chlamydia in 2018 was the

highest it had ever been (Bowen et al., 2019; Zell, 2021). Congenital and newborn syphilis cases, as well as syphilis cases among people with vaginas of reproductive age, each increased by over 36% between 2017 and 2018, and deaths from congenital syphilis were 22% higher in 2018 (Bowen et al., 2019; Zell, 2021). Overall STI rates are highest among those ages 15-24, and chlamydia, gonorrhea, and syphilis are all more common in cisgender women than men (Bowen et al., 2019; Zell, 2021).

Early detection and treatment are crucial, as sequelae of untreated cases (in addition to mortality for some STIs) include significant morbidity such as infertility, coinfection with HIV and other diseases, and stigmatization (Rutstein et al., 2017; Zell, 2021). Treatment is especially critical before and during pregnancy, because STIs increase rates of adverse outcomes for both gestational parent and the fetus/newborn (Goldenberg et al., 1997; Workowski & Bolan, 2015; Zell, 2021). Simple and effective treatment protocols are available for most sexually transmitted infections, particularly during early disease stages (Bowen et al., 2019; Workowski & Bolan, 2015; Zell, 2021). STI testing, treatment and subsequent health complications cost the U.S. healthcare system billions of dollars each year, and these costs would be even greater without the prevention and treatment programs that are already in place (Kwame et al., 2013; Zell, 2021). An analysis of 2014-2015 National Center for Health Statistics data showed that Medicaid paid for a disproportionately high number of STI-related appointments (Pearson et al., 2019; Zell, 2021).

Urogenital Infections Treatable with Antibiotics or Antifungals

Urogenital infections including urinary tract infections (UTIs), bacterial vaginosis (BV), and vulvovaginal candidiasis (VCC) are common in pregnancy and are the single largest reason for outpatient medical visits requiring treatment that may include antibiotics or antifungals (Schappert & Rechtsteiner, 2011; Zell, 2021). These infections can increase the chance of pregnancy and newborn complications and require appropriate and timely treatment (Schappert & Rechtsteiner, 2011; Zell, 2021). Sequelae of inadequate, absent, or delayed treatment of urinary infections includes recurrence as well as kidney infection and its associated complications: kidney injury, sepsis, and septic shock (Johnson & Russo, 2018; Kolman, 2019; Zell, 2021). UTIs during pregnancy are particularly consequential as they are associated with a higher preterm birth rate; hence, screening and treatment for asymptomatic bacteriuria is recommended for all pregnant people and routinely done by licensed midwives during care already (Henderson et al., 2019; Szweda & Jóźwik, 2016; Zell, 2021).

As the most widespread cause of vaginal symptoms among those ages 15-44, BV, which is an intravaginal bacterial imbalance, represents a significant SRH concern (Koumans et al., 2007; Zell, 2021). Both symptomatic and asymptomatic cases are associated with increased risk of multiple conditions including co-infection with HIV, cervical HPV, chlamydia, gonorrhea, and trichomonas; cervical intraepithelial neoplasia, a precursor to cervical cancer; and possibly pelvic inflammatory disease, although research on the latter is not definitive (Atashili et al., 2008;

Brotman et al., 2010; Gallo et al., 2012; Gillet et al., 2011, 2012; Taylor et al., 2013; Zell, 2021). BV is also associated with pregnancy complications, namely preterm birth, spontaneous abortion, and infection of the laboring person (Leitich et al., 2003; Zell, 2021). BV is more common among those of Latinx ethnicity and Black race than among non-Hispanic Whites, and may therefore contribute to disparities in the other aforementioned outcomes particularly when untreated (Koumans et al., 2007; Zell, 2021). All symptomatic and/or pregnant individuals with BV should be treated to relieve symptoms and reduce risks, and treatment of asymptomatic cases should be considered as well in light of the associated morbidity (Workowski & Bolan, 2015; Zell, 2021).

VCC, typically caused by *Candida albicans*, affects the majority of people with vulvas and vaginas worldwide during their life, and many also suffer from recurrent episodes (Blostein et al., 2017; Denning et al., 2018; Zell, 2021). Overgrowth of the fungal organisms is more common during pregnancy and is associated with an increased rate of preterm delivery; appropriate treatment likely reduces this risk (Roberts et al., 2015; Zell, 2021). Not only is VVC uncomfortable, it impacts psychological wellbeing, sexual activity, depression and anxiety risk, and several other quality-of-life measures when recurrent (Fukazawa et al., 2019; Zell, 2021). Economic losses due to decreased productivity related to recurrent VVC are significant in high-income countries such as the U.S. (Denning et al., 2018; Zell, 2021). Antifungal treatments are available over-the-counter and are widely accessed for self-treatment, but are often used inappropriately and may be ineffective (Sihvo et al., 2000; Zell, 2021). Access to education, diagnosis, and treatment by trained providers would increase treatment effectiveness and decrease impacts on quality of life (Theroux, 2005; Workowski & Bolan, 2015; Zell, 2021).

Breast Infections Treatable with Antibiotics or Antifungals

Thrush, mastitis, and other infections of the breast are common complications of postpartum and lactation (Angelopoulou et al., 2018; Zell, 2021). When untreated, mastitis can result in abscesses and other complications (Irusen et al., 2015; Jahanfar et al., 2013; Zell, 2021). Mastitis and breast pain are also common reasons for early cessation of breast/chestfeeding (Gianni et al., 2019; Morrison et al., 2019; Zell, 2021). Lactation is crucial for both parent and infant health. For the infant, human milk consumption is associated with decreased respiratory and diarrheal infections and associated mortality, higher IQ scores, and fewer dental malocclusions and ear infections (Bosnjak & Grgurić, 2013; Horta & Victora, 2013; Victora et al., 2016; Zell, 2021). For the lactating parent, breast/chestfeeding is protective against breast, ovarian, and endometrial cancer; increases interpregnancy intervals; decreases rates of postpartum depression; reduces future risk of diabetes mellitus; and improves cardiovascular health (Ip et al., 2009; Jordan et al., 2017; Nguyen et al., 2017; Victora et al., 2016; Zell, 2021). Low-income individuals are at greater risk for early breastfeeding discontinuation, and cite similar reasons as do broader population samples; decreasing barriers to discontinuation, including improving access to mastitis treatment, could help reduce this gap (Hornsby et al.,

2019; Zell, 2021). There is widespread agreement that feeding an infant human milk for the first year of life is essential for optimal health, and continuing lactation into the child's 2nd year and beyond is beneficial (American Academy of Family Physicians [AAFP], 2014; American Academy of Pediatrics [AAP], 2012; Zell, 2021).

C. Access to healthcare impacts outcomes

Timely diagnosis and appropriate treatment of sexually transmitted, urogenital, and breast infections reduce their associated morbidities (Angelopoulou et al., 2018; Workowski & Bolan, 2015; Zell, 2021). Provision of effective contraception decreases the personal and societal burden of unintended pregnancy and short interpregnancy intervals, while screening for cervical and breast cancers reduce their incidence and high mortality rates (Curry et al., 2018; Huynh et al., 2013; Myers et al., 2015; Zell, 2021). Additionally, health education by providers improves use of contraception, compliance with preventive care, and duration of lactation (Lopez et al., 2016; Zell, 2021).

One method of increasing access to healthcare is increasing the number of qualified providers (U.S. Department of Health and Human Services [DHHS], 2019; Zell, 2021). LMs are one eligible profession that is well-suited to provide more SRH care than the current law allows. By reorganizing tasks and optimizing a "skill mix" of healthcare providers best suited in the delivery of particular services, such as sexual and reproductive care, health care advocates and policymakers "...make better use of existing human resources and expand and strengthen coverage of key health interventions" (Colvin et al., 2013, p. 1211 as cited in Segadelli, 2016).

2. Explain how the proposal addresses the problem and benefits the public (refer to RCW 18.120.030(4)).

Many conditions occur and arise commonly within the context of a low-risk pregnancy; the inability to prevent, treat, and prescribe for these conditions is a barrier to accessible care for the reproductive population licensed midwives serve. This proposal creates a voluntary pathway to appropriate education and regulation for licensed midwives to supply needed components of routine perinatal care. It acknowledges the minimal additional training necessary for LMs to fill the growing need for additional SRH providers while respecting that not all LMs may desire to engage in SRH care in the pregnant and postpartum period, a model that mirrors that in comparable high-resource settings with excellent reproductive health outcomes, such as British Columbia, Canada.

Licensed midwives are responsible for the healthcare needs of low-risk pregnant people experiencing healthy pregnancies. The current restrictions on the LM scope of practice inhibiting the ability to prescribe for, treat, prevent, and manage commonly occurring prenatal and postpartum conditions, including family planning services, unduly burden the public and the healthcare system. As a result of these restrictions, LMs are prevented from practicing to the full responsibility contemplated by statute and rule forcing childbearing members of the public to schedule additional appointments with other care providers for medications and devices deemed essential by the World Health Organization. The loss to follow-up that can occur as a result of this fracturing of care is significantly more likely to impact already vulnerable and marginalized populations. This proposal not only addresses these problems but also offers the following well-documented benefits to the public:

- Continuity of care
- Optimal birth spacing enabled by increased access to contraception and contraceptive uptake
- Timely cost-effective treatment of common STIs, UTIs, and other urogenital and/or breast/chest infections
- Increased access to care that meets the Triple Aim (improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations) (Berwick et al., 2008).

A. This Proposal Provides Increased Effectiveness Through Continuity of Care

Continuity of care increases adherence to treatment and patient satisfaction while reducing loss to follow-up. It is vital to decreasing unnecessary additional visits to urgent care or emergency departments and improves resolution of complaints. The midwifery model of care centers around client-provider continuity as a means of fostering trust and increasing safety

(MANA, 2016; Zell, 2021). The midwifery continuity model results in increased satisfaction, equal or better parent-infant outcomes, decreased interventions, and lower costs when compared to other perinatal care models (Sandall et al., 2016; Zell, 2021). A systematic review showed that midwifery clients' preference for continuity was based on the development of trust, personalized and relational care, and resulting confidence and empowerment (Perriman et al., 2018; Zell, 2021). This proposal takes advantage of this continuity of care to reduce costs and waste by enabling the prevention & efficient treatment of common conditions identified by midwives. Since clients might not attend an additional visit with another provider due to cost or insurance obstacles, time, inconvenience, transportation barriers, or new provider trust issues, it also prevents the delay in care and loss to follow-up that can occur when care needs to be sought from a different provider than one's midwife.

Continuity of care is a quality construct recognized in the medical profession as well (Zell, 2021). Interpersonal continuity of client care by primary care providers increases preventive care utilization, decreases hospitalizations and emergency department visits, and improves satisfaction (Adler et al., 2010; Cabana & Jee, 2004; Saultz & Albedaiwi, 2004; Saultz & Lochner, 2005; Van Walraven et al., 2010; Zell, 2021). Continuity with a physician regardless of specialty is associated with decreased mortality (Gray et al., 2018; Zell, 2021).

Likely related to both continuity and other characteristics of midwifery care, community-based midwifery clients have a very high satisfaction rate of 97%, (Johnson & Daviss, 2005; Zell, 2021). A participatory action research project conducted by the collective Black Women Birthing Justice found that midwifery clients were more likely to report receiving trusting, supportive, and empowering care than were clients of other provider types (Oparah et al., 2016; Zell, 2021). Client satisfaction is an essential indicator of healthcare quality that is determined predominantly by interpersonal provider qualities (Batbaatar et al., 2017; Zell, 2021). Those who are satisfied with their medical providers are more likely to adhere to preventive care recommendations including vaccination and breast/cervical cancer screening (Jerant et al., 2014). Provider-client communication quality also increases breast and cervical cancer screening compliance (Peterson et al., 2016; Zell, 2021). Satisfaction with one's healthcare provider, and consistent contact with a single healthcare provider have a statistically significant impact on initiation and continuation of contraceptive use (Guttmacher Institute, 2008; Segadelli, 2016).

Improving postpartum visit utilization is advised by ACOG (2018) due to the importance of follow-up care in increasing contraceptive use and decreasing morbidity from chronic health conditions (Zell, 2021). The National Committee for Quality Assurance (2019) reported that only 63% of Medicaid recipients attended a postpartum visit between 3-8 weeks after birth in 2018, with those on commercial (Zell, 2021) insurance plans attending at the higher but still unsatisfactory rates of 69% and 76%, respectively (Zell, 2021). Several other studies have found similarly poor rates of postpartum follow-up for Medicaid recipients as well as for those with private insurance or no insurance (Bennett et al., 2013; Masho et al., 2016; Weir et al., 2011;

Wilkinson et al., 2018; Zell, 2021). Visit attendance for individuals with pregnancy-related conditions such as hypertensive disorders and diabetes are of particular concern (Zell, 2021). Follow-up in this high-risk group is lower among people with mental health conditions, Black and Latinx individuals, and those with low educational attainment (Jones et al., 2019; Zell, 2021). Disparities in postpartum follow-up care utilization for all pregnancies have been found based on disability, parity, substance abuse, income, marital status, inadequate prenatal care, Medicaid insurance, age, and employment status (Baldwin et al., 2018; Dibari et al., 2014; Weir et al., 2011; Zell, 2021). Continuity and satisfaction may influence return to care in the postpartum period, another benefit to the public offered by this proposal (Zell, 2021). Although no research has been conducted on postpartum visit attendance for community midwives, informal discussions with direct-entry midwives reveal that it is rare for a client to not complete their entire course of postpartum care (Zell, 2021).

B. This Proposal Increases Access to Contraception and Contraceptive Uptake which results in Optimal Birth Spacing

Given the role service providers play in contraceptive compliance, it stands to reason that midwifery-led care, with its strong focus on relationship-building, client-centeredness, and an expansive postpartum care schedule (compared to traditional obstetric models), fosters an environment which may increase contraceptive prevalence and compliance (Segadelli, 2016). The American College of Nurse-Midwives administered a survey in 2013 regarding reproductive health care experiences and perceptions in family planning and contraception and found that "many [people] said they felt rushed or pressured to make a decision, and that they did not have adequate time to explore options beyond what was first recommended by their health provider" and that "they faced barriers to having follow-up conversations with their providers about side effects they were experiencing or their desire to switch birth control methods, including long wait times to schedule an appointment or difficulty getting their provider on the phone" (ACNM, 2013, p. 2 as cited in Segadelli, 2016). From these findings and others, the ACNM asserts that "midwives are uniquely positioned to address the knowledge and service gap in birth control and family planning for U.S. [reproductive individuals]," as they provide "personalized services tailored to each [person's] unique needs—a style of care that is especially suited to assist [people] in making important birth control and family planning decisions" (ACNM, 2013, p. 4 as cited in Segadelli, 2016).

This proposal aims to take advantage of LM patients' existing high return rate for postpartum care and the fact that postpartum persons report better birth control education from midwives than other obstetrical providers (Declercq et al., 2014; Segadelli, 2016). Additionally, the individualized care and respectful client-provider relationships that improve effectiveness and satisfaction with contraceptive counseling are core aspects of the midwifery model of care

(MANA, 2016; Zell, 2021). It is therefore reasonable to conclude that if LMs were able to provide contraceptives at preexisting postpartum visits, their clients would be at lower risk for unintended pregnancies, be better educated about and more satisfied with their family planning, and the related healthcare costs of attending additional appointments would be mitigated (Zell, 2021).

Postpartum people are already in an episode of health care and are thus a "captive audience"—a public health concept aimed at increasing delivery of services to people at times they are naturally interfacing with the health care system to increase health promotion efforts (Edvardsson et al, 2011; Segadelli, 2016). This proposal maximizes what can be achieved during this time when many postpartum people are naturally interacting with midwives as their primary SRH providers or primary care providers. Midwives are currently situated to provide information, counseling and education around contraceptive and family planning options as a routine part of postpartum care (MEAC, 2014; Segadelli, 2016). The evidence from several systematic reviews suggests that antenatal contraceptive education and options counseling, as well as earlier prenatal care, home visitation schedules, and intense or substantial interaction with maternal health care providers increases the likelihood of contraceptive uptake and thus serves to optimize birth spacing (Borda & Winfrey, 2010; Sonalkar et al., 2014; Segadelli, 2016). The Midwives' Model of Care™, with its extended prenatal visits (for many, up to one hour of time with the care provider) and focus on client education, client self-determination, and shared decision-making provides an optimal opportunity for contraceptive counseling, education, and provision (Segadelli, 2016).

Provision of all forms of non-permanent contraception by LMs during the postpartum period benefits the public because it increases access to contraception (Zell, 2021). Implications for U.S. public health include increased overall contraceptive use as well as decreased healthcare costs due to a reduction in unintended pregnancy (Foster et al., 2015; Zell, 2021). This proposal also aims to ensure that families who choose licensed midwives for their care can elect all forms of non-permanent contraception through their LM because oral contraceptive pills (OCPs), while not as effective in preventing pregnancy, are utilized by a greater proportion of the U.S. population than are LARC methods (Daniels & Abma, 2018; Mansour et al., 2010). OCPs are particularly popular among those under age 30; between 2015-2017, 16.6% of people with uteruses between ages 15-19 and 19.5% of those ages 20-29 were using OCPs, higher than any other method (Daniels & Abma, 2018; Zell, 2021).

By granting LMs the ability to prescribe and/or insert all forms of contraceptives, with adequate training in their use, Washington State would confer midwifery patients access to their desired method from a healthcare provider they have purposefully chosen, and therefore the ability to more effectively and autonomously control their family size and meet their other SRH goals (Zell, 2021). While providing over-the-counter access for oral contraceptives would increase accessibility even beyond that enabled by this proposal, increasing the number of providers able

to prescribe OCPs is the next-best option (Zell, 2021). For example, pharmacists are permitted to prescribe hormonal contraception in several states, and the majority of pharmacists are interested in doing so, but significant barriers to implementation remain even after legislation is passed (Rafie et al., 2019; Zell, 2021). As providers who already counsel about family planning methods and sexual health and perform reproductive health examinations and screening tests, this proposal allows LMs to provide an alternative or adjunctive solution (Zell, 2021).

Washington State has long been a leader of innovative family planning programs (Cawthon, 2015), and has "a particularly strong history of supporting the development of the direct-entry midwifery profession as well as choice and access to care for childbearing women" (Midwives' Association of Washington State [MAWS], 2011a as cited in Segadelli, 2016). Licensed midwifery care is client-centered and promotes elements central to public and personal health that may be critical to effective family planning services (ACNM, 2012; Collins et al., 2015; MEAC, 2014; Segadelli 2016). "The midwifery hallmarks that make midwives exceptional providers of maternity care, such as incorporation of scientific evidence into clinical practice and empowerment of [individuals] as partners in health care, are also qualities that make midwives ideal providers of gynecologic care" (Likis, 2012, p. 545 as cited in Segadelli, 2016). LMs in Washington State are optimally positioned to step into a role as contraceptive care providers. Expansion of access to these services is an essential preventative health measure for Washington's childbearing people and this proposal would help the state achieve this goal.

C. Patients will benefit from Timely Cost-Effective Treatment of STIs, UTIs, and Other Urogenital and/or Breast/Chest Infections

As perinatal care providers who diagnose STIs, UTIs, other urogenital infections, and breast infections during the childbearing year, LMs could decrease the morbidity from these conditions if they had the ability to treat them as well (Zell, 2021). As discussed previously, the need for treatment during pregnancy and the postpartum period is often both time-sensitive and crucial due to significant risks to the parent and/or fetus (Zell, 2021). LMs currently must refer clients to a different provider with prescriptive authority for treatment, but the need to attend an additional appointment is a barrier that may both delay care and increase personal and systemic healthcare costs (Kwame et al., 2013; Zell, 2021). Some clients may not attend an extra visit at all, electing to use natural remedies or forego treatment, due to concerns about insurance coverage, out-of-pocket costs, inconvenience, or transportation difficulties (Abdel-Aleem et al., 2016; Blanchard et al., 2008; Vang et al., 2018; Zell, 2021). By permitting LMs to prescribe medications for the prevention and treatment of common conditions during the prenatal, intrapartum, and postpartum periods, this proposal would increase client safety and choice (Zell, 2021).

D. Families Across Washington State will Benefit from Improved Access to Care

All families but especially those living in rural and urban perinatal care shortage areas stand to benefit when the licensed midwives they choose can offer them ready access to the medications and devices relevant to their low-risk perinatal care. This improved access to midwives who can practice to the full extent of their areas of competence has the potential to improve health, health equity, and consumer choice. A recent midwifery-focused series published in The Lancet (2014) found that midwifery-led care is cost-effective, affordable, and sustainable, and that supporting a system-level shift in the delivery of maternal and SRH is essential to meeting the still outstanding healthcare needs of communities (Segadelli, 2016). In summary, The Lancet findings support the assertion that educated, trained, licensed, and regulated midwifery care is associated with efficient use of resources and improved maternal and child health outcomes, and that such care is most effective when midwives are integrated into larger healthcare systems (Effland, 2016; Segadelli, 2021). This proposal seeks to improve midwifery integration into the healthcare system in Washington State for the benefit of families.

The current healthcare system in the U.S. is the most expensive in the world (IHI, 2016). In addition, people living in the U.S. suffer more chronic and expensive health conditions than ever before (IHI, 2016). This necessitates a reimagining of how certain healthcare services are provided, and by whom. This proposal does just that. As discussed above, more primary care providers are moving into specialties and out of basic preventative medicine, including in the field of ob/gyn, which has historically provided the vast majority of women's healthcare in this country (Rayburn, 2011; Rayburn & Tracy, 2016; Rayburn et al., 2012; Segadelli, 2016). It is projected that Washington State will need a 32% increase in primary care providers, by 2030 to meet the State's growing healthcare demands (Peterson et al., 2013), an issue that will be particularly salient for already medically underserved areas and rural communities. It can be reasonably assumed that highly specialized providers are more costly to train, maintain, and to acquire services from than general practitioners and LMs that are highly trained and qualified to perform a vast majority of preventative healthcare tasks. Because many midwives train within and stay in their own community, these midwives could be crucial to filling the projected provider shortage gap and this proposal helps to ensure they will be better prepared to do so.

In addition, midwives are already educated about and well-versed in the specific psychosocial and physiological concerns unique to pregnant and postpartum people (MEAC, 2014; Segadelli, 2016). The relationship formed with patients through the antepartum, intrapartum, and postpartum periods, and the individualized care provided, makes midwives qualified (if not preferred) care providers to help individuals navigate all aspects of care common with a low-risk pregnancy and postpartum, including electing a contraceptive method that best suits their needs (Segadelli, 2016). This proposal enables clients to have access to these services through their LM and avoids them needing to seek care from a different provider risking delays and loss to follow-up (Pourat et al., 2015; Rivas, 2013; Segadelli, 2016; Wellings et al., 2012). The desires and self-determination of individuals can be respected and the barriers to access to care

can be remedied by expanding the midwife's scope to include provision of a wide variety of contraceptive services, in addition to the education and counseling already routinely provided, as well as care for common the prevention and treatment of common pregnancy and postpartum conditions as this proposal outlines.

E. Midwifery and the Triple Aim

Promoting the Midwifery Model of Care is one innovative and proven solution to address the U.S. health care system's soaring costs and less-than-optimal outcomes. There is growing recognition of the quality and value that midwifery brings to the maternity care system, a model of care that aligns perfectly with the so-called "Triple Aim." The Institute for Healthcare Improvement's (IHI) Triple Aim is a framework for optimizing health system performance. According to this framework, new designs must be developed to simultaneously achieve the following three goals:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Midwifery can and should be a part of these newly designed systems because as a profession licensed midwives are already uniquely prepared to attain the "Triple Aim." Patient satisfaction with midwifery-led care is high and does not sacrifice quality of care (numerous studies throughout North America and other similar resource-rich countries affirm this finding) (Johnson & Daviss, 2005). Data also supports the assertion that midwifery-led care improves long-term indicators of health and health promotion behaviors, such as higher rates of lactation at six weeks postpartum (as one example) (Renfrew et al., 2014). In addition, data continues to reveal the cost-savings of midwifery care. It is reasonable to assert that the well-established cost-savings of midwifery care would extend to other areas of preventative medicine if scope of practice were increased to include such services as outlined in this proposal. Doing so would also facilitate greater study as to the cost benefit of midwifery-led care outside of perinatal care exclusively.

Licensed midwifery care is desired by a growing number of families in Washington State, with LMs attending greater than five percent of the total births; this is over five times the national average of births attended at home or in freestanding birth centers, which has remained at about one percent (MAWS, 2016). For this population of individuals, midwives are de facto primary care providers, and often address these clients preventative healthcare needs while being simultaneously limited in their actual provision of contraception. As already noted, client satisfaction with midwifery care is high, and licensed midwifery care in Washington State is tremendously cost-effective. LMs in Washington State carry liability insurance and are represented by a well-established and active professional organization, the Midwives' Association of Washington State (MAWS), which includes a legally-protected Quality

Management Program (QMP) that allows for consistent and constant evaluation of the safety of midwifery practice and imposes sanctions and/or reparations for violations of those standards. Washington State provides a well-regulated environment for LMs, making it an ideal place to consider expansion of scope of practice to include limited prescriptive authority and other tasks in SRH as outlined in this proposal.

3. What is the minimum level of education and training necessary to perform the new skill or service based on objective criteria?

Based on a review of literature across various professions, Licensed Midwives could acquire the necessary skills to offer all contraceptive options and antibiotics for common perinatal infections in a 5-hour training, with time to competency for LARC insertions being approximately 4-5 insertions (Segadelli, 2016; Zell, 2021). This additional training would complement the training LM's must complete in order to qualify for state licensing. See *Appendix A.*

As mentioned above, CNMs in Washington State and in many places throughout the country enjoy full prescriptive authority. A gap analysis performed by Zell (2021), attached as *Appendix C*, demonstrates that minimal gaps exist between the competencies demonstrated by CNMs during their education and training (American College of Nurse Midwives (ACNM) competencies) and those achieved by midwives trained through institutions accredited by the Midwifery Education Accreditation Council (MEAC) (the pathway for most LMs in Washington State).The identified gaps are easily addressed with minimal continuing education or slight adaptations to pre-service midwifery training.

Engaging in risk assessment for appropriate contraceptive options and ability to assess contraceptive medical eligibility are arguably some of the most invaluable and important elements of safe, effective contraceptive service provision, and they are skills for which midwifery competency has already been established (MEAC, 2014; RCW 18.50.040; WAC 246-834-066; Segadell, 2016). Using an evidence-based approach, the CDC provides practice recommendations for contraceptive use and clearly describes tests and examinations that are necessary for safe and effective contraceptive provision (Segadelli, 2016). In assessing people for contraception, at least two elements are essential: people should not be pregnant at the time they begin contraception, and people should be engaged by care providers in a thorough discussion and review of health and obstetrical/gynecological history (Segadelli, 2016). Both of these (confirmation of pregnancy or lack thereof and review of health history) are skills midwives already engage in as part of routine prenatal care and risk assessment of clientele (MEAC, 2014; RCW 18.50.040; WAC 246-834-066; Segadelli, 2016).

Appendix B provides a list of tests and examinations that are necessary to increase safe and effective use of various contraceptive choices. The table also lists the midwifery core competencies that meet or surpass the skills and scope necessary to fully engage in the medical provision of care and risk assessment. Individuals with underlying health conditions or pathology may have different testing requirements, but this table presumes that most midwives are care providers for healthy, low-risk pregnant people without underlying health conditions, as required

by statute and rule (Segadelli, 2016). As stated above, beyond these tests and procedures, all women receiving contraception should undergo a thorough medical, lifestyle, and gynecologic health history review, which is already performed by most midwives when accepting individuals into their care (MEAC, 2014; Segadelli, 2016).

A national call for increasing access to oral contraceptives by permitting over-the-counter (i.e., non-prescription) access has been signed by over 100 organizations, including ACOG, ACNM, the American Academy of Nursing, and many advocacy groups focusing on reproductive rights for women and the LGBTQ+, Black, Indigenous, and Latinx communities (Oral Contraceptives Over the Counter Working Group, 2020; Zell, 2021). A systematic review showed that consumers and pharmacists support over-the-counter access to OCPs, as do physicians to a lesser degree (Kennedy et al., 2019; Zell, 2021). In fact, oral contraceptives are available without a prescription, whether formally or informally, in more than two-thirds of the 147 countries included in a global review (Grindlay et al., 2013; Zell, 2021). High-income countries, including the U.S., Canada, Australia, and the majority of Western Europe, are far more likely to require a prescription than are middle- or low-income countries (Grindlay et al., 2013; Zell, 2021). Consumers are generally able to self-screen effectively for contraindications, do not suffer from increased side effects, and have higher rates of use when OCPs are available over-the-counter (Kennedy et al., 2019; Zell, 2021). If individuals accessing OCPs can effectively self-screen for contraindications, surely trained healthcare providers such as LMs could safely prescribe this method (Zell, 2021).

4. Explain how the proposal ensures practitioners can safely perform the new skill or service

This proposal was developed after consulting existing models that have enabled the public to have access to essential medications and resources through their midwife. Precedent exists for license extension options that enable healthcare providers to complete continuing education or additional didactic and skills-based training requirements to facilitate families' increased access to high quality healthcare through their chosen provider.

For currently licensed midwives: continuing education of at least 5 hours (didactic and clinical) and evaluation processes. Certificate(s) of completion submitted to and approved by the licensing board.

For student midwives: education addressed within their current curricula (didactic and clinical) and evaluation processes. Adjustment to the Washington State licensure exam to cover new topic areas, and ensure all **incoming** LMs to Washington State have required competency.

Midwives from other jurisdictions seeking licensure in Washington State: submit verification of knowledge and skills with other application paperwork (may need to take continuing education similar to current WA LMs if necessary). At present, LM applicants who did not graduate from a MEAC accredited school can "demonstrate competency in the use and administration of legend drugs and devices" in order to meet licensure requirements (WAC 246-834-066).

Training to competency for pharmacokinetics and contraception is neither novel nor untested. Many professions in Washington State, including naturopathic physicians and advanced registered nurse practitioners have added prescriptive authority beyond what is being sought here to their scope of practice safely and effectively. The addition of expanded scope over time in these professions has been a success for the Washington State healthcare consumer. The midwifery laws in Oregon, New Mexico and Colorado take into account that midwives can broaden or deepen their training and gain experience even after completion of their midwifery education and training (Colorado Revised Statues § 12-225-107; New Mexico Administrative Code 16.11.3; Oregon Administrative Rules 332-026-0000, as cited in Effland et al., in press). A license extension option for suturing is available in Colorado, procurement and use of legend drugs and devices in Oregon is dependent on completion of continuing education on relevant pharmacology topics, and New Mexico offers and encourages midwives to pursue updates to their knowledge regarding medications (Effland et al., in press). Expectations in New Zealand are similar and uphold midwifery autonomy placing the burden of responsibility on the midwives who "are expected to recognise and action any knowledge deficit they may have and to take part in an education programme to rectify this" (New Zealand College of Midwives , p. 1 as cited in Effland et al., in press). The midwifery profession in New Zealand and New Mexico are considered

by their laws to be capable of taking into account the health of the public (New Mexico Administrative Code 16.11.3; Australian and New Zealand Council of Chief Nursing and Midwifery Officers, n.d. as cited in Effland et al., in press).

5. Explain how the current education and training for the health profession adequately prepares practitioners to perform the new skill or service (refer to RCW 18.120.030(4)).

Appendix D provides an overview of proposed pre-service curricula for midwifery students and programs developed by Zell (2021). The same curricula can be used in selecting appropriate continuing education courses to meet educational and experiential gaps. The goal is to provide the greatest public good with the least barriers to continuing education possible. The University of British Columbia in B.C., Canada, where direct-entry midwives are primary, autonomous care providers capable of the full scope of care described in this application, utilizes a continuing education model to ensure competency in the areas of STIs and hormonal contraception specifically, with each module accounting for 2.5 hours of training. We proposed that **any** continuing education credits that meet these core curricular models, and are at least 5 hours (or credit equivalent) are sufficient based on the evidence and based on models from similar resource-rich settings.

6. Is an increase in education and training necessary? If so, are the approved educational institutions prepared to incorporate the increase?

Please see *Appendix E* for proposed educational competencies to be incorporated at the national level (MEAC). Midwifery educational institutions should be well-poised to address this gap, as this scope expansion is concordant with the International Confederation of Midwives' core competencies for midwifery globally. Should MEAC be unable or unwilling to incorporate these competencies, the rules and regulations for Washington licensure for LMs can still exceed national standards, as is already the case with regard to antepartum experience requirements in Washington (the national certifying body requires 60 births total; Washington State licensing requires 100 births total).

7. How does the proposal ensure that only qualified practitioners are authorized to perform the expanded scope of practice?

The proposal initially involves a voluntary licensure extension for limited prescriptive authority, so the Department' rules and regulations will govern appropriate training and competency, in collaboration with the Midwives' Association of Washington State. This method is well-documented as successful in guiding safe, regulated practice in other jurisdictions where contraception and prescriptive management is practiced by direct-entry midwives (such as British Columbia, Canada). This allows currently qualified and practicing LMs to incorporate more comprehensive care in service of the childbearing population immediately, while providing time for educational programs, competency exams, and clinical training opportunities to expand for pre-service midwifery students.

Conclusion

Licensed direct-entry midwives (LMs) attend births and/or offer care in nearly all counties in Washington State, including counties where patients would otherwise have to travel quite far to reach another provider. Under current law, LMs are not permitted to prescribe the majority of contraceptives or infection treatments, even though testing and educational counseling related to these conditions, medications, and devices is within their scope of practice. The inability of licensed midwives to prevent, treat, and prescribe for these conditions or to provide the full range of contraceptive options creates unnecessary barriers to care, exacerbates health inequities, and undermine our state's efforts to improve health outcomes and reduce unintended pregnancy.

We are seeking a Sunrise Review to create an additional professional training option so Licensed Midwives can offer all contraceptive options and antibiotics for common perinatal infections in order to meet the growing and increasingly diverse demands of the childbearing population in Washington State. The desires and self-determination of individuals can be respected and the barriers to access to care can be remedied by expanding the midwife's scope to include provision of a wide variety of contraceptive services, in addition to the education and counseling already routinely provided, as well as care for common the prevention and treatment of common pregnancy and postpartum conditions as this proposal outlines.

This proposal aligns with the state's commitment to eliminating health inequities, increasing access to affordable reproductive health services, improving maternal-child health, and promoting reproductive autonomy.

- It will increase access to contraception and contraceptive uptake, which results in optimal birth spacing;
- Patients will benefit from Timely, Cost-effective Treatment of STIs, UTIs, and other Urogenital and/or Breast/Chest Infections;
- Families across the state will benefit from Ready Access to Care; and
- It will help increase continuity of care and patient satisfaction.

The proposal acknowledges the minimal additional training necessary for LMs to fill the growing need for additional sexual and reproductive health (SRH) providers, and is modeled on the practices of other jurisdictions with excellent reproductive health outcomes, such as British Columbia, Australia, and New Zealand .[2]

[2] Midwives in other high-income countries often have broader scopes of practice than LMs and/or have mechanisms by which to expand autonomy and access to medications and contraceptives (Australian College of Midwives [ACM], 2016; New Zealand College of Midwives [NZCOM], 2014; Ordre des Sage-Femmes, 2017; Stewart et al., 2012; Wilson et al., 2018; Zell, 2021). Either sufficient pre-service training or post-registration continuing education is utilized to ensure competency.

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Appendices

Licensed Midwives
Scope of Practice Sunrise Review

June 2021

Appendices	

Appendix A

Education and Training[3]

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 (RCW18.50.040(1) and WAC 246-834-060(2));
- Complete at least three years 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;
- Complete at seven clock hours of HIV/AIDS education (WAC 246-834-060);
- 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) andWAC 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 (NARM) and the Washington state-licensure examination and the midwifery jurisprudence examination (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.
- In addition to state licensure, the American Midwifery Certification Board may also grant theCertified Midwife® or Certified Professional Midwife® certifications, but these are not required for licensure in Washington, nor do they eliminate the need for state licensure.

[3] Chapter 246-834 WAC; 2013 Sunrise Report

Appendix B *(Segadelli, 2016)*

Contraceptive Method	Mandatory tests/ examinations	Tests/examinations that substantially increase safety and effectiveness	Midwifery competency
Intrauterine device	• Pregnancy test • Bimanual examination and cervical inspection (CDC, 2013)	STI screening (if not previously screened according to CDC recommendations) (CDC, 2013)	• Perform pelvic examination • Calculate the estimated date of birth and assess gestational period through query about LMP, bimanual examination, and/or urine pregnancy testing (this competency is not specific to providing contraception, but shows that midwives are expected to be competent in bimanual exam and urine pregnancy testing) • Physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy (MEAC, 2014) • Understanding or knowledge of basic pharmacokinetics of family planning drugs and agents; all currently available methods of family planning, including medical eligibility criteria and appropriate timeframes for method use; and methods and strategies for guiding pregnant people and/or couples needing to make decisions about methods of family planning (MEAC, 2014)
Implant	Pregnancy test (CDC, 2013)	None	Same as above
Injectable	Pregnancy test (CDC, 2013)	None	Same as above
Combined hormonal contraceptives	Pregnancy test Blood pressure (CDC, 2013)	None	• Same as above • Take and assess maternal vital signs including temperature, blood pressure, pulse (MEAC, 2014)
Progestin-only pills (POP)	Pregnancy test (CDC, 2013)	None	Same as above
Emergency contraception pills	Pregnancy test (CDC, 2013)	None	Same as above

Appendix C– Gap Analysis *(Zell, 2021)*

ACNM category	ACNM competency	Met by MEAC?	MEAC competency
II. Components of Midwifery Care	C. Knowledge of the legal basis for practice	Y	1.13 the legal and regulatory framework governing reproductive health for women of all ages, including laws, policies, protocols and professional guidelines 1.14 policies, protocols, laws and regulations related to therapeutic abortion (TAB) care services 1.40 comply with all local regulations for birth and death registration, mandatory reporting for physical abuse, and infectious disease reporting 1.42 assume administration and management tasks and activities, including but not limited to: a. compliance with privacy and protected health information regulations (i.e., HIPAA compliance), b. compliance with workplace safety regulations (i.e., OSHA compliance

III. Components: Midwifery Management Process	A. Obtains all necessary data for the complete evaluation of the client	Y	2.4 components of a health history, family history, and relevant genetic history 2.5 physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy 2.15 take a comprehensive health and obstetric, gynecologic and reproductive health history 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 2.24 use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis 3.8 components of a health history and focused physical examination for antenatal visits 3.14 normal findings [results] of basic screening laboratory tests including, but not limited to: a. routine pregnancy bloodwork 3.37 take an initial history and perform ongoing history each antenatal visit 3.38 perform a complete physical examination and explain findings to the woman 3.39 take and assess maternal vital signs including temperature, blood pressure, pulse 3.40 draw blood and collect urine and vaginal culture specimens for laboratory testing 3.47 perform a pelvic examination, including sizing the uterus, if indicated and when appropriate during the course of pregnancy 3.49 calculate the estimated date of birth and assess gestational period through query about LMP, bimanual examination, and/or urine pregnancy testing 5.21 take a selective history, including details of pregnancy, labor and birth 5.22 perform a focused physical examination of the mother
IV. Components: Fundamentals	A. Anatomy and physiology, including pathophysiology	Y	2.2 female and male anatomy and physiology related to conception and reproduction 3.1 anatomy and physiology of the human body 3.2 the biology of human reproduction, the menstrual cycle, and the process of conception 5.1 physical and emotional changes that occur following childbirth, including the normal process of involution 5.2 the normal process of involution and physical and emotional healing following SAB or TAB

			5.3 signs and symptoms of sub-involution and/or incomplete SAB or TAB (e.g., persistent uterine bleeding) 5.5 physiology and process of lactation and common variations including engorgement, lack of milk supply, etc.
IV. Components: Fundamentals	B. Normal physical, psychological, emotional, social, and behavioral development, including *growth and development related to gender identity, sexual development, sexuality, and sexual orientation*	N	2.1 growth and development related to sexuality, sexual development, and sexual activity
IV. Components: Fundamentals	F. Pharmacokinetics and pharmacotherapeutics	N	2.7 basic principles of pharmacokinetics of family planning drugs and agents 3.12 pharmacotherapeutic basics of drugs recommended for use in medical abortion 3.23 basic principles of pharmacokinetics of drugs prescribed, dispensed or furnished to women during pregnancy 3.24 effects of prescribed medications, ultrasound, street drugs, traditional medicines, and over-the-counter drugs on pregnancy and the fetus
IV. Components: Fundamentals	G. Principles of individual and group health education and counseling	Y	1.36 engage in health education discussions with and for women and their families 1.9 principles of health education
V. A. Primary Care	1. Applies nationally defined goals and objectives for health promotion and disease prevention	Y	1.2 principles of community-based primary care using health promotion and disease prevention and control strategies 1.11 relevant national or local programs or initiatives (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country or locality)

V. A. Primary Care	3. Utilizes nationally defined screening and immunization recommendations to promote health and detect and prevent diseases	Y	1.11 relevant national or local programs or initiatives (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country or locality) 2.14 principles of screening methods for cervical cancer, (e.g., Pap test; colposcopy) and interpretation of test results 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests
V. A. Primary Care	5. Utilizes advanced health assessment skills to identify normal and deviations from normal in the following systems: a. Breast	Y	2.15 take a comprehensive health and obstetric, gynecologic and reproductive health history 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman
V. A. Primary Care	5. Utilizes advanced health assessment skills to identify normal and deviations from normal in the following systems: g. Genitourinary	N	2.11 signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 2.24 use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis 5.11 signs and symptoms of life threatening conditions that may first arise during the postpartum period, including but not limited to: f. urinary retention 5.32 provide education and guidance on exercise in the postpartum period, including Kegel exercises and abdominal muscle strengthening

V. B. Preconception Care	1. Performs thorough evaluation including complete health history, dental history, family history, relevant genetic history, and physical exam	Y	2.4 components of a health history, family history, and relevant genetic history 2.5 physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 2.15 take a comprehensive health and obstetric, gynecologic and reproductive health history 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 3.38 perform a complete physical examination and explain findings to the woman
V. B. Preconception Care	4. Performs health and laboratory screenings	Y	2.5 physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests
V. B. Preconception Care	5. Counsels regarding fertility awareness, cycle charting, signs and symptoms of pregnancy, pregnancy spacing, and timing of discontinuation of contraceptive method	N	2.8 natural family planning methods 2.10 methods and strategies for guiding women and/or couples needing to make decisions about methods of family planning 2.16 engage the woman and her family in preconception counseling, based on the individual situation, needs and interests 3.4 signs and symptoms of pregnancy 5.18 methods of family planning appropriate for use in the immediate postpartum, post SAB and post TAB periods, including but not limited to progestin-only oral contraceptives 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community 5.29 educate a woman and her family on sexuality and family planning following childbirth 5.33 educate and advise women (and family members, when appropriate), on sexuality and family planning post SAB and TAB

V. C. Comprehensive Gynecologic Reproductive /Sexual Health care	1. Understands human sexuality, including biological sex, intersex conditions, gender identities and roles, sexual orientation, eroticism, intimacy, conception, and reproduction	N	1.18 unique healthcare needs of women from distinct ethnic or cultural backgrounds, or a variety of family structures and sexual orientations 2.1 growth and development related to sexuality, sexual development, and sexual activity 2.2 female and male anatomy and physiology related to conception and reproduction 2.3 cultural norms and practices surrounding sexuality, sexual practices, marriage and childbearing 3.2 the biology of human reproduction, the menstrual cycle, and the process of conception
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care	2. Utilizes common screening tools and diagnostic tests, including those for hereditary cancers	Y	2.14 principles of screening methods for cervical cancer, (e.g., Pap test; colposcopy) and interpretation of test results 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 2.23 take and order cervical cytology (Pap) test 2.24 use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis ADDITIONAL 2.27 perform acetic acid visualization of the cervix and interpret the need for referral and treatment ADDITIONAL 2.28 perform colposcopy for cervical cancer screening and interpret the need for referral and treatment
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care	3. Manages common gynecologic and urogynecologic problems	N	2.11 signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country 3.40 draw blood and collect urine and vaginal culture specimens for laboratory testing 3.54 identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for: e. genital herpes 3.57 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition

			5.11 signs and symptoms of life threatening conditions that may first arise during the postpartum period, including but not limited to: e. incontinence of feces or urine, cystocele/rectocele, f. urinary retention
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care	4. Provides comprehensive care for all available contraceptive methods	N	2.8 natural family planning methods 2.9 all currently available methods of family planning, including medical eligibility criteria and appropriate timeframes for method use 2.10 methods and strategies for guiding women and/or couples needing to make decisions about methods of family planning 2.21 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) locally available and culturally acceptable methods of family planning 2.22 advise women about management of side effects and problems with use of family planning methods 5.18 methods of family planning appropriate for use in the immediate postpartum, post SAB and post TAB periods, including but not limited to progestin-only oral contraceptives REMAINDER ARE ALL ADDITIONAL FOR MEAC 2.25 insert and remove intrauterine contraceptive devices 2.26 insert and remove contraceptive implants 2.29 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) emergency contraception medications, in accord with local policies, protocols, law or regulation 2.30 provide commonly available methods of barrier, steroidal, mechanical, and chemical methods of family planning 5.36 provide family planning services concurrently as an integral component of postpartum care
V. C. Comprehensive Gynecologic / Reproductive	5. Screens for and treats sexually transmitted infections including partner evaluation, treatment, or referral as indicated	N	2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 2.20 provide collaborative care, support and referral for treatment for the HIV positive woman and HIV counseling and testing for women who do not know their status (however authorized to do so in the jurisdiction of practice)

/Sexual Health care			2.11 signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country 2.12 indicators of common acute and chronic disease conditions specific to a geographic area of the world that present risks to a pregnant woman and the fetus (e.g., HIV; TB; malaria and referral process for further testing and treatment including post-exposure preventive treatment 2.24 use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis (*continued on next page)*
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care *(continued)*	5. Screens for and treats sexually transmitted infections including partner evaluation, treatment, or referral as indicated		3.38 perform a complete physical examination and explain findings to the woman 3.54 identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for: e. genital herpes 3.57 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care	5. Screens for and treats sexually transmitted infections including partner evaluation, treatment, or referral as indicated	N	2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 2.20 provide collaborative care, support and referral for treatment for the HIV positive woman and HIV counseling and testing for women who do not know their status (however authorized to do so in the jurisdiction of practice) 2.11 signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country 2.12 indicators of common acute and chronic disease conditions specific to a geographic area of the world that present risks to a pregnant woman and the fetus (e.g., HIV; TB; malaria and referral process for further testing and treatment including post-exposure preventive treatment 2.24 use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis 3.38 perform a complete physical examination and explain findings to the woman 3.54 identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for: e. genital herpes

			3.57 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition)
V. C. Comprehensive Gynecologic / Reproductive /Sexual Health care	6. Provides counseling for sexual behaviors that promotes health and prevents disease	Y	1.9 principles of health education 1.36 engage in health education discussions with and for women and their families 2.6 health education content targeted to sexual and reproductive health (e.g., sexually transmitted infections; HIV; newborn and child health) 2.13 indicators and methods for advising and referral of dysfunctional interpersonal relationships, including sexual problems, gender-based violence, emotional abuse and physical neglect 5.29 educate a woman and her family on sexuality and family planning following childbirth 5.33 educate and advise women (and family members, when appropriate), on sexuality and family planning post SAB and TAB
V. D. Antepartum Period	1. Confirmation and dating of pregnancy using evidence-based methods	Y	3.4 signs and symptoms of pregnancy 3.5 examinations and tests for confirmation of pregnancy 3.6 signs and symptoms and methods for diagnosis of an ectopic pregnancy 3.7 principles of dating pregnancy by menstrual history, size of uterus, fundal growth patterns, and use of ultrasound 3.47 perform a pelvic examination, including sizing the uterus, if indicated and when appropriate during the course of pregnancy 3.49 calculate the estimated date of birth and assess gestational period through query about LMP, bimanual examination, and/or urine pregnancy testing.
V. D. Antepartum Period	2. Management of unplanned or undesired pregnancies, including: a. Provision of or referral for options counseling, supporting individualized decision-making based on patient needs	Y	1.14 policies, protocols, laws and regulations related to therapeutic abortion (TAB) care services 3.10 factors involved in decisions relating to unintended or mistimed pregnancies 3.56 inform women who are considering therapeutic abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining therapeutic abortion, and to support women in their choice 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community

V. D. Antepartum Period	2. Management of unplanned or undesired pregnancies, including: b. Provision of or referral for medication abortion as consistent with the individual's ethics in support of patient autonomy and in line with state scope of practice and licensing statutes	N	1.14 policies, protocols, laws and regulations related to therapeutic abortion (TAB) care services 3.11 all currently available methods of therapeutic abortion (TAB) and their medical eligibility criteria 3.12 pharmacotherapeutic basics of drugs recommended for use in medical abortion 3.56 inform women who are considering therapeutic abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining therapeutic abortion, and to support women in their choice
V. D. Antepartum Period	2. Management of unplanned or undesired pregnancies, including: c. Referral for aspiration or surgical abortion as indicated	Y	3.11 all currently available methods of therapeutic abortion (TAB) and their medical eligibility criteria 3.13 principles of uterine evacuation via manual vacuum aspiration (MVA) 3.56 inform women who are considering therapeutic abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining therapeutic abortion, and to support women in their choice 5.16 principles of manual vacuum aspiration of the uterine cavity to remove retained products of conception
V. D. Antepartum Period	3. Management of spontaneous abortion, including: c. Counseling, management, and/or referral for inevitable or incomplete spontaneous abortion, as appropriate - including options for medication management, aspiration, and surgical care procedures	N	3.54 identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for: f. inadequate or excessive uterine growth, including suspected oligo- or polyhydramnios, molar pregnancy; j. vaginal bleeding (with or without cramping) 5.3 signs and symptoms of sub-involution and/or incomplete SAB or TAB (e.g., persistent uterine bleeding) 5.4 signs and symptoms of SAB or TAB complications and life threatening conditions (e.g., persistent vaginal bleeding, infection) 5.16 principles of manual vacuum aspiration of the uterine cavity to remove retained products of conception 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community 5.34 assess for uterine involution following a SAB or TAB; treat or refer as appropriate

V. D. Antepartum Period	3. Management of spontaneous abortion, including: d. Recognizing indications for and facilitating collaborative care or referral, as appropriate	Y	5.3 signs and symptoms of sub-involution and/or incomplete SAB or TAB (e.g., persistent uterine bleeding) 5.4 signs and symptoms of SAB or TAB complications and life threatening conditions (e.g., persistent vaginal bleeding, infection) 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community 5.34 assess for uterine involution following a SAB or TAB; treat or refer as appropriate
V. D. Antepartum Period	3. Management of spontaneous abortion, including: e. Providing follow-up services for preconception or pregnancy prevention depending on patient need	N	2.16 engage the woman and her family in preconception counseling, based on the individual situation, needs and interests 5.18 methods of family planning appropriate for use in the immediate postpartum, post SAB and post TAB periods, including but not limited to progestin-only oral contraceptives 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community 5.33 educate and advise women (and family members, when appropriate), on sexuality and family planning post SAB and TAB
V. D. Antepartum Period	4. Uses management strategies and therapeutics to promote normal pregnancy as indicated	N	3.8 components of a health history and focused physical examination for antenatal visits 3.14 normal findings [results] of basic screening laboratory tests including, but not limited to: a. routine pregnancy bloodwork, b. urine dipstick, f. GBS vaginal/rectal culture 3.15 normal progression of pregnancy: body changes, common discomforts, expected fundal growth patterns, weight gain 3.19 safe, locally available non-pharmacological methods for the relief of common discomforts of pregnancy 3.23 basic principles of pharmacokinetics of drugs prescribed, dispensed or furnished to women during pregnancy 3.24 effects of prescribed medications, ultrasound, street drugs, traditional medicines, and over-the-counter drugs on pregnancy and the fetus 3.37 take an initial history and perform ongoing history each antenatal visit 3.38 perform a complete physical examination and explain findings to the woman 3.54 identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for: e. genital herpes, o. exposure to or contraction of infectious disease (e.g., HIV, Hep B & C, Varicella, Rubella, cytomegalovirus), q. Toxoplasmosis

			3.57 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition
V. D. Antepartum Period	5. Utilizes nationally defined screening tools and diagnostics as indicated	Y	1.11 relevant national or local programs or initiatives (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country or locality) 2.14 principles of screening methods for cervical cancer, (e.g., Pap test; colposcopy) and interpretation of test results 2.17 perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman 2.18 order and/or perform and interpret laboratory tests used in providing well woman care including, but not limited to: CBC, thyroid function tests, urinalysis, chemistry panels 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 3.14 normal findings [results] of basic screening laboratory tests including, but not limited to: a. routine pregnancy bloodwork 3.40 draw blood and collect urine and vaginal culture specimens for laboratory testing

V. D. Antepartum Period	8. Screens for health risks, including but not limited to intimate partner gender-based violence, infections, and substance use and/or dependency	Y	2.12 indicators of common acute and chronic disease conditions specific to a geographic area of the world that present risks to a pregnant woman and the fetus (e.g., HIV; TB; malaria and referral process for further testing and treatment including post-exposure preventive treatment 2.19 request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs, and PAP tests 3.33 means and methods of advising about care, treatment and support for the HIV positive pregnant woman including measures to prevent maternal-to-child transmission (PMTCT) (including feeding options)
V. D. Antepartum Period	10. Provides anticipatory guidance related to birth, lactation and infant feeding, parenthood, and change in the family constellation	Y	1.9 principles of health education 1.36 engage in health education discussions with and for women and their families 3.36 the physiology of lactation and methods to prepare women for breastfeeding 5.6 the importance of immediate/early/exclusive breastfeeding for mother and child
V. F. Period following Pregnancy	1. Manages physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth	Y	5.1 physical and emotional changes that occur following childbirth, including the normal process of involution 5.2 the normal process of involution and physical and emotional healing following SAB or TAB 5.3 signs and symptoms of sub-involution and/or incomplete SAB or TAB (e.g., persistent uterine bleeding) 5.9 indicators of subinvolution (e.g., persistent uterine bleeding, infection) 5.24 assess for uterine involution and healing of lacerations and/or repairs and educate on ways to promote healing 5.34 assess for uterine involution following a SAB or TAB; treat or refer as appropriate
V. F. Period following Pregnancy	7. Facilitates the initiation, establishment, and continuation of lactation where indicated; and/or counseling about safe formula feeding when indicated	Y	3.33 means and methods of advising about care, treatment and support for the HIV positive pregnant woman including measures to prevent maternal-to-child transmission (PMTCT) (including feeding options) 5.5 physiology and process of lactation and common variations including engorgement, lack of milk supply, etc. 5.6 the importance of immediate/early/exclusive breastfeeding for mother and child 5.10 indicators of maternal breastfeeding problems or complications, including mastitis 5.26 initiate and support uninterrupted [immediate and exclusive]breastfeeding 5.27 teach mothers how to express breast milk, and how to handle and store expressed breast milk

			6.14 principles of infant nutrition, feeding cues, and infant feeding options for babies (including those born to HIV positive mothers) 6.24 position infant to initiate breast feeding as soon as possible (within one hour) after birth and support exclusive breastfeeding
V. F. Period following Pregnancy	8. Advises regarding resumption of sexual activity, contraception, and pregnancy spacing	Y	5.15 approaches and strategies for providing special support for adolescents, victims of gender- based violence (including rape) 5.18 methods of family planning appropriate for use in the immediate postpartum, post SAB and post TAB periods, including but not limited to progestin-only oral contraceptives 5.19 care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community 5.29 educate a woman and her family on sexuality and family planning following childbirth 5.33 educate and advise women (and family members, when appropriate), on sexuality and family planning post SAB and TAB
V. G. Well neonate (newborn immediately after birth and *up to 28 days of life)*	4. Evaluates the neonate, including: d. Identification of deviations from normal and consultation and/or referral to appropriate health services as indicated	Y	6.15 signs, symptoms, and indications for referral or transfer, for selected newborn complications, including but not limited to: d. jaundice, j. hypoglycemia, m. dehydration, q. thrush, t. failure to thrive 6.25 recognize indications of need, stabilize, and transfer the at-risk newborn to emergency care facility 6.26 educate parents about danger signs in the newborn and when to bring infant for care

V. G. Well neonate (newborn immediately after birth and *up to 28 days of life)*	5. Develops a plan in conjunction with the neonate's primary caregivers for care during the first 28 days of life, including the following nationally-defined goals and objectives for health promotion and disease prevention: b. *Feeding and weight gain, including management of common lactation and infant feeding problems*	Y	3.57 dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition 5.5 physiology and process of lactation and common variations including engorgement, lack of milk supply, etc. 5.10 indicators of maternal breastfeeding problems or complications, including mastitis 6.8 normal growth and development of the preterm infant 6.9 normal newborn and infant growth and development 6.11 elements of health promotion and prevention of disease in newborns and infants (HIV, Hepatitis B & C), including essential elements of daily care (e.g., cord care, nutritional needs, patterns of elimination, care of the uncircumcised penis) 6.14 principles of infant nutrition, feeding cues, and infant feeding options for babies (including those born to HIV positive mothers) 6.27 educate parents about normal growth and development of the infant and young child, and how to provide for day-to-day needs of the normal child 6.32 provide well-baby care up for a minimum of 6 weeks of age

Appendix D

Proposed Pre-service Infection / Contraceptive Management Curricula for Midwifery Students & Programs (Zell, 2021)

Midwifery Infection Management Module	
Module description:	This module covers diagnosis and treatment of infections that are relevant to the midwife's scope of practice. Infections discussed include urinary tract infections, reproductive tract infections, and breast/chest infections. Recommended treatment regimens along with pharmacology of each medication are covered in detail.
Purpose:	To prepare midwives and student midwives to identify and treat infections that are relevant to pregnancy and postpartum care and sexual and reproductive health care.
Target audience:	Certified professional midwives, licensed midwives, registered midwives or equivalent whose scope of practice does not include treatment of reproductive tract, urinary tract and breast infections, and students in MEAC-accredited midwifery education programs or similar courses of study.
Delivery mode:	Online, face-to-face, or hybrid
Competencies covered:	The midwife has the knowledge and/or understanding of: • pharmacokinetics of medications used to treat infections within the midwife's scope of practice, including reproductive tract infections, urinary tract infections, and breast/chest infections The midwife has the skill and/or ability to: • screen for, diagnose and treat urinary tract infections; breast/chest infections; and reproductive tract infections, including sexually transmitted and endogenous infections; in client and partner according current guidelines • prescribe, dispense, furnish or administer antibiotics, antifungals, antivirals, and other treatments as indicated for a presenting condition
Learning objectives:	Upon completion of this module, students will be able to: 1. Diagnose sexually transmitted infections, other reproductive tract infections, urinary tract infections, and lactation-related infections based on clinical signs and symptoms and/or laboratory tests

	2. Prescribe appropriate medications for clients and partners for treatment of the following, accounting for medical history and pregnancy/lactation status: chlamydia, gonorrhea, trichomoniasis, syphilis, herpes simplex virus, mycoplasma genitalium, bacterial vaginosis, vulvovaginal candidiasis, lactation-related breast/chest and nipple fungal infections, mastitis, and urinary tract infections 3. Describe mode of action, indications, contraindications, side effects, and safety considerations for recommended medications used to treat chlamydia, gonorrhea, trichomoniasis, syphilis, herpes simplex virus, mycoplasma genitalium, bacterial vaginosis, vulvovaginal candidiasis, lactation-related breast/chest and nipple fungal infections, mastitis, and urinary tract infections 4. Counsel clients on appropriate use, side effects, and adverse effects of medications prescribed or recommended for treatment of chlamydia, gonorrhea, trichomoniasis, syphilis, herpes simplex virus, mycoplasma genitalium, bacterial vaginosis, vulvovaginal candidiasis, lactation-related breast/chest and nipple fungal infections, mastitis, and urinary tract infections 5. Counsel clients on recommended follow-up after treatment of chlamydia, gonorrhea, trichomoniasis, syphilis, herpes simplex virus, mycoplasma genitalium, bacterial vaginosis, vulvovaginal candidiasis, lactation-related breast/chest and nipple fungal infections, mastitis, and urinary tract infections 6. Discontinue treatment as indicated and/or refer for management of side effects, adverse effects, or problems with medications used to treat chlamydia, gonorrhea, trichomoniasis, syphilis, herpes simplex virus, mycoplasma genitalium, bacterial vaginosis, vulvovaginal candidiasis, lactation-related breast/chest and nipple fungal infections, mastitis, and urinary tract infections 7. Understand and follow public health reporting requirements regarding sexually transmitted infections in their legal jurisdiction of practice

Midwifery Infection Management Module

Module Content

1. **Introduction**
    a. Course overview
    b. Terminology
    c. Learning objectives
    d. Infections covered in the course
    e. Prescription writing

2. **Chlamydia**
    a. Diagnosis
        i. Clinical diagnosis: symptoms and exam
        ii. Testing: NAAT, culture (urine, cervical, vaginal, rectal, and pharyngeal), serology
        iii. Clinical diagnosis
    b. Treatment
        i. Indications for treatment
        ii. Antibiotic regimens: PO
            1. amoxicillin
            2. erythromycin
            3. azithromycin
            4. aoxycycline
        iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
        iv. Partner treatment
    c. Pregnancy and lactation
        i. Risks
        ii. Recommended treatment regimens
        iii. Test of cure and re-testing recommendations and timing
    d. Follow-up
        i. Consider test of cure in 3-4 weeks by NAAT
        ii. Re-testing in 6 months
        iii. Reporting requirements

3. **Gonorrhea**
    a. Diagnosis:

i. Clinical diagnosis: symptoms and exam
ii. Testing: NAAT, culture (urine, cervical, vaginal, rectal, and pharyngeal)

b. Treatment
i. Indications for treatment
ii. Antibiotic regimens: IM, PO
1. Cefixime
2. ceftriaxone
iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatment
iv. Antimicrobial resistance
v. Partner treatment

c. Pregnancy and lactation
i. Risks and vertical transmission
ii. Recommended treatment regimens
iii. Test of cure and re-testing recommendations and timing

d. Follow-up
i. Test of cure in 3-7 days by culture for all patients
ii. Re-testing in 6 months
iii. Reporting requirement

4. Trichomoniasis

a. Diagnosis:
i. Clinical signs and symptoms
ii. Testing: point of care testing (pH, whiff test, microscopy), NAAT (vaginal, cervical, urine)

b. Treatment:
i. Indications for treatment
ii. Antibiotic regimens: PO
1. oral metronidazole
iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
iv. Partner treatment

c. Pregnancy and lactation
i. Risks to pregnancy
ii. Treatment considerations with breast/chestfeeding infant

d. Follow-up
i. No test of cure required
ii. Not reportable

5. Syphilis

a. Diagnosis
    i. Clinical signs and symptoms based on infection stage
    ii. Testing: PCR (of lesions only), serology (treponemal and non-treponemal)
b. Treatment
    i. Indications for treatment
    ii. Antibiotic regimens: IM, IV, PO
        1. benthazine penicillin G
        2. doxycycline
        3. ceftriaxone
    iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
    iv. Partner treatment based on infection stage
c. Pregnancy and lactation
    i. Risks and vertical transmission
    ii. Recommended treatment regimens
    iii. Jarisch-Herxheimer reaction
    iv. Additional follow-up testing recommendations
d. Follow-up
    i. Lab testing based on infection stage
    ii. Reporting requirements

6. Herpes simplex virus

a. Diagnosis
    i. Clinical diagnosis
    ii. Confirmation of diagnosis: NAAT or culture (lesion)
    iii. Serology to diagnose primary vs. non-primary first episode
b. Treatment
    i. Indications for treatment
    ii. Antiviral regimens: PO
        1. Acyclovir
        2. Valacyclovir
        3. famiciclovir
    iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
    iv. Suppressive therapy based on frequency of outbreaks
c. Pregnancy and lactation

i. Risks to fetus based on timing and type of outbreak
ii. Suppressive therapy
iii. Recommended treatment regimens

d. Follow-up
i. Monitoring for recurrent outbreaks
ii. Not reportable

7. Bacterial vaginosis

a. Diagnosis
i. Clinical symptoms
ii. Testing: point of care (pH, whiff test, microscopy), culture (vaginal)

b. Treatment
i. Indications for treatment
ii. Antibiotic regimens: PO, PV
1. Metronidazole
2. clindamycin
iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
iv. Evidence on treating partners

c. Pregnancy and lactation
i. Risks to pregnancy
ii. Recommended treatment regimens
iii. Test of cure at 1 month
iv. Treatment considerations with breast/chestfeeding infant

d. Follow-up
i. Risk reduction
ii. Confirmation of diagnosis with recurrent episodes
iii. Not reportable

8. Vulvovaginal candidiasis

a. Diagnosis
i. Clinical symptoms
ii. Testing: point of care (microscopy), culture (vaginal)

b. Treatment
i. Indications for treatment
ii. Antifungal regimens: PO, PV

1. fluconazole
2. clotrimazole
3. miconazole
4. second line options

iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
iv. Antifungal resistance

c. Pregnancy and lactation
   i. Risks to pregnancy
   ii. Recommended treatment regimens
   iii. Treatment considerations with breast/chestfeeding infant
d. Follow-up
   i. Risk reduction
   ii. Recurrent episodes
   iii.

9. Breast/chest and nipple thrush

a. Diagnosis
   i. Clinical diagnosis: symptoms and exam
   ii. Confirmation of diagnosis: skin scraping, milk culture
b. Treatment
   i. Indications for treatment
   ii. Antifungal regimens: topical, PO
      1. miconazole
      2. clotrimazole
      3. fluconazole
      4. nystatin
   iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
   iv. Treatment of the infant
c. Pregnancy
   i. Recommended treatment regimens
d. Follow-up
   i. Risk reduction
   ii. Referral to/provision of lactation support prn

10. Lactational mastitis

a. Diagnosis
   i. Clinical diagnosis: symptoms and exam

ii. Human milk culture for antibiotic selection
iii. Imaging referrals for complicated cases

b. Treatment
    i. Brief overview of nonpharmacologic treatment
    ii. Indications for antibiotic treatment
    iii. Antibiotic regimens: PO
        1. dicloxacillin
        2. cephalexin
        3. erythromycin
        4. trimethoprim-sulfamethoxazole
        5. referral for other regimens
    iv. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
c. Pregnancy
    i. Treatment precautions
d. Follow-up
    i. Prevention
    ii. Referral for complicated cases
    iii. Referral to/provision of lactation support prn

11. Urinary tract infections

a. Diagnosis
    i. Clinical symptoms and exam
    ii. Testing: clean catch urinalysis and urine culture
b. Treatment
    i. Indications for treatment
    ii. Antibiotic regimens: PO
        1. nitrofurantoin
        2. trimethoprim-sulfamethoxazole
        3. fosfomycin
        4. cephalexin
        5. pivmecillinam
        6. referral for other regimens
    iii. Mode of action, pharmacokinetics, indications, contraindications, side effects, and appropriate use of all treatments
c. Pregnancy and lactation
    i. Recommended treatment regimens
    ii. Antibiotic safety in pregnancy
    iii. Test of cure in pregnancy

d. Follow-up
    i. Test of cure not indicated for uncomplicated cases if non-pregnant
    ii. Referral for complicated cystitis, pyelonephritis, other complications

Midwifery Contraceptive Management Module	
Module description:	This module covers provision of contraceptive methods including those relevant to the postpartum and post-abortion periods. As students are already familiar with contraceptive counseling and identifying method eligibility criteria, the focus of this module is prescribing, dispensing, and inserting hormonal and intrauterine methods. Affirming care for individuals of all gender identities is also discussed.
Purpose:	To prepare midwives and student midwives to manage and prescribe all available contraceptive methods. The optional clinical portion of the module enables midwives to achieve competency in inserting intrauterine devices.
Target audience:	Certified professional midwives, licensed midwives, registered midwives or equivalent whose scope of practice does not include comprehensive contraceptive management, and students in MEAC-accredited midwifery education programs or similar courses of study.
Delivery mode:	Didactic portion: Online, face-to-face, or hybrid Optional clinical portion: Field placement
Competencies covered:	The midwife has the knowledge and/or understanding of: • mode of action, indications for use, benefits and risks of all currently available contraceptive methods • growth, development, and significance of gender identity and expression, intersex conditions, and the spectrum of transgender identities, including unique healthcare needs The midwife has the skill and/or ability to: • counsel regarding appropriate use of all currently available contraceptive methods including timing of discontinuation • prescribe, insert, furnish, or administer all currently available contraceptive methods, including emergency contraception, and manage common side effects • provide contraceptive or preconception services concurrently as an integral component of postpartum care and spontaneous and therapeutic abortion services
Learning objectives:	Upon completion of this module, students will be able to 1. Describe mode of action, indications, benefits and risks of intrauterine, injection, combined hormonal, progestin-only, and emergency contraceptives 2. Counsel clients on appropriate use of contraceptive methods, including cautions and timing of discontinuation based on desire for conception

	3. Prescribe combined hormonal, progestin-only, injection and emergency contraceptives as appropriate based on the needs, desires, and medical profile of the client 4. Prescribe, insert and remove intrauterine contraception (after completion of optional clinical portion) as appropriate based on the needs, desires, and medical profile of the client 5. Identify appropriate contraceptive methods for the post-abortion, postpartum, and/or lactating individual 6. Refer for management of side effects, adverse effects, or problems with contraceptives; advise clients of indications for method discontinuation; and/or select and prescribe new methods in partnership with the client 7. Exhibit an understanding of gender identity and expression, common experiences of transgender individuals in healthcare settings, and provide affirming care to individuals of all genders

Midwifery Contraceptive Management Module

Module content:

1. **Introduction**
    a. Course overview
    b. Terminology
    c. Learning objectives
    d. Contraceptive methods covered in the course
    e. Prescription writing

2. **Combined hormonal contraceptives**
    a. Information pertaining to all methods
        i. Hormonal constituents
        ii. Mode of action
        iii. Contraindications
        iv. Postpartum and post-abortion safety and timing of initiation
        v. Effects on lactation
        vi. Timing of discontinuation for conception
    b. Combined oral contraceptive pill
        i. Formulations and dosing
            1. Selecting formulations for individual clients
        ii. Side effects, risks, benefits
            1. Problem solving and expectations for common side effects
        iii. Effectiveness, efficacy, continuation rate
        iv. Proper use
            1. Instructions for use
            2. Initiation and backup methods
            3. Missed dose counseling based on part of cycle
            4. Continuous and extended use options
    c. Vaginal contraceptive ring
        i. Pharmacokinetics
        ii. Dosing

iii. Side effects, risks, benefits
iv. Effectiveness, efficacy, continuation rate
v. Proper use
    1. Instructions for use and insertion
    2. Initiation and backup methods
    3. Counseling on backup after expulsion or delay in insertion/removal
    4. Extended use and decreased hormone-free interval options

d. Transdermal contraceptive patch
    i. Pharmacokinetics
    ii. Dosing
    iii. Side effects, risks, benefits
    iv. Effectiveness, efficacy, continuation rate
    v. Proper use
        1. Instructions for use and application
        2. Initiation and backup methods
        3. Counseling on backup after detachment or delay in reapplication
        4. Extended and continuous use options

3. Progestin only contraceptives

a. Progestin-only contraceptive pill
    i. Hormone and dosing
    ii. Mode of action
    iii. Side effects, risks, benefits
    iv. Effectiveness, efficacy, continuation rate
    v. Contraindications
    vi. Postpartum and post-abortion use
        1. Safety
        2. Use during lactation
    vii. Proper use
        1. Instructions for use including time of day
        2. Initiation and backup methods
        3. Missed dose counseling based on possibility of conception
        4. Appropriateness of method based on user adherence
    viii. Timing of discontinuation for conception

b. Depot medroxyprogesterone acetate
    i. Hormone and dosing
    ii. Mode of action

iii. Side effects, risks, benefits
    1. Cautions regarding long-term use
iv. Effectiveness, efficacy, continuation rate
v. Contraindications
vi. Postpartum use
    1. Safety
    2. Impact on milk supply based on timing of initiation
vii. Proper use
    1. Instructions for administration
    2. Initiation and backup methods
    3. Missed dose protocol
    4. Follow-up plan for receiving subsequent injections
viii. Discontinuation timing
    1. Safety concerns
    2. Delayed return to fertility

c. Contraceptive implant
    i. Hormone and dosing
    ii. Mode of action
    iii. Side effects, risks, benefits
    iv. Effectiveness, efficacy, continuation rate
    v. Contraindications
    vi. Postpartum use
        1. Safety
        2. Use during lactation
    vii. Proper use
        1. Insertion instructions
            a. Video tutorial
            b. Information about required training by manufacturer
        2. Initiation and backup methods
        3. Duration of efficacy
        4. Removal instructions and troubleshooting
d. Levonorgestrel intrauterine system
    i. To be covered in intrauterine contraception section

4. Intrauterine contraception

a. Information pertaining to both types
    i. Risks, including insertion risks

ii. Contraindications
iii. Pregnancy with IUD in place
iv. Postpartum use
1. Safety
2. Insertion timing options
3. Post-abortion insertion
4. Use during lactation

b. Levonorgestrel intrauterine system
i. Dosing options
ii. Mode of action
iii. Side effects and benefits
iv. Effectiveness, efficacy, continuation rate
v. Proper use
1. Backup methods
2. Duration of efficacy

c. Copper intrauterine device
i. Brands and quantity of copper
ii. Mode of action
iii. Side effects and benefits
iv. Effectiveness, efficacy, continuation rate
v. Proper use
1. Backup method not needed
2. Duration of efficacy
3. Use as emergency contraception covered in pertinent module

d. OPTIONAL: Insertion training
i. Video-based tutorial
ii. Hands-on instruction/practice on uterine models
iii. Clinical placement including directly supervised successful insertion of at least 5 IUDs of any type(s)

5. Emergency contraception

a. Information pertaining to all types
i. Recommendation to counsel all clients
ii. Offering prescriptions in advance of need
iii. Effective for only one episode of unprotected sex

b. Copper intrauterine device
i. Effectiveness as emergency contraception
ii. Timing of insertion

c. Oral ulipristal acetate
    i. Hormone and dosing
    ii. Mode of action
    iii. Effectiveness
        1. No change based on timing within recommended window
        2. No change based on BMI
    iv. Side effects and risks
    v. Contraindications
        1. Cautions with lactation
    vi. Proper use
        1. Prescription required
        2. Timing of administration
        3. Counsel to delay breast/chestfeeding for at least 36 hours and up to 1 week
        4. Delay of 5 days before re-starting hormonal contraceptive therapy, followed by backup method use
d. Oral levonorgestrel
    i. Hormone and dosing
    ii. Mode of action
    iii. Effectiveness
        1. Based on timing after unprotected sex
        2. May be reduced with higher BMI
    iv. Side effects, no known risks
    v. Contraindications
        1. Cautions with lactation
    vi. Proper use
        1. No prescription required; available over the counter
        2. Timing of administration
        3. No breast/chestfeeding for 8 hours
e. Oral Yuzpe regimen
    i. Dosing of combined hormonal contraceptive pills
    ii. Mode of action
    iii. Effectiveness
        1. Based on timing after unprotected sex
        2. Significantly lower than other emergency contraception options
    iv. Side effects
        1. High rates of side effects
        2. Recommendation for over the counter anti-nausea medications
    v. Contraindications

vi. Proper use
    1. Obtaining pills – by prescription as emergency contraception OR use of existing pills for combined hormonal contraception users
    2. Timing of administration for two doses
vii. Caution: Should only be used when other emergency contraception methods are unavailable

6. Gender identity

a. Basic concepts
    i. Gender identity
    ii. Phenotype and genotype
    iii. Gender expression
    iv. Transgender spectrum and related terms
    v. Intersex conditions
b. Significance
    i. History of pathologization and medical care for trans people
    ii. Individual negative experiences and discrimination in healthcare settings
        1. Resulting lack of trust for medical providers
    iii. Health disparities
c. Implications for care
    i. Gender-affirming care basics
        1. Trauma informed care
        2. Using appropriate terminology
        3. Consent and safety
    ii. Creating a safe and welcoming practice
    iii. Taking a respectful and relevant health history
    iv. Physical exam
    v. Contraceptive counseling for gender diverse clients

Appendix E *(Zell, 2021)*

Proposed MEAC Competencies	
New Proposed Competencies	The midwife has the knowledge and/or understanding of: • pharmacokinetics of medications used to treat infections within the midwife's scope of practice, including reproductive tract infections, urinary tract infections, and breast/chest infections • mode of action, indications for use, benefits and risks of all currently available contraceptive methods • growth, development, and significance of gender identity and expression, intersex conditions, and the spectrum of transgender identities, including unique healthcare needs The midwife has the skill and/or ability to: • screen for, diagnose and treat urinary tract infections; lactation-related infections; and reproductive tract infections, including sexually transmitted and endogenous infections; in client and partner according to current guidelines • prescribe, dispense, furnish or administer antibiotics, antifungals, antivirals, and other treatments as indicated for a presenting condition • counsel regarding appropriate use of all currently available contraceptive methods including timing of discontinuation • prescribe, insert, furnish, or administer all currently available contraceptive methods, including emergency contraception, and manage common side effects • provide contraceptive or preconception services concurrently as an integral component of postpartum care and spontaneous and therapeutic abortion services

Appendix D - Public Comments

Midwifery Sunrise Review Comments

Through July 16th, 2021

Name	Comment
Kara Lynn Neff, LM	I cannot express how much this change would positively impact my clients. I live in a fairly rural area, Yelm, and when I have a client with a simple UTI and they are medicaid clients I have tried getting them seen at the local SeaMar clinic, which is their provider of record. However, that provider is not comfortable treating pregnant women and always tells me they have to see an OB. The only OB that backs up midwives currently in my area is in Tacoma and he doesn't have immediate appointments available. I have two women in my practice who are repeat clients sooner than they had intended to be repeat clients because I couldn't prescribe birth control of their choice and with their busy schedules as new moms they didn't get around to seeing their PCPs. With the shortage of providers and the increased difficulty with squeezing in an extra appointment, due to the COVID pandemic it would relieve some of the burden on upper level practitioners if we as licensed trained midwives could provide these basic needs for our clients. Thank you so much for considering this proposal. I sincerely hope you decide to accept it.
Senator Karen Keiser 33rd District of Washington	I very much support the review of scope for midwives with the consideration of allowing broader scope including prescribing of appropriate pregnancy and post-partum prescription drugs. I would also hope your review will include a broader range of review beyond the USA experience. I understand that Germany, for example, has a very mature midwives profession with very positive outcome measures.
Amber Hettinger	I do think it is in the public's best interest to increase the midwifery services. Right now they're so over booked that it's hard to enjoy the experience.
Joella Folk, LM	I would like to lend my support to most of the current RCW changes drafted in this bill. Removing unnecessary gender oriented language shows up to date and inclusivity of the Department of Health's role. I am opposed to removing "female" until an appropriate medical term has been established to denote the specific anatomy being studied. We as health care providers want to be inclusive but we also need to expect standards and hold language that allows for specificity and anatomical accuracy. As a midwife I would also like to give my support to the proposed limited prescriptive changes to this RCW. This is a change that has been needed for decades. Licensed midwives are primary care providers to their pregnant and postpartum clients. As such, they should have the legal scope that allows treatment of common and ordinary conditions of pregnancy that do not require high-risk medical assessment. When our clients present with symptoms of a UTI, for example, our only option is to send them to Urgent care or to another primary care provider who has prescriptive authority. This is an inappropriate use of our already overcrowded Urgent Care facilities and a much greater cost to the client and insurance company to require such a process when they already have a primary care provider who is capable of diagnosing and verifying the condition and required treatment through laboratory analysis. This also delays treatment for a minimum of 1-2 days. Another example is requiring a client to see another provider for prophylactic antiviral medication for Herpes virus. There is a standard protocol and treatment for this condition in a pregnant client. It is a waste of

	resources and greater cost to individuals and insurance companies to require additional visits for something that does not require expertise or advanced evaluation. I appreciate the opportunity to offer my support on this measure and for the considerations being made.
Faisa Farole, LM	I am a licensed midwife serving underserved population in King and Pierce counties. It is so needed for LMs to be able to prescribe limited common prescriptions for parental and postnatal and contraceptions. Some of the clients I have do not see any providers prior to coming to my care. And they are most likely not to see any providers after the baby so it would be so nice to be able to provide them holistic care including prescribing prenatal vitamins, iron tablets and contraceptions.
Taylor Kaminski Doula/ASQ Administrator	I am writing in regards to Midwives being allowed to do more in the scope of Pregnany and postpartum care. It is so vital, especially for the commUnity I live and work in which is predominantly Immigrant/Refugee. It is harder on this community to have to travel for further services that they could instead get from their Midwife, they are having to go somewhere else in addition to having their Midwife. It's unfortunate because Midwives can provide these extra services. I am Hoping they will soon be allowed to do so. I also have had the privilege of having a wonderful Midwife, Faisa Farole at Global Midwifery and she has been able to provide me such great care for my last three pregnancies. I wouldn't go anywhere else to get any other check ups or anything further, if she can't do it I won't have it done.
Taylor	I fully support the expansion of the scope of work Midwives can do! It is so important to so many!
Zeinab Farole	I'm emailing to support the Licensed Midwife practice scope expansion. Thank you.
Niha Dhillon	I support the expansion of LM scope.
Kiona Nessenbaum	I strongly support the expansion of the scope of practice for licensed midwives in Washington state to include limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with the appropriate training. This expansion will benefit the midwives themselves as well as those that utilize midwifery care by allowing them to have the majority of their needs met in one place when it is related to pregnancy, birth or postpartum.
Rebecca Martin	Specifically, the proposal would add "limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with appropriate training." Key words "limited" "those with APPROPRIATE TRAINING". Why would you not allow someone qualified to do what they are qualified to do?? My other thought is if you are squeamish add it to the license after a period of time to gain experience. Three years? Five years? An experienced midwife is worth more than her weight in gold. Personal experience speaking here.
Dr. Joseph Pizzorno, ND	I am writing in support of the proposed expansion of the midwifery scope of practice. Having been a licensed midwife, a member of the Seattle Midwifery School education committee during its development of their educational standards several decades ago,

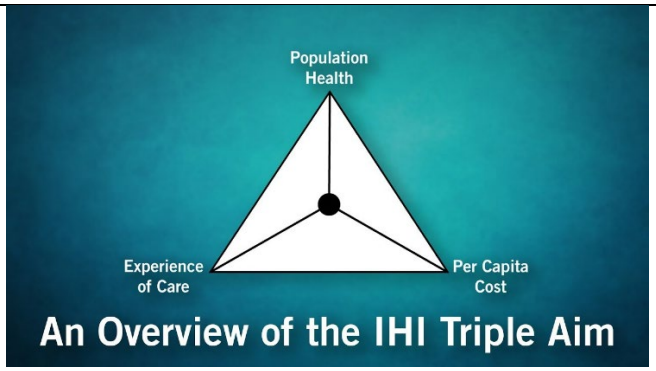
	and a thought leader educator in the fields of naturopathic, integrative and functional medicine I believe I am well qualified to comment. My strong belief is that healthcare professionals should have a legal scope of practice consistent with their field of medicine and their accredited training. The diagnosis and treatment of the typical health challenges women experience during pregnancy and the perinatal period are well within the skills base of a properly trained midwife. Having to refer patients with low severity issues to other healthcare professionals is inconvenient and expensive for the patient. Pregnant women usually have a special relationship with their childbirth expert and prefer consistent care from someone they know and trust. Of course, midwives must be trained to recognize the limits of their skills and to understand when a referral is required for the patient's best care. Please let me know if I can be of further assistance.
Cynthia Jaffe, LM	Thank you for this opportunity for comments. I am a Licensed Midwife working in a rural part of Washington state. Access to medical care is difficult for many people in my community and it is very often that I find myself sending clients to the emergency department of our local hospital to be treated for a simple urinary tract infection because they have no primary care provider. We would welcome an increase in the scope of our practice to provide our patients with comprehensive care during their pregnancies. It seems shortsighted that we can send in the lab work to identify a urinary tract infection but then need to send clients on to someone else for the prescribing of medication. The same holds true for postpartum care when many of our clients would like a form of birth control that we cannot prescribe or dispense. I have seen unplanned pregnancies as a result of the delay in finding providers to provide birth control services. I welcome the proposed changes as an opportunity to provide better care to our clients.
Jazmine Fox-Stern	This sounds like a sensible policy. Please do increase the scope of practice to allow highly trained midwives to better serve their patients.
Melissa Chinn DO FACOG FACOOG	With respect to midwife privileges, any expansion is a bad idea. I am an OB GYN who had to deal with the bad outcomes from poor decisions that licensed midwives have made. They do not have the education necessary to understand how medications work. I have seen too much harm than good from these individuals. Please leave that ability to actual medically trained professionals such as CNMs to have that prescriptive authority.
James Gray, MSW	Instead of expanding the scope of practice with additional training I would suggest increasing the funding for primary care training for Family medicine doctors as can provide more comprehensive care.
Amanda Smith	I fully support the expansion of the scope of practice for midwives. They provide excellent care for low risk pregnancy care that is much needed in our state. Adding this scope to their care will allow them to further their support to our communities and the families they serve.
Jessica Ellis	I am a mother of two who has received care from midwives during both of my pregnancies and births, and who also works in healthcare. Receiving care from midwives was extremely beneficial to me and my family, however one barrier we met was the difficult that came from their inability to prescribe and administer commonly used medications. For example, I had substantial nausea, and had I needed prescription

	medications, I would have had to visit a different provider. I was not able to obtain the recommended immunizations from my midwife. I had to coordinate my post-birth contraceptive needs with a different provider. Working in health care, I know that the complexity in coordinating care between providers leads to worse outcomes. It makes life more difficult for mothers and families, and makes it less likely that we will receive what we need. Midwives are well positioned to make informed, safe, prescribing choices with those medications commonly used in the course of pregnancy and childbirth.
Julia Montgomery	As a healthcare professional who works with midwives regularly I am fully in support of the change in scope of practice. I see this change as having a positive impact on our communities and furthering access to healthcare that individuals may not be able to access otherwise.
Dr. Kovner, ND	I think expanding the scope of licensed midwives to include limited prescription writing is a brilliant idea. As a WA State licensed ND, I appreciate the midwives I work with and hold them in highest regard, academically and professionally. They're highly trained and capable of safe prescribing. Thank you for hearing my argument.
Kay Biccum, DO	I worry that this training should be significantly longer than 5 hours to fully address the covered material for the scope increase.
Marco Aurilio	Increasing the scope of practice, availability and ability for CPM, and LM [Midwives] to practice in hospitals while increasing their reimbursement rate will: • allow healthy low risk women to have healthier births, with lower risk of nosocomial infection • allow hospitals to deal with and focus on birth complications better • likely lower infant mortality with better prenatal care • save WA state $$100's of millions in Medicaid and insurance OB costs • serve as a model to help the rest of the US evolve and improve its rating of 31st in global infant mortality, while making federally mandating midwifery legal and integrated in all 50 states.. feel free to contact me for statistical and clinical evidence support for these statements
Candace Mabbitt, CNM, ARNP	I, Candace Mabbitt, am a Certified Nurse Midwife (CNM), in WA state and am writing to provide feedback for the 2021 Sunrise Review in progress pertaining to scope of midwifery practice for Licensed Midwives (LMs) in our state. Certified Nurse Midwives are trained to provide care across the reproductive life span. This includes wellness care, reproductive healthcare, gender affirming care, menopause management and some primary care. CNMs have full prescriptive authority in WA state. I am also the American College of Nurse Midwives WA Affiliate President representing 273 CNMs in our state. I practice with Providence Midwifery Group providing full midwifery services to the surrounding community. This includes a good working relationship with community based LM practices. I have seen first hand the barriers to quality care that patients have to navigate when needing additional services during pregnancy or postpartum. A simple UTI that could be diagnosed and treated with their chosen provider, currently requires an additional trip to the urgent care, emergency room or other clinic. This takes time

	and costs more money. It also allows the disease process to progress so a patient may then have a full kidney infection by the time they get treatment which increases risk of preterm labor leading to worse outcomes for patients and an increase in maternal morbidity and mortality. This is not okay, we can do better! I am in SUPPORT of the Sunrise Review to increase the midwifery scope of practice for Licensed Midwives (LMs) who have completed the proposed additional training and have been granted a license extension. This change meets the needs of our communities by increasing access to care and improving overall health outcomes. Please feel free to reach out to me with any questions or concerns. Thank you for taking the time to read my comments and for this initiative to better serve our communities.
Alanna Gardiner	Hello my name is Alanna Gardiner and I wanted to write in and express my support for having midwifery care expanded in Washington State. I had all three of my children born with attending midwives, at Wenatchee Midwife Service and Childbirth Center in Wenatchee, WA. The care I received was superb, and I was able to develop a personal relationship with the women caring for me and my babies. This is one of the reasons why I would love to see their scope of practice expanded...it would allow me to return to them for extended reproductive care, even though I don't plan to have any more children. I hope this small note will make a difference in helping more women like me receive pre- and post-natal care from well-trained professionals but in a smaller, more intimate setting than a hospital or other clinic. The personal care, attention, and comfort that I found with my midwives was hands-down the best part of being pregnant, and I highly recommend midwifery to any other pregnant woman I know. Thank you for considering both this letter and the proposed bill as well.
Ashley Kristofzski, MSN, RNC-OB	I, Ashley Kristofzski, am a Student Nurse Midwife (SNM), in WA state and am writing to provide feedback for the 2021 Sunrise Review in progress pertaining to scope of midwifery practice for Licensed Midwives (LMs) in our state. Certified Nurse Midwives are trained to provide care across the reproductive life span. This includes wellness care, reproductive healthcare, gender affirming care, menopause management and some primary care. CNMs have full prescriptive authority in WA state. I am in SUPPORT of the Sunrise Review to increase the midwifery scope of practice for Licensed Midwives (LMs) who have completed the proposed additional training and have been granted a license extension. This change meets the needs of our communities by increasing access to care and improving overall health outcomes.
Doug Whelan, MD	At first glance, and based on interactions with non-medically based LM's, I think CNM's and NP's are the only ones with adequate understanding of pharmacology, physiology and possible contraindications to various treatments. A limited number of relevant medications need to be available to LM's, LPM's, such as oxytocin following delivery, silver nitrate, possibly PCN for GBS carriers. Expansion of prescribing authorization

	should probably be limited to RN based training with advanced degree, such as the CNM's or NP's. In low resource based environments (such as overseas,) this may be different. In the US there is greater availability of care from providers with adequate basic training for prescribing medications and treatments within their scope of practice. Marketing comprehensive medical care capability should be carefully monitored so the public is protected from misrepresentation of scope of practice. Prescribing under the supervision of those with further training (such as with PA's,) may be acceptable. When I consider the level of scrutiny applied to physicians (by credentialing, licensing committees, marketing, etc) , I'm concerned that the public is not protected from those being reimbursed for services rendered beyond the basic levels of training expected of other providers. Standards of care should be at the highest level available in our society.
Rebecca Bartsch, MSM, LM, IBCLC	I'm a Licensed Midwife in WA and I fully support adding limited prescription authority to the scope of practice of Licensed Midwives. It is a well known fact that the perinatal period presents a prime opportunity to provide preventive care, treatment for long-standing health concerns, and general health education beyond the issues specific to pregnancy, as pregnant and postpartum people are regularly accessing healthcare during that time even if they do not regularly seek healthcare ordinarily. For this reason, midwives are uniquely positioned to address all manner of social and health concerns beyond just the pregnancy itself. In this effort, we often come to a point where we've identified or diagnosed the issue, educated the patient about the issue, and yet have to send them elsewhere to have it treated. This is not only inconvenient for our patients, but also creates the risk that the patient will fail to follow-up and miss the care they need altogether. This can be dangerous depending on the situation. Wherever possible, Licenced Midwives should be the one-stop-shop for the pregnant and postpartum people in their care. Adding limited prescription authority would increase our ability to help our patients and decrease the chances that they miss out on the care they need. Receiving additional training for additional scope is not a new concept in healthcare provider licensing, and is absolutely doable in this situation. Help us help our patients by pushing this issue forward!
Le'a Minton, APRN, MSN, CNM, IBCLC	I am writing in strong support of allowing licensed midwives to prescribe, carry and administer medications pertaining to pregnancy and postpartum that they have been trained to use. Having properly trained licensed midwives be able to prescribe and administer life saving medications is important for the safety of mothers and infants.
Robin Richter	Please expand midwives scope of care. I've had three children with my midwives and several times I've had to search for a doctor or go to a walk in clinic to get a prescription I needed for my pregnancy, instead of being able to get it from my midwives. It was a complete waste of my time, the other doctors time, and my money. There is no reason why midwives scope of care should not be expanded. Please do the right thing and expand their scope.
Karen Hays, DNP, CNM, ARNP	I am writing to support the Sunrise Review proposal to expand the Licensed Midwife's scope of practice to include limited prescriptive authority for contraception and conditions common to the perinatal and postpartum periods.

	I practiced as a Licensed Midwife (LM) in Washington State from 1993-1996. I then earned a Certified Nurse-Midwife (CNM) and Advanced Registered Nurse Practitioner (ARNP) credential. Although I continued to work with LMs and attend home and birth center births in the community for several years as a CNM, the prescriptive privileges I now enjoyed were such a relief to my clients. My consultation and referral protocols for refractory or complicated cases did not change, as those are already required by midwifery and nurse practitioner laws, practice guidelines, and professional ethics. With prescriptive privileges, no longer did I need to arrange referrals for someone needing a basic antibiotic for a urinary tract infection or mastitis (both of which can become dangerous if treatment is delayed), or for an effective contraceptive to prevent another pregnancy from occurring too soon (which can present risks to the pregnant person). Clients with top notch insurance and the ability to suddenly drop everything to spend half a day or a whole day to see another healthcare provider to obtain one simple item can usually manage these short-term referrals for care. But many clients who were under-insured or uninsured often had to delay treatment as we made phone call after phone call to try to find a clinic reasonably close to their residence that could see them quickly and affordably and at a time of day that would not jeopardize their employment. In addition, for many clients, the long time it takes to develop trust with a healthcare provider was a feature often absent in these time-sensitive referrals, a problem enhanced by concerns for the baby when taking medication during pregnancy or lactation. Thus, it usually fell on me as the known and trusted LM to do most of the teaching and adherence monitoring and counseling and troubleshooting and follow-up laboratory studies (if indicated) to ensure that the prescribed treatment or contraceptive was utilized properly. Basically, as an LM I was doing all the (unpaid) work around prescribing except actually prescribing the medication or device. Please don't misunderstand me - my personal situation of becoming an ARNP-CNM with prescriptive privileges is not the answer here! Years of extremely expensive nursing and nurse-midwifery education is not the solution for LMs in Washington State who only ask to be able to prescribe well-defined categories of contraceptives and a limited number of treatments for commonly encountered infections. Having been educated first as a Licensed Midwife (Seattle Midwifery School) and then as a Certified Nurse-Midwife (University of Washington), I can attest that the LM has the basic scientific and bioethical foundation from which they can acquire the competencies for the limited scope of practice expansion described in this Sunrise Review. With additional training, as any licensed healthcare provider participates in when learning new knowledge or a new skill, the 5000+ Washington state residents every year who seek Licensed Midwifery care can be served more efficiently, effectively, and economically when they experience one of these common and usually easily treatable infections, or when they desire to begin a highly effective contraception method during their early postpartum weeks. By decreasing barriers to clients accessing necessary and time-sensitive healthcare, this carefully thought-out proposal meets the very definition of the Institute for Healthcare Improvement's Triple Aim.

	 Thank you for your consideration of this Sunrise Review.
Blythe Parker, LM	I am writing in support of the Sunrise Review for Licensed Midwives to be able to meet the growing and increasingly diverse demands of the childbearing population in WA State by increasing the Scope of Practice to treatment of infections with antibiotics and prescribing ability for family planning. As a licensed midwife serving a rural population, I believe that families deserve timely access to the quality care they need. This legislative change will: • Help us reduce & eliminate barriers to care while increasing preventative care Decrease morbidity associated with untreated conditions: • Situations where LMs could efficiently treat their clients with antibiotics if permitted include mastitis, urogenital infections, and sexually transmitted infections Ensure families have the tools to plan their family size & space their pregnancies: • When people must attend an additional visit for a contraceptive prescription or insertion they are more likely to use less effective methods or no method Reduce costs and barriers to care by: • Eliminating unnecessary additional visits with another provider • Needing to seek contraceptive care from a different provider than their midwife risks delay and loss to follow-up, and this loss to follow-up is significantly more likely to impact already vulnerable and marginalized populations Updates the arcane law that only enables LMs to prescribe diaphragms and cervical caps to their clients: • These contraceptive methods are rarely used in the United States and have much lower effectiveness than other more common, modern methods Requires additional didactic and skills-based training for midwives who want to offer these services: • Other health professions employ this approach to practice updates Improves perinatal outcomes by: • Increasing midwifery integration into the healthcare system

	• Expanding client choice of practitioner who can meet their routine perinatal needs, particularly in medically under-served rural and urban areas Ensures pregnant and postpartum persons can receive initial basic treatments from their midwife: • Consultation and referral will still be employed for refractory or complicated cases (already law)
Tamara Ellen Merritt, D.O.	I am writing in support of the proposed expansion of the scope of practice for licensed midwives in the state of Washington. I completed my residency training at University of New Mexico, where the family practice department works closely with and backs up many of the licensed midwives in Albuquerque. I have thus been fortunate to continue working with licensed midwives in Chelan and Okanogan Counties since moving to Washington in 2006. I have shared numerous patients with them through the years, and I feel like I am well-qualified to speak on behalf of their competence, their skill set, and the necessary support and care they provide to many women in communities around the state and in my community in particular. Licensed midwives are more than capable of identifying and prescribing antibiotics and antifungals for mastitis, urogenital infections, and sexually transmitted infections. Right now I have two shared patients the midwife has contacted me for to provided needed prescriptions, and for both of these the midwife is knowledgeable and educated in what and why to prescribe. They are also trained and able to provide contraception of all sorts, and providing prescriptions for and insertion of long-acting reversible contraception is definitely something licensed midwives do in many states, including New Mexico where I completed my training. In our rapidly growing area, we do not have enough health care providers to meet the needs of our expanding patient population, so most of us would welcome this continuity of care provided by midwives (rather than discussing with patients what contraception to use then having to schedule another visit with me or a colleague to achieve that, often incurring additional cost and time away from their family). Licensed midwives also often are able to reach patient populations that tend to not otherwise utilize healthcare resources for various reasons. I have found that working together with the midwives in my area helps both of us to provide for the needs of individuals that might not usually access the healthcare system, and I feel strongly that allowing licensed midwives an expanded scope in these two ways will be a benefit for healthcare providers and patients and the families in our state. Please contact me can I be of any further assistance.
Rosanna Davis, LM, CPM	I am president of California Association of Licensed Midwives, Rosanna Davis. I am writing to express CALM's support for Hawaii midwives to add to their practice law: limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with appropriate training. California licensed midwives have such authority and training, which works well in practice. Having such authority contributes to the safety and wellbeing of the people served by California licensed midwives.

Evangely Santiago-Prado	My name is Evangely, a 22 year old underrepresented Hispanic women who experienced pregnancy for the first time in 2021 in the middle of a pandemic. Studies show that minorities face disproportionate healthcare malpractice and racism than any other community in America. As a result of continued racism during my first prenatal appointments, I resorted to home birth with my midwife being of a underrepresented community as well. In doing so, I experienced one on one comprehensive care that catered to my specific needs as an individual. However, the limits put upon my midwifes license restricted her of prescribing common medications for pregnancy which forced me to aquire third party services that prolonged the process of acquiring the medications I needed. This process is not an equal opportunity for pregnant women who would like to exercise their right of home birth. It is rather built to deter woman from doing so due to midwife restrictions. Please expand licensed midwife scope. This expand will allow midwives to prescribe common medication for pregnancy. This is specially important for folks in our communities who are underrepresented and face racism in the Healthcare industry.
Debbie Owens, ARNP	I am a ARNP for over 20 years and currently work with a recent Midwife graduate. We have worked together for about 3-4 years and I have watched her going through school, graduating and now setting up her own practice. She is EXCELLENT and has a broad knowledge base and I feel she should be able to provide contraception to her patient or treat her UTI while pregnant or post partum. This is all part of the big picture and makes no sense she can not provide these services! I do believe all the Midwives deserve to have their authority expanded to prevent barriers in health care to their patients. Please do forward my support and I do hope the proposals will pass.
Bahja Farole	Expand midwife license scope.
Jamila Farole	Please expand licensed midwife scope. Thank you!
Caranina Palomino, CNM, ARNP	I would like to voice my strong support for the expansion of LM's scope of practice to include prescriptive authority for contraception and to treat common conditions in the perinatal period. As a nurse midwife working closely with LMs I am aware with their pivotal role serving our community and ensuring families are healthy. Their care and support of families goes above and beyond, they are able to get to know families and create trusting relationships, and they are clinical experts caring for pregnancies and other reproductive health concerns. Increasing midwifery integration in the healthcare system is proven to improve perinatal outcomes and this bill is one step towards that goal in Washington. Utilizing LMs to their full abilities safely and effectively bridges gaps our clients currently experience in their care as well as improving and streamlining care overall. Thank you for joining me in your support of expanding the LM scope of practice,
Chelsey Swan, LMT, CEIM	I am writing to you in order to submit my support for the licensed midwives sunrise review. I am a local, Kirkland based, perinatal massage therapist and educator. I have a very busy private practice of pregnant and postpartum families and new parents. Through my direct work with these families I see firsthand how challenging it can be to get the care and treatment they need in a timely manner. For example, mastitis is an infection in the breast that can occur with lactation. This is something that is easily

	diagnosed by midwives and should be treated by them as well. Let's eliminate unnecessary additional visits with another care provider. I support increasing the licensed midwifery scope of practice to include prescriptive authority for all contraception options and antibiotics for common perinatal infections. It only makes sense to expand their scope to include these key/basic elements of perinatal care. Increasing the scope of practice in this way will help reduce and eliminate barriers to care while increasing access to preventative care. Licensed midwives are highly skilled medical professionals and are experts in physiologic birth. With additional training to include all contraception options as well as antiobiotic prescriptive authority, midwives can continue to improve perinatal outcomes by ensuring pregnant and postpartum persons can receive initial basic treatments from their midwife. Please approve this sunrise review. Thank you!
Shoshi Dersh, RN BSN	Hi! I wanted to put in my support of legislation to allow licensed midwives to prescribe pregnancy related medications such as antibiotics. This will increase access to care and allow more people to have healthy pregnancy's. I am an obstetrical nurse who seeks midwifery care for my pregnancy and I strongly believe in the unique care that licensed midwives provide their patients. To be able to fully care for patients, they need to be able to help with contraceptives and other medications that needs arise for during pregnancy. Thank you for considering!
Sydney B. Johnson RN, MSN	As both a Washington state Registered Nurse and client of Washington state Licensed Midwives who have now helped catch both of my children, I feel an urgent need to advocate for both the appropriate and essential nature of this expansion of the midwifery scope of practice legally permissible in WA state. This expansion of scope would include midwives providing the type of care they are prepared for in school. They are knowledgeable and well-educated in prescribing a limited scope of medications for infections that arise in pregnancy and the postpartum period such as STIs, UTIs, and mastitis. The legal freedom to prescribe these medications would alleviate a large care gap for pregnant and postpartum folks presented with these issues who have to then attempt to seek out an alternative care provider. Left untreated in the absence of alternative care, these infections can be extremely harmful both to pregnant/postpartum persons and their babies. It boggles my mind that Licensed Midwives in WA state cannot prescribe birth control beyond the archaic and ineffective methods of diaphragms and cervical caps. Licensed midwives are trained in how to place IUDs; why are they unable, then, to do so at a 6 week postpartum visit for one of their clients? They should be able to prescribe any type of birth control their clients have interest in, as they are already well-prepared and trained to do so, and as primary care providers in the postpartum period, put in the position of educating clients about their birth control options. This barrier LMs currently face in their inability to prescribe most methods of birth control points to a significant potential for a gap in care that could cause substantial harm to clients. Families deserve access to timely care and the ability to space their families as desired. Often by the time they are in the position of scheduling an appointment with an alternative provider to receive birth control, the potential of an unplanned pregnancy in the immediate postpartum period has been present for some time. This is concerning especially for families who have limited access to care or face barriers related to socioeconomic status, geographical location, insurance, etc.

	I support this legislation as it is essential for improving perinatal outcomes and continuity of care for LMs and their clients. I know I personally would have greatly benefited from being able to receive more consistent and immediate care for initial, basic perinatal concerns from my midwife/care provider of my pregnancy vs. having to seek care for basic issues outside of that established relationship. I support this legislation as it essential for removing barriers that clients of LMs face when presented with basic perinatal issues, especially in areas that are rural or underserved by alternative care providers. Let's put the prescriptive power midwives already deserve into their hands and improve access to care by this simple step. I support this legislation because it increases the visibility and integration of licensed midwives into our healthcare system in a very important, very necessary way as the desire and need for community-based birth in WA continues to grow. Allowing LMs this scope garners them much-deserved respect from the broader medical community.
Melanie Smith, for the Washington State Psychological Association	I am attaching comments from the Washington State Psychological Association regarding the scope of practice change request by the midwives. Please let me know if you have any questions. Statement of WSPA Support for the Licensed Midwives Scope-of-Practice Sunrise Application, Summer 2021 The Washington State Psychological Association (WSPA) reviewed the Sunrise Application, submitted to the Washington State Department of Health (DOH) by the Licensed Midwives of Washington (LMW). The proposed scope of practice expansion would permit Licensed Midwives to prescribe all contraceptive options and medications/therapies needed for the prevention and treatment of common prenatal and postpartum conditions. WSPA supports this proposed scope of practice change for Licensed Midwives in the State of Washington. The Applicant has addressed public safety by identifying the training, continuing education and disciplinary procedures required of LMW. The application also has shown that the proposed procedures and prescriptive authority are already practiced safely and effectively by Licensed Midwives in other states, including California, Hawaii, New Mexico, Rhode Island, and Utah. The case for the expansion of scope of practice for non-physician trained healthcare providers has become even more compelling with significant shortages of physician providers. Support nationally for scope of practice expansion for non-physician providers continues to grow and is predicated on demonstrable evidence (e.g., Dower, Moore, & Langelier, 2013; Institute of Medicine, Safriet, 2002). Psychologists are trained in biopsychosocial models that emphasize the importance and interdependence of physical, emotional and social health. We are acutely aware that physical well-being and health are paramount to a patient's behavior health. Increased access to medical care, including Midwifery that is safe and effective is an important factor in the overall well-being of our shared patients. The application noted that limited access to physicians would be eased by this expansion of scope of practice for Licensed Midwives.

	In light of the evidence provided by the Applicant, efforts to restrict this scope of expansion for Licensed Midwives in Washington can at best be described as misguided, and at worst, as guild protection. WSPA supports LMW in their pursuit to provide greater access to these services.
Alyca Green	I am writing to submit a comment on the potential expansion of the LM scope of practice to include limited prescriptive authority for contraception and conditions common to the prenatal and postpartum periods. I am greatly in support of this expansion not only as a certified professional midwife, but also as a childbearing and currently pregnant consumer of midwifery. It is very frustrating for both the clients and providers during the postpartum period when seeking solutions to prevent unplanned pregnancy and we have only diaphragms and cervical caps to offer, contraceptive methods that are rarely used in the United States and have much lower effectiveness than other more common, modern methods. Allowing Licensed Midwives (LMs) the capability of offering all contraceptive options and antibiotics for common perinatal infections decreases a lack of follow up and eliminates barriers to care, it allows myself and my clients to remain in the capable care of a provider they already have an established trusting relationship with. Thank you for your serious consideration on this review.
Serenity Quiggle, MSM, LM	I'm writing in support of the proposed change to the scope of Licensed Midwives in the state of Washington. I write in the capacity of a Licensed Midwife, who is actively practicing, and invested in the welfare of the clients we provide care for, as well as Washington State itself. The proposed change in scope would quite clearly allow us to provide better care. Following are a few reasons I feel this would be the case: -- Licensed Midwives are the front line of healthcare for many pregnant people. We can (and frequently do) identify and test for varying issues that arise commonly in pregnancy, such as reproductive and urinary tract infections. We are trained to know when they are occurring, and then to assess that they've been successfully treated, yet we are not allowed to treat the infection itself, leaving a gap where additional providers are required for proper care to occur. The proposed change of scope allows Licensed Midwives who've sought specific training around these treatments to provide them, removing the need for people to access another provider. This lowers additional cost to clients, insurance companies and the state overall, by allowing the client to retrieve treatment in the same location they've acquired testing & follow-up care. In our practice, approximately 50-75% of our clients access state-provided healthcare, and often must use Urgent Care or Emergency Departments to access a treatment as simple as antibiotics. This is a gross misuse of these higher level facilities, of the additional provider's time, and of state funding overall when needing to pay for these higher-level facilities and providers. So much money is misused when these treatments could instead be given by the Licensed Midwife they are already in contact with. Additionally, untreated infections can have devastating effects on a pregnancy. Some clients may not be able to physically or financially access another provider easily, or it

	may take some additional time, leaving these infections the chance to increase prior to treatment. This possible problem could be mitigated by their current Licensed Midwife being able to provide treatment in a more timely and accessible manner. As a Licensed Midwife myself, I would gladly and gratefully commit to any additional training needed in order to help ease this burden of current state funding, to provide access to those of my clients who may not be able to get to an additional provider for care, and to simplify the process of treatment. I know many other Licensed Midwives who would make this commitment as well. -- Concerning birth control: Licensed Midwives are currently able to provide VERY limited options of birth control; ones that are not modern methods being used by the majority of the population, and are also not as cost-effective as some of the newer options. The proposed change in scope simply updates and modernizes the options we can provide to our clients, giving them birth control choices they are actually interested in using. In conclusion, I urge you to consider this proposed change, not only to ease arising issues of provider access, to allow people to choose the types of birth control they wish to use, and to allow continuity of care for clients in a more streamlined manner, but overall, to decrease misuse of state funding and insurance payment requirements. When resources can be allocated efficiently, more people overall can access care. Please allow us, as Licensed Midwives, to do our part for these issues in a committed, responsible manner.
Naomi O'Callaghan, MSM, LM, CPM	I'm writing in support of the proposed change to the scope of Licensed Midwives in the state of Washington. I write in the capacity of a Licensed Midwife, who is actively practicing, and invested in the welfare of the clients we provide care for, as well as Washington State itself. The proposed change in scope would quite clearly allow us to provide better care. Following are a few reasons I feel this would be the case: - Licensed Midwives are the front line of healthcare for many pregnant people. We can (and frequently do) identify and test for varying issues that arise commonly in pregnancy, such as reproductive and urinary tract infections. We are trained to know when they are occurring, and then to assess that they've been successfully treated, yet we are not allowed to treat the infection itself, leaving a gap where additional providers are required for proper care to occur. The proposed change of scope allows Licensed Midwives who've sought specific training around these treatments to provide them, removing the need for people to access another provider. This lowers additional cost to clients, insurance companies and the state overall, by allowing the client to receive treatment in the same location they've acquired testing & follow-up care. In our practice, approximately 50-75% of our clients access state-provided healthcare, and often must use Urgent Care or Emergency Departments to access a treatment as simple as antibiotics. This is a gross misuse of these higher level facilities, of the additional provider's time, and of state funding overall when needing to pay for

	these higher-level facilities and providers. So much money is misused when these treatments could instead be given by the Licensed Midwife they are already in contact with. Additionally, untreated infections can have devastating effects on a pregnancy. Some clients may not be able to physically or financially access another provider easily, or it may take some additional time, leaving these infections the chance to increase prior to treatment. This possible problem could be mitigated by their current Licensed Midwife being able to provide treatment in a more timely and accessible manner. As a Licensed Midwife myself, I would gladly and gratefully commit to any additional training needed in order to help ease this burden of current state funding, to provide access to those of my clients who may not be able to get to an additional provider for care, and to simplify the process of treatment. I know many other Licensed Midwives who would make this commitment as well. -- Concerning birth control: Licensed Midwives are currently able to provide VERY limited options of birth control; ones that are not modern methods being used by the majority of the population, and are also not as cost-effective as some of the newer options. The proposed change in scope simply updates and modernizes the options we can provide to our clients, giving them birth control choices they are actually interested in using. In conclusion, I urge you to consider this proposed change, not only to ease arising issues of provider access, to allow people to choose the types of birth control they wish to use, and to allow continuity of care for clients in a more streamlined manner, but overall, to decrease misuse of state funding and insurance payment requirements. When resources can be allocated efficiently, more people overall can access care. Please allow us, as Licensed Midwives, to do our part for these issues in a committed, responsible manner.
Emily Coates	I am a senior midwifery student at Firstlight Midwifery in Tacoma, WA. I am preparing to graduate from a MEAC program, and sit for my national and state exams. I have served hundreds of midwifery clients during the course of my residency, and enjoy working in an environment where we have a supportive and collaborative obstetrician to whom we can refer clients who need prescriptions that are currently outside of our scope of practice. It is so important for midwives and obstetricians to be able to work collaboratively in order to ensure midwifery clients have access to interventions that are outside the scope of midwifery. However, it is also true that the needs of midwifery clients represent an undue burden on our transfer relationships. We should be referring clients who have needs outside of the common, minor complications of pregnancy. In my coursework, I am required to know the first line treatments for common infections such as urinary tract infections, mastitis, yeast infections, and prevention of HSV outbreak. Making referrals for these common complications delays treatment for matters that are best served by quick intervention, and burdens already busy practitioners with problems that really don't provide adequate reimbursement for the amount of investment they have to make with our clients. As I prepare to enter the ranks of WA midwives, I do so with a deep appreciation for the infrastructure and collaboration that make out of hospital birth safe and sustainable.

	This expansion of scope for licensed midwives is a common sense addition to that safety and sustainability. Thank you for your time and consideration of this important suggested expansion.
MariClaire Eastabrooks	Please allow me to introduce myself. My name is MariClaire Eastabrooks and I am a birth and postpartum doula, as well as a grateful recipient of the wonderful care of licensed midwives, as I've previously given birth at home on two separate occasions. Did you know that there is currently a review happening in WA state to expand the scope of licensed midwives? The specific expansion being considered is "limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with appropriate training." What could this include? That will be a conversation for further clarification once the review is complete. When I think of how this might be implemented, I think predominantly of things like urinary tract infections, yeast infections, mastitis treatment, and HSV outbreak prevention. All of those are very common conditions associated with very straightforward prescription requirements, and all of those require a consult with an OB or PCP. As I have been a midwifery client, I know how frustrating it feels to have to see another provider (even though there are some wonderful OBs out there!) for something that my midwife knows how to treat. I ask that you take action to support expanding the scope of licensed midwives in Washington so that other birthing people in our state can continue to get the appropriate, timely, and thorough care we all deserve. Thank you for your time and consideration on this important matter,
Beth Arcese, MA, LM, CPM. Mother	I am writing as both a consumer of midwifery from 2004-2007 and a Licensed Midwife from 2012 to present. After my second baby I had sudden onset of mastitis with a high fever just days after giving birth. My midwife was able to diagnose, but not treat the condition. I was delirious with fever, had a newborn nursing every two hours and was recovering from a significant laceration with a lot of sutures. Having lived through one of the scenarios this bill is trying to correct, I can tell you, it would have made a huge difference for me if my Licensed Midwife could have offered me home care that included a prescription for antibiotics. As a midwife, I know that we care for people from broad educational, political, religious and class backgrounds. Some of our clients engage seamlessly with mainstream medical care. Others are very hesitant - either from personal experience or sociocultural influence. If I could get clients set up with a contraception plan during their final visit (during which a full physical is performed including pelvic and breast exams, pap as needed and optional STI testing), I could help those reluctant clients engage in active birth control. Many of them instead choose to rely on less effective non-prescription methods and often return with a pregnancy that happened earlier than desired. Those on medicaid then cost the system (taxpayers) much more with the unintended pregnancy. While pregnancies are good for business, we Licensed Midwives prefer to engage in care that leads to spaced pregnancies and avoidance of unintended pregnancy. That is what is best for society, families, and the wellbeing of patients and infants. In my county, access to OBGYNs is increasingly limited and new patients are often unable to establish care.

	UTIs are not uncommon during pregnancy and create a direct threat to the wellbeing of the pregnant person and the fetus. When an LM refers a patient to their PCP for an Rx, they don't always go and they don't always get in right away. By prescribing common antibiotics to treat this condition, I could assure my clients prompt treatment without extra visits elsewhere and increase compliance with the recommended course of care. When UTIs go untreated (or only treated "naturally,") they can escalate to pyelonephritis, leading to costly ER visits and increased risks. Licensed Midwives are already trained to give antibiotics in labor by IV, an even more concentrated use of common medications. With additional training on the use of antibiotics to treat common STIs, UTIs and mastitis, LMs could support the healthcare system by decreasing demand on OBs, PCPs, and clinics by treating the common infections that are already screened/tested for within their scope. Midwives are capable of providing pap smears and utilizing routine and emergency treatments with instruments and medications during labor, delivery and immediate postpartum, when sometimes urgently needed. Adding routine prescriptive authority for those with appropriate training to insert IUDs and prescribe hormonal birth control makes sense, saves money, time, unintended pregnancies and provides the kind of care most patients of Licensed Midwives desire. Thank you for your support of this bill. I look forward to these changes that will keep Washingtonians safe and healthy.
Meredith Milholland	I am writing to share my support of the expansion of the scope of practice for LMs to include limited prescriptive ability for antibiotics and birth control options. As a consumer of midwifery care, this would have made such a difference to me! Having to set up additional appointments postpartum to reach these services was a hassle and stressor.
Chelsy Iorio	I'd like to comment in favor of expanding scope of practice for licensed midwives in WA state. Reproductive health is an intimate affair for women and having a stellar relationship with a practitioner she feels safe with is very important. I would much rather pursue reproductive health care from my midwife with whom I've already had a long time to build a close relationship than with the male OB at the health department who I've seen once. Please make it easier for women like me to receive care with a provider who is familiar and convenient.
Mary Mittell, CNM	I am writing to provide feedback for the 2021 Sunrise Review in progress pertaining to scope of midwifery practice for Licensed Midwives (LMs) in our state. My name is Mary Mittell, and I am a Certified Nurse Midwife (CNM) in WA state--and appreciate how safely expanding scope of practice benefits patients. Certified Nurse Midwives are trained to provide care across the reproductive life span. This includes wellness care, reproductive healthcare, gender affirming care, menopause management and some primary care. CNMs have full prescriptive authority in WA state. I am living/working in Seattle and care for a high-risk, low income population through a Federally Qualified Health Center. I am proud of my work as a CNM--and, also, when I was pregnant with my own two children, I went to LMs for my pregnancy care. The LMs I saw are excellent clinicians and provided very high-quality of care--but there were episodes (when I had a UTI and

	when I needed contraception postpartum) where I had to go outside their practice in order to get the care I need. I am in SUPPORT of the Sunrise Review to increase the midwifery scope of practice for Licensed Midwives (LMs) who have completed the proposed additional training and have been granted a license extension. This change meets the needs of our communities by increasing access to care and improving overall health outcomes.
Jennifer Wharton	I am writing to express my strong support in expanding midwifery scope of practice to include limited prescription authority for contraceptives and antibiotics. Midwives are trusted community health professionals and serve an important role in increasing equity and access for women and birthing people in Washington. Expanding their scope of practice to include common well-woman prescriptive authority will allow them to serve even more individuals in this trusted model of care. Thank you for your consideration of this sunrise language.
Carrie Fathke, MD	I reviewed the proposed changes in the licensed scope of practice. My concern is on the behalf of patients. It takes years of dedicated training and experience to become a physician. The reason we, as a profession, have dictated that scope and depth of training is necessary to ensure a physician not only has subject matter expertise but understands when circumstances are atypical. That takes years of training, education and thousands of patient care hours under supervision of experienced physicians. My concern is that with a high school education/GED, 2-3 year training and only 50 patients in clinical training, licensed midwives will have a challenging time identifying an atypical situation and disease course. This could be consequential for a young woman with cervical cancer, a woman with subtle contraindications for different contraception types, when to recognize that treating common symptoms is masking a more complex disease state, etc…. I believe strongly there is a role of licensed midwives in our healthcare infrastructure but working in partnership with a physician who diagnoses and develops a care plan then working with a licensed midwife, advanced registered nurse practioner or physician assistant to execute the plan of care depending on the complexity of the plan. To the discussion about continuity of care and lack of physicians in underserved areas, telemedicine is fast becoming an expected tool in healthcare delivery. This will mean that the expertise gap in health care will become less of an issue in the future.
Kaitlin Murray	Hi! I'm writing to comment on the midwife scope of practice posted on the DOH website. I would absolutely support the expansion of the scope of practice for midwives. In my area i do not have access to an OBgyn that I feel comfortable with and has my best interest at heart. Expanding the scope of practice for midwives would give me better access to a provider I could see regularly for birth control, antibiotics, etc without having to make a separate appointment with a doctor I have to travel farther for. As a working parent this would improve my quality of life greatly. I also feel more comfortable discussing my medical needs with the midwives. Having their services expanded would be a dream come true. Thank you for your consideration of my comments.

Rebekah Ashton, DNP, CNM, IBCLC	I, Rebekah Ashton, am a Certified Nurse Midwife (CNM) in WA state and am writing to provide feedback for the 2021 Sunrise Review in progress pertaining to scope of midwifery practice for Licensed Midwives (LMs) in our state. Certified Nurse Midwives are trained to provide care across the reproductive life span. This includes wellness care, reproductive healthcare, gender affirming care, menopause management and some primary care. CNMs have full prescriptive authority in WA state. I am living/working in King County and have cared for individuals and families seeking sexual and reproductive health care for 25 years in clinic and inpatient Labor and Births settings. I am also a consumer of LM healthcare and as an educated and critical consumer I trust the professional model completely. I am in SUPPORT of the Sunrise Review to increase the midwifery scope of practice for Licensed Midwives (LMs) who have completed the proposed additional training and have been granted a license extension. This change meets the needs of our communities by increasing access to care and improving overall health outcomes.
Sarah Paradis	I just wanted to share my experiences with midwifery care and how them being able to prescribe a standard array of medication would be incredibly beneficial to those in their care. With my last pregnancy I developed severe morning sickness. Because my midwives couldn't prescribe the anti-nausea medication I needed and I had to wait for a doctor to evaluate my need, I spent several days vomiting when I could have been more comfortable and eating well had my midwives been able to write a script for zofran. Most recently I've had a case of mastitis while still in their care and had to resort to a trip to urgent care, with my newborn, to seek antibiotics because they were unable to write a script themselves. Thank you for considering widening their scope and allowing them to prescribe these medications as needed to their clients.
Elizabeth Shocklee	With regards to the proposed expansion for midwives scope of practice: I was fortunate to work with an incredible team of midwives throughout my first pregnancy this year. I recently went in for my 6 week appointment, at which I was able to receive a pap smear but not a prescription for birth control. Unfortunately, this means I now have to go in for a separate appointment with my obgyn. It would have made so much more sense to have contraception available through the team I've been working with, especially as a busy parent of a newborn. I truly hope this change is made in order to provide new mothers with a more concise pathway to contraception.
Micah Matthews for the Washington Medical Commission	Sunrise review regarding a change in the scope of practice for licensed midwives The Washington Medical Commission (WMC) is the regulatory body for the practice of Allopathic Medicine, also referred to as conventional medicine. The WMC currently regulates about 35,000 physician and physician assistant licenses, approximately 31,000 MDs and more than 4,000 PAs. It is the purpose and responsibility of the WMC to protect the public, by ensuring quality healthcare is provided by our licensed practitioners. The WMC establishes, monitors, and enforces qualifications for licensure, consistent standards of practice, and continuing competency. Rules, policies, and procedures developed by the WMC promote the delivery of quality healthcare to the people in Washington.

	I thank the Washington Department of Health for the opportunity to review and comment during their Sunrise Review regarding a change in the scope of practice for licensed midwives by allowing them prescription authority for contraception, medications and therapies for various common conditions in pregnancy and postpartum While we support the concept as provided by the Midwives' Association of Washington State we have a concern. As written, the midwives scope expansion would be handled only through one party rulemaking. This leaves out consultation or collaboration with other authorities that have experience regulating these practices. Additionally, the WMC has some proposed changes to the proposed draft legislation *Concerning the Practice of Midwifery* H-1639.1/21: • For clarity and accuracy, section one of the proposed draft legislation should be changed to add definitions for pre, intra, and postpartum and include timeframes for each phase. • Section four of the proposed draft legislation should be modified to include explanation for "common prenatal and postpartum conditions" or a listing of these conditions and what prescriptions would be authorized in these cases. It is not possible to determine what training would be appropriate if prescriptions and conditions are not specified in statute. Other concepts within the draft bill have the WMC support: • We agree with the concept of providing treatment of sexually transmitted diseases for patients and partners. WMC has had a similar guideline in place since 2008 and it is a standard public health practice. • We support the proposal for birth control expansion. From a continuity of care perspective, it is appropriate. The WMC has had a policy4 since 2018 that endorses continuity of care as the best standard for patients. Thank you for your time, consideration and recognition of the requests from the Washington Medical Commission regarding the Sunrise Review to increase the scope of practice for Washington state midwives. If you have any questions or follow up requests, please contact me at your convenience.
Elizabeth Whitaker, BSN, MN	I, Elizabeth G Whitaker, was licensed as a Certified Nurse Midwife (CNM) in WA state and am writing to provide feedback for the 2021 Sunrise Review in progress pertaining to scope of midwifery practice for Licensed Midwives (LMs) in our state. Certified Nurse Midwives are trained to provide care across the reproductive life span. This includes wellness care, reproductive healthcare, gender affirming care, menopause management and some primary care. CNMs have full prescriptive authority in WA state. I live in Kittitas County and am currently retired from the local public health department. I am in SUPPORT of the Sunrise Review to increase the midwifery scope of practice for Licensed Midwives (LMs) who have completed the proposed additional training and

	have been granted a license extension. This change meets the needs of our communities, especially in rural areas where licensed health care providers may be located at a significant distance, by increasing access to care and improving overall health outcomes.
Hannah Calhoun	My journey started with Vancouver community midwives when I was pregnant with my third baby I switched from having an OB and I never will go back Midwives are gentle they listen inform us educate us on our pregnancy labor and delivery they take time to get to know us and not just push in as many people as they can into a day. Having my midwives be able to do PAP smears and write up Prescriptions for birth control and antibiotics would be a life saver not having to go back to my OB office post delivery. This is a change that needs to happen!!!!
Steven Aguilu, MD	I agree with the tenor and principle of this letter and would support the clarification of training and knowledge base. Prescriptive authority in WA state is already too liberal in my opinion. I see a lot of misuse and misleading patient education from alternative medicine professionals and in rare cases, potential harm. This is not a turf battle... it is just good patient care and concern. By the way paragraph 5 last line says “emphasis” and I think may have meant to use the word “emphasize”. Thank you for your work.
Mindy Juan, MD	I would like to submit comments that agree with the WSMA stance on this issue. This is as follows: The proposal lacks a definition of prescriptive authority and treatable conditions. This proposal would benefit from provisions that define to what extent and under what circumstances prescriptive authority would be permitted. Currently, only Section 4 of the bill draft makes an attempt to outline the boundaries of the proposed prescriptive authority, stating “A midwife licensed under this chapter who has been granted a limited prescriptive license extension by the secretary may prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal and nonhormonal family planning methods, as prescribed in rule.” Additional clarity is critical for patient safety due to the complexities of the prenatal and postpartum periods. As an example, a postpartum patient with “routine” abdominal pain treated with antibiotics for possible uterine infection could actually be septic and require admission for IV antibiotics or a patient who needs contraception and would be well suited with an IUD but instead is given oral contraceptives which are contraindicated because of the patient’s hypertension. This language is vague and does not provide adequate safeguards to ensure appropriate use of prescriptive authority by licensed midwives to prevent and treat common prenatal and postpartum conditions. For example, the definition of the postpartum period can range anywhere from 6 weeks up to one year and “common prenatal and postpartum conditions” lacks specificity in accounting for the type of conditions and corresponding drugs needed for prevention and treatment falling under these categories. Furthermore, “hormonal and nonhormonal family planning methods” could include a wide range of contraceptive devices. While licensed midwives may currently fit and prescribe intravaginal diaphragms and cervical caps, other long-acting reversible contraceptive devices are intrauterine, making these insertions more complex and requiring more rigorous education and training in order to safely perform these procedures. There are a variety of contraindications associated with postpartum IUD

	placement, including intrauterine infection at the time of delivery, postpartum hemorrhage, and puAerperal sepsis – which only serve to emphasis the importance of adequate education and training and patient safety sideboards. Drugs, procedures, and treatments, and the circumstances in which they may occur, should be specifically stipulated to maintain patient safety standards. Not stipulating these parameters in statute, and instead leaving the complex details of determining when and how the proposed prescriptive authority would apply to the rulemaking process, would be a missed opportunity for the Legislature to ensure patient safety. The proposal needs clarity in defining to what extent and under what circumstances this proposed prescriptive authority would apply. Concerns with permissive language pertaining to the drug types included within the proposed prescriptive authority. Building on our first concern, the proposal needs more specificity concerning the drug types that are allowed within the proposed prescriptive authority. Upon review of the language in Section 4 (referenced above) it is unclear what drugs or classes of drugs would be included, leaving this determination to the rulemaking process. Rules are meant to be an interpretation of the law, so it is important that underlying statutes are in place to ensure the Legislature's intent to protect the public by ensuring safe and appropriate use of the proposed prescriptive authority. The current language is too broad and offers limited boundaries on prescriptive authority with respect to licensed midwives' education and training. Drugs, procedures, and treatments should be specifically stipulated to determine the appropriate sideboards needed to maintain patient safety standards. The WSMA opposes increases in non-physician practitioner's scope of practice without stipulating appropriate education and training requirements. In Section 2 of the bill draft, it states "For those candidates seeking a limited prescriptive license extension, additional study and training is required, as prescribed by the department by rule." In this current form, the language does require licensed midwives seeking a prescriptive authority license extension to complete additional education and training but lacks any specificity on what additional education and training will be required. We appreciate that the Midwives Association of Washington acknowledges that prescriptive authority would require additional education and training but contend that the requirements must be outlined to ensure practitioners receive the level of education and training needed to safely utilize the proposed prescriptive authority. There is a danger that many common conditions could mimic a complex, life-threatening condition and the provider must have adequate education and training to differentiate. For example, a pregnant patient prescribed triamcinolone steroid ointment for abdominal itching thought to be pruritic urticarial papules and plaques of pregnancy (PUPPP) could be cholestasis of pregnancy and result in fetal death. Given the lack of specificity in the current language detailing the boundaries of the proposed prescriptive authority, the recommendation in the applicant report of a one-time 5-hour continuing education course is insufficient given the possible latitude of the prescriptive authority as currently outlined. While licensed midwives share an important role in providing care to Washington state patients, their skillsets are not interchangeable with physicians or certified nurse-midwives, who have undergone more extensive medical education and training. For context, physicians attend medical school for four years, complete residencies ranging from four to seven years, and complete 12,000 to 16,000 patient care hours. Certified nurse-midwives are Advanced Registered Nurse Practitioners (ARNPs), whose educational background includes 2-4-year nursing programs that

	comprise advanced coursework in physiology, health assessment, and pharmacology. ARNPs must then complete a nurse-midwifery graduate program, with specific training to provide care across the reproductive lifespan, in order to become licensed as a certifiednurse midwife. CNMs also predominantly practice in hospital settings with the support of a fully supplied and staffed hospital. In comparison, licensed midwives complete a three-year educational training program overviewing gestational parents, newborns, and a wide range of associated health topics that isn't intended to provide the level of thoroughness of a physician's education and training and participate in 100 births prior to licensure. Licensed midwives also typically practice in birth centers and patient's homes, rather than a clinical environment. While this level of education and training is sufficient under the current scope of practice for licensed midwives, the lack of comprehensive medical training underscores the WSMA's recommendations to outline more specificity and sideboards in statute to ensure patient safety. Simply providing counseling on related reproductive health care issues does not automatically translate to the level of education and training required to prescribe, perform procedures such as IUD implantations, and formulate overarching medical decisions. The WSMA cannot make recommendations on what level of education and training would be sufficient without further details relating to our first two concerns outlined above. It is paramount that the DOH consider the scope of the proposed prescriptive authority in order to determine whether the current language provides adequate education and training requirements. Attempts to increase access to care will only be meaningful if the providers delivering the care have the adequate education and training. The WSMA and our physician and physician assistant members value their collaboration with licensed midwives and recognize their significance in caring for our state's residents. Licensed midwives are an asset to patients and the entire health care provider community and so we look forward to working with the DOH and other stakeholders to remedy these concerns. Thank you again for the opportunity to provide comment on the sunrise review proposal. Thank you very much,
Tessa Nearing	I am writing to express my support of the proposed changes to licensed midwives' scope of practice. I had my son in 2014 at an out of hospital birth center, attended by a midwife. My provider came to my home for postpartum visits, something I am extremely grateful for. At 10 days postpartum, on my husband's first day back to work, I developed bilateral mastitis. It was extremely painful and I developed a high fever as a result of the infection. My midwife could tell I had mastitis, but lacked the power to write a prescription for antibiotics. Even though she called my primary care physician's office to let them know I had mastitis, I was still required to pack up my 10 day old baby and go into the doctor's office in person with a 103 degree fever for them to confirm that I had mastitis. If my midwife had the ability to prescribe an antibiotic for me, I would have received treatment earlier and would have saved myself a lot of physical and mental anguish. I hope this change of practice is approved!
Marc Reiswig, MD	Thank you for the opportunity to comment on the sunrise review related to midwives' authority to prescribe medications. As an emergency physician working in an emergency department, I have appreciated my interactions with midwives who have sent their patients to the Emergency Department when pregnancies/births have complications. This has also given me a first-person opportunity to see complications related to midwifery. Most of the complications I have seen are related to midwives not recognizing when a patient's

	issues are getting beyond the midwife's scope of knowledge/practice. I foresee the proposal exacerbating this issue. Specifically, the proposal, as written, is overly broad. It lacks adequately defined prescribing limits, does not have reasonable safeguards in place, and is unusually vague. In short, it is excessively permissive both in scope and drug categories. In addition, the proposal does not have adequate initial and continuing education requirements related to this prescriptive authority. This proposal increases the risk to patients' health and does not serve to alleviate any problems. This is not an access to care issue. Pregnancy and birthing services in the State are very good, in part thanks to midwives. This proposal would result in patients' access to a higher level of care be delayed when midwives attempt to treat things for which they are inadequately trained. I believe the Washington State Medical Association (WSMA) will likely have similar patient safety concerns, and I recommend carefully considering any thoughts they might have on this issue.
Nancy Sapiro, for the American College of Obstetricians and Gynecologists – WA Section	RE: Sunrise Review proposal addressing increasing midwifery scope of practice On behalf of the American College of Obstetricians and Gynecologists – WA Section, we appreciate having the opportunity to comment on the Department of Health's sunrise review concerning increasing the scope of practice for midwives. While ACOG is committed to increasing access to care for birthing parents and supporting patient choice, we do have concerns that the current proposal is overly broad and could negatively impact patient safety. ACOG generally supports a collaborative relationship with all midwives, as we believe this improves patient care. We also support licensed midwives (LMs) having prescription authority for some medications, particularly if they allow for improved immediate patient care in the antepartum/peripartum/postpartum periods. Using a harm reduction framework, we know patients ARE receiving care from direct entry midwives, and we support that experience being as safe as possible. Licensed midwives have had legal authority to practice in Washington State for decades and already are legally permitted to use several drugs for pregnancy, delivery, and newborn care. ACOG supports over the counter access for most oral contraception, so we feel very comfortable extending prescriptive authority to licensed midwives for this. As to other forms of contraception that require procedural intervention to initiate or discontinue, we do have concern with extending the prescriptive license for midwives as currently presented. We believe the proposed educational coursework to increase the scope of practice is insufficient. Currently, there are FDA restrictions around anyone providing subdermally implanted contraception (Nexplanon) without going through a mandatory 2-hour training provided by Merck. We do not know if there are restrictions on licensed midwives accessing this training. Anyone who wishes to provide subdermally implanted contraception is currently required to have completed this mandatory training.

	Regarding Intrauterine Devices (IUD's), currently there are no required training programs in the US to be an IUD provider, as this training typically happens during formalized training programs, like a medical residency, or certified nurse midwife (CNM) training and practicums. ACOG has some concern about the limited amount of training and observed insertions that are presented in this proposal. By way of example, there are several programs that conduct such trainings globally in low- and middle-income countries (LMIC), where the majority of reproductive health care is provided by nurses who have more limited formal training than our nurses or CNMs have in the US. These IUD training programs are often 4-5 days long, include practice and sign off on a simulation model, then a minimum of 10 observed insertions. There are no data that clearly describe what the adequate amount of education and training is for someone to be an effective IUD provider, however we believe that it is more than that presented in the proposed draft. Finally, we note that antibiotics are also mentioned as medications for which the licensed midwives would like prescriptive authority. There are some situations during pregnancy and postpartum where this may be completely appropriate (e.g., treating asymptomatic gonorrhea or chlamydia). However, many indications for antibiotics during pregnancy can also be cause for greater concern, and these patients would likely benefit from being evaluated by an OBGYN or someone with more medical training. Overall, the proposed idea has some merit, however as it is currently written, ACOG feels it is overly broad and may not always be in patients' best interests. We are concerned that an expansion of ability to provide care will occur without the appropriate expansion of the necessary education, monitoring, and certification for licensed midwives needed to ensure patient safety. At this time, we cannot support these changes but look forward to opportunities to collaborate to further the care of women's health, respect the diversity of choices patients make in identifying their clinicians, and ensure the safest possible outcomes.
Leslie Edwards, for the Planned Parenthood Alliance Advocates in Washington	Planned Parenthood Alliance Advocates – Washington (PPAA) is pleased to submit the following comments in strong support of the Midwives Association of Washington's proposal to expand the midwifery scope of practice to include prescriptive authority for contraception and certain other pregnancy-related medications and therapies. PPAA is committed to ensuring that all people in Washington can access quality, affordable sexual and reproductive health care services that help them plan their families and achieve their personal pregnancy goals. This includes supporting access to high-quality contraceptive and other sexual and reproductive health (SRH) care from qualified providers who are well positioned to meet patients' unique health care, cultural, and other needs, such as licensed midwives. We strongly support this proposal because it will promote access to high quality, patient-centered contraceptive, pregnancy, and postpartum care, and in turn will promote equitable access to health care, reduce health disparities, and improve outcomes across the state. Consistent access to birth control gives people the ability to decide when and if they have children, giving them more career and education opportunities, encouraging healthier pregnancies, and fostering healthy children and families. Increasing access to high-quality, client-centered contraceptive care is an important tool to help Washingtonians achieve their pregnancy goals and promote positive maternal and child health outcomes.i

	Leading medical authorities, including the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association, and the American Academy of Family Physicians, agree on the benefits of comprehensive birth control access and recommend that patients have access to the full range of FDA-approved contraceptives. Washington voters and policymakers have also long recognized access to contraception as a critical part of individuals' basic health care needs, and in recent years Washington has taken a number of important steps to improve access to contraception and the full range of SRH services. Despite the many measures our state has passed to protect the right to affordable contraception and other SRH services, not all Washingtonians are able to access these rights. Department of Health (DOH) data shows that despite the progress our state has made in improving access to the tools Washingtonians need to plan their families and achieve their pregnancy goals, over one third of pregnancies in Washington are unintended. This rate is even higher for Medicaid patients, Washingtonians with low incomes, Black and Hispanic Washingtonians, and others who have long faced disproportionate barriers to health care and other resources.ii Washington State has also seen an alarming increase in sexually transmitted infections in recent years, aligning with nationwide trends of increased rates of chlamydia, gonorrhea, and syphilis. Due to centuries of systemic racism that exacerbates other barriers to care, this trend also disproportionately impacts Black and Hispanic Washingtonians.iii Ensuring that Washingtonians in need of SRH services can access a qualified provider to meet these needs is a critical component of our state's ability to address these health trends and promote health equity for all Washingtonians. DOH's "Health of Washington Report – Sexual Health" identifies a shortage of qualified providers as a barrier to SRH services, noting that "many primary healthcare providers are not trained to address health concerns related to sexual issues, and culturally appropriate prevention services are often unavailable."iv Washington's most recent physician supply estimate underscores this concern: the report notes that the supply of physicians specializing in obstetrics and gynecology decreased slightly between 2019 and 2020.v Licensed midwives are well-position to address these shortages and ensure that all Washingtonians have access to qualified, culturally competent providers to meet their sexual and reproductive health care needs. Midwives already provide a wide range of pregnancy-related care, including contraceptive counseling, testing for sexually transmitted infections, and more. Allowing qualified midwives to build on these services by prescribing a broader range of contraception, treatment for the common sexually transmitted infections and urinary tract infections they diagnose, and other pregnancy-related medications will increase Washingtonians' ability to access the care they need at their preferred health care provider. Allowing midwives to prescribe contraception is particularly critical to ensuring that all people in Washington can access culturally competent, client-centered contraceptive care from a trusted and qualified provider. Many patients – particularly those in rural and medically underserved areas – may have no source of care other than their midwife. And because midwives can already provide contraceptive counseling and STI testing, allowing licensed midwives to address the needs identified during patient visits will increase continuity of care for patients who have already developed a relationship

	with a trusted midwife. This will empower patients to receive care from a provider who is familiar with their individual SRH needs and goals without forcing patients to receive unnecessary referrals to another provider they may not know or trust. For patients who lack reliable transportation, have competing work and family obligations, or cannot afford to pay for an extra medical appointment, allowing qualified midwives to offer this care may be the difference between their patients being able to access needed SRH care and going without. Thank you for the opportunity to comment. We urge you to build on the work our state has already done to increase access to SRH services by giving qualified midwives the prescriptive authority they need to provide critical, client-centered SRH care to their patients and improve health equity and outcomes for Washington patients.
Sarah Rafton, for the Washington Chapter of the American Academy of Pediatrics	The Washington Chapter of the American Academy of Pediatrics (WCAAP) is supportive of and grateful for the opportunity for midwives licensed under chapter 18.50 RCW to provide essential routine prophylactic medications (vitamin K, erythromycin ointment, Hepatitis B vaccine, and HBIg when indicated) to newly delivered infants. Medications prescribed to any neonate beyond these routine prophylactic medications, or clinical needs outside of typical newborn health, require a thorough evaluation by an independent health care provider with comprehensive pediatric training and ability to follow the infant clinically beyond two weeks of life. For these reasons, we respectfully share with you that this proposal, as currently written, would exceed appropriate prescriptive authority for newborns. We are happy to work with you or relevant parties in any way to improve the proposed legislation.
Maya Horrocks, LM, CPM	As a licensed midwife of 7+ years, I fully support the expansion of scope of care for LMs to include certain prescriptive authority for common pregnancy/postpartum needs. Bridging the care gap of the time between us diagnosing a problem such as mastitis or a UTI and them getting the treatment they need. We have referred people to clinics for clear infections only to have our patients turned away and symptoms dismissed for their infections to worsen. Simultaneously, when birthing people are given the birth control of their choosing prior to their departure from their final postpartum, they are truly able to be in "control". Another place where RX from us would be incredibly appropriate and patient centered would be our ability to administer misoprostol for a missed miscarriage. The list goes on. Please support this scope expansion for the best of the families in WA State!
Samantha Owings	I am writing because I believe that the Midwife's Association of Washington should have their scope of practice broadened. With the current regulations if I was to experience a UTI or a yeast infection in pregnancy my midwife would have to refer me to my PCP. The issue is that some PCP's don't feel comfortable treating pregnant women. Some might refer to an OBGYN at their clinic while others send us back to our midwives. This makes it hard for us to receive the care that we need in a timely manner, also creates more unnecessary medical bills, causes stress, and can even create bigger medical problems down the road. Continuity of care is important as is ensuring that all pregnant women can receive the best medical care possible no matter who is providing their care. Thank you for all that you do and hearing my thoughts of the matter.

Louise S. Miller, for the Washington State Society of Anesthesiologists	RE: Sunrise review proposal addressing midwifery prescriptive authority On behalf of the Washington State Society of Anesthesiologists (WSSA), we appreciate the opportunity to comment on the Department of Health's sunrise review concerning proposed prescriptive authority for midwives. The WSSA members agree with the concerns outlined by the Washington State Medical Association (WSMA), particularly regarding whether the current language provides adequate education and training requirements for licensed midwives in the expanded role being proposed. Ensuring patient safety and access to high quality health care should be the state's foremost consideration when evaluating the scope of practice expansion for a health profession. The WSSA shares WSMA's concerns with the ambiguity in the proposal as drafted, and believes it lacks clarity in defining the circumstances under which the prescriptive authority would apply. In addition, the education and training requirements for midwives prescribing medication must be explicitly outlined to ensure practitioners receive the level needed to safely utilize the proposed prescriptive authority. WSSA encourages the Department of Health to consider the recommendations from WSMA regarding appropriate parameters for prescriptive authority for midwives as well as their other patient safety concerns.
Kristin Effland, LM, CPM, MA	I am writing as a rural consumer of Licensed Midwifery In Washington state for my own two children and as a Licensed Midwife who previously practiced for nine years in two different medically underserved areas of the state. I also currently teach as an Adjunct Faculty member at Bastyr University in the Department Midwifery and as a Core Faculty member at the Midwives College of Utah. As an LM, I am more than willing to do any continuing education and training necessary for a license extension option to offer families this access to routine medications relevant to pregnancy and postpartum that the World Health Organization considers essential. As an instructor for the last eight years at the two MEAC accredited midwifery schools that train the majority of LMs who practice in Washington state, I feel confident that our curricula could be updated to ensure that future LMs would be prepared for this expanded scope. I have seen firsthand the burden on individual families and the healthcare system in rural areas when I was unable to offer my clients their chosen family planning method at their six week postpartum visit. More than once, I diagnosed a UTI but had to refer clients who needed a simple antibiotic to an urgent care facility or an ER sometimes forcing them to travel more than an hour from their home. Not only does this inefficiency cost the healthcare system money, but it also delays treatment and causes unnecessary inconveniences for families. Besides my own experience as an LM, my students share case examples with me as well that illustrate the value of this increased access for families. In one case, a student shared a story about an African-American client of theirs who was a pregnant mother of

	three working as a nurse during the coronavirus pandemic. The student and her supervising LM recognized her symptoms and sent her urine off for the appropriate labs revealing the bladder infection they suspected she had. Rather than being able to get a simple prescription from her LM, her primary maternity care provider, this client delayed attending an additional appointment to get the prescription antibiotics she needed. As a result, this busy working mother ended up having to be hospitalized for a kidney infection. Thank you for taking these important topics into consideration,
Leslie A. Linares-Hengen, MD	With regards to current sunrise proposals, I do not support broad prescription authority for midwives.
Hoda Mohamud	I support the expansion of LM scope.
A. Maya Johnson, LM, CPM, MA	Hello, my name is Andrea Maya Johnson and I support the limited prescription authority for contraception and medications and therapies for various common conditions in pregnancy and postpartum, for those with appropriate training proposal.
Jeffery Aristotle Pecoraro, MSN, RN, CNOR, CCM, CRC	I am writing to provide comment on the the midwifery scope of practice. In addition to opposing this proposal, there should not be an authorization for this “discipline” in the first place. As the United States has a higher percentage of fetal demise than that of comparable countries, compounded by health disparities from social determinants of health, we need highly educated and clinically trained individuals to handle these challenges. Furthermore, even for prescribing authority for a topical, the individual should have the necessary education regarding pharmcotherapeutics. I invite these individuals that“play nurse” to join the nursing workforce, and attain the training to be a certified nurse midwife, gaining the necessary education and training to handle every type of situation that may happen.
Paul Naber, PharmB, R.Ph	As a health care provider for over 50 years, continuing education equipped to practice Clinical Pharmacy for over 50 years as good as a newly graduated Clinical Pharmacist, I am indicating: We should NOT increase Midwifery Scope of Practice; rather we should decrease Midwifery Scope of Practice.
Erica Davidson	I wanted to write to you to tell you that I am in support of the broaden of midwives scope of practice to include antibiotics, other medications and contraception. I was under the care of a midwife for both of my pregnancies and it would have been nice to be able to continue care with her for contraception after my children were born. I also just think that it is so helpful oto not have to go to multiple other caregivers to get prescriptions while you’re already under the care of your midwife. Thanks for considering this proposal, I think it would be a great benefit for all.
Katie Klassen	I had all three of kids with a LM midwife out of hospital. During these pregnancies there were various times I had to make extra appointments for antibiotics which became increasingly difficult once I had multiple children. Which means higher cost also. It also would have be so much easier if my midwife could have placed my IUD. She is a place of comfort, she is gentle and a 6 week postpartum visit already includes a vaginale exam. I had to have an additional appointment plus obviously an additional vaginal exam for this placement but a practitioner who has barely a fraction of the bedside manner. Which is incredibly disappointment especially when it comes to to something like this. All that said, I am a big support of the proposal to increase the midwifery scope of practice.

Brianna Label, MD, FAAP	I am writing in regards to the Sunrise Review Proposal regarding midwifery scope of practice. As a Pediatrician in the State of Washington for over 10 years, I care for a large number of children in our state, many of whom have been cared for by midwives. They are a valued part of patient care but licensing and regulation should continue in a way that provides proper education and training for the scope of practice authorized. The proposal is lacking in many specifications and definitions that would allow for better access to care in a well-defined manner with safeguards for our community. At present, the lack of specification regarding the exact training required including types and hours of training, certification process to ensure proper education and types of drugs to be safely managed after training means that women and children are at risk and the burden to our healthcare community will increase. While we support improving access to care, your pediatricians ask that you ensure proper training and certification of our healthcare partners to continue a trend of equitable, quality, evidence-based care.
Emma Grabinski, MD, FACOG	I am writing to support the WSMA's stance on the proposal to increase the midwifery scope of practice. I work with a highly competant group of CNMs, and am disappointed to read the proposed increased scope for licensed midwifes. I believe that women, especially pregnant women, deserve excellence in care. These proposals would potentially put women in harms way by allowing undertrained providers to attempt to diagnose and treat conditions for which they do not have adequate training. It also devalues the years of training, experience, CME, and rigorous examinations that CNMS and OBGYNs are required to do, when licensed midwives are considered equivalent. I am also concerned that this further erodes public trust in highly qualified medical professionals. Please reconsider this extremely dangerous proposal.
Danelle Aurilio, LM, CPM, MSM	This increase in scope of care will improve the health of Washingtonians by reducing barriers to care and increasing preventative care. Licensed midwives in this state offer exceptional care at a low price and expanding LM scope will allow LMs to treat clients with certain infections, support family planning in their clients, eliminating the need for visits with another provider. Reduce costs and barriers to care by: • Eliminating unnecessary additional visits with another provider • Needing to seek contraceptive care from a different provider than their midwife risks delay and loss to follow-up, and this loss to follow-up is significantly more likely to impact already vulnerable and marginalized populations LMs will be required to do additional didactic and skills-based training for midwives who want to offer these services, keeping the profession accountable even as scope expands.: • Other health professions employ this approach to practice updates Improves perinatal outcomes by: • Increasing midwifery integration into the healthcare system

	• Expanding client choice of practitioner who can meet their routine perinatal needs, particularly in medically under-served rural and urban areas Ensures pregnant and postpartum persons can receive initial basic treatments from their midwife: • Consultation and referral will still be employed for refractory or complicated cases (already law)
Nancy Allin	This is an important level of scope for the many families that utilize midwifery care in the state. It will speed up the response to situations that the midwives in the front lines to address and with the knowledge of their client's history and health status. I strongly support this.
Linda van Hoff, for ARNPs United of Washington State	ARNPs United of Washington State (AUWS), who represents over 9,000 Advanced Practice Nurses (Nurse Practitioners, Nurse Anesthetists, Nurse Midwives, and Clinical Nurse Specialists) urges you to support the sunrise review application regarding Licensed Midwives (LMs). Under current law, LMs are not permitted to prescribe the majority of contraceptives or infection treatments, even though testing and educational counseling related to these conditions, medications, and devices is within their scope of practice. The inability of licensed midwives to prevent, treat, and prescribe for these conditions or to provide the full range of contraceptive options creates unnecessary barriers to care, exacerbates health inequities, and undermine our state's efforts to improve health outcomes and reduce unintended pregnancy. This proposal aligns with efforts for eliminating health inequities, increasing access to affordable reproductive health services, improving maternal-child health, and promoting reproductive autonomy. • It will increase access to contraception and contraceptive uptake, which results in optimal birth spacing; • Patients will benefit from Timely, Cost-effective Treatment of STIs, UTIs, and other Urogenital and/or Breast/Chest Infections; • Families across the state will benefit from Ready Access to Care; and • It will help increase continuity of care and patient satisfaction. Access to sexual and reproductive health (SRH) care is instrumental in improving public health outcomes and maintaining reproductive autonomy. LMs are well-suited to provide more SRH care than the current law allows.
Alex Wehinger, for the Washington State Medical Association	On behalf of the Washington State Medical Association (WSMA), we appreciate the opportunity to comment on the Department of Health's (Department) sunrise review concerning proposed prescriptive authority for midwives licensed under chapter 18.50 RCW (hereafter referred to as licensed midwife/midwives), not to be confused with certified nurse-midwives (CNMs). The WSMA is thankful for our continued partnership with licensed midwives as valued and respected health care providers who often work closely with physicians. While we are committed to increasing access to high-quality medical care for all our state's residents, we have concerns with the undefined terms in the proposal as drafted that may result in ambiguity and misinterpretation. The WSMA believes the proposal would

	benefit from clarity to ensure a balance between enhancing access to care while preserving quality and patient safety. The WSMA met with the Midwives Association of Washington to discuss their proposal, ask questions, and talk through our preliminary concerns. That discussion informed our recommendations outlined below that we feel are necessary and that make the proposal stronger, including where and how to apply appropriate parameters related to the proposed prescriptive authority and other patient safety protections. **The proposal lacks a definition of prescriptive authority and treatable conditions.** This proposal would benefit from provisions that define to what extent and under what circumstances prescriptive authority would be permitted. Currently, only Section 4 of the bill draft makes an attempt to outline the boundaries of the proposed prescriptive authority, stating "A midwife licensed under this chapter who has been granted a limited prescriptive license extension by the secretary may prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal and nonhormonal family planning methods, as prescribed in rule." Additional clarity is critical for patient safety due to the complexities of the prenatal and postpartum periods, especially in patients with other non-pregnancy related medical conditions. As an example, a postpartum patient with "routine" abdominal pain treated with antibiotics for possible uterine infection could actually be septic and require admission for IV antibiotics. Consider another patient who needs contraception and would be well suited with an IUD but instead is prescribed oral contraceptives which are contraindicated because of the patient's hypertension. The language in the proposal is vague and does not provide adequate safeguards to ensure appropriate use of prescriptive authority by licensed midwives, within the scope of their training and education to prevent and treat common prenatal and postpartum conditions. For example, the definition of the postpartum period can range anywhere from six weeks to up to one year and "common prenatal and postpartum conditions" lacks specificity in accounting for the type of conditions and corresponding drugs needed for prevention and treatment falling under these categories. Furthermore, "hormonal and nonhormonal family planning methods" could include a wide range of contraception. While licensed midwives may currently fit and prescribe intravaginal diaphragms and cervical caps, other long-acting reversible contraceptive devices are intrauterine or surgically implanted forms of hormonal contraception such as Nexplanon, making these insertions more complex and requiring more rigorous education and training in order to safely perform these procedures. Long-acting reversible contraception such as IUDs and Nexplanon are highly effective, but they do require a high degree of skill for proper placement. An IUD is placed into the uterus after dilating the cervix. If this is placed improperly, it has a higher rate of expulsion or malposition. More concerningly, there is a risk of uterine perforation where the IUD perforates through the uterine wall and into the abdominal or pelvic cavity which would prompt the need for surgical removal. In the hands of an experienced clinician, the risk of uterine perforation is low—1/1,000—however, in inexperienced hands this risk is likely far higher. There are also a variety of contraindications associated with postpartum IUD placement, including intrauterine infection at the time of delivery, postpartum hemorrhage, and puerperal sepsis. On a similar note, a Nexplanon insertion

	is a procedure which requires an incision into the skin and proper placement of the implant into the arm. This must be done under sterile conditions and carries a risk of infection, hematoma, and nerve injury if not done properly. These scenarios only serve to emphasize the importance of adequate education and training, patient safety guardrails, and an ongoing partnership with physician specialists. Drugs, procedures, and treatments, and the circumstances in which they may be prescribed and treated, should be specifically stipulated to maintain patient safety standards. Not stipulating these parameters in statute, and instead leaving the complex details of determining when and how the proposed prescriptive authority would apply to the rulemaking process, would be a missed opportunity for the Department to ensure patient safety. The proposal needs clarity in defining to what extent and under what circumstances this proposed prescriptive authority would apply. **Concerns with permissive language pertaining to the drug types included within the proposed prescriptive authority.** Building on our first concern, the proposal needs more specificity concerning the drug types that are being sought to be within the prescriptive authority of licensed midwives. Upon review of the language in Section 4 (referenced above) it is unclear what drugs or classes of drugs would be included, leaving this determination to the rulemaking process. Rules are meant to be an interpretation of the law, so it is important that underlying statutes are in place to ensure the Legislature's intent to protect the public by ensuring safe and appropriate use of the proposed prescriptive authority. The current language is very broad and offers limited boundaries on prescriptive authority with respect to licensed midwives' education and training. Drugs, procedures, and treatments that would be within the scope of the proposed prescriptive authority should be stipulated to determine the appropriate sideboards needed to maintain patient safety standards. **The WSMA opposes increases in non-physician practitioner's scope of practice without stipulating appropriate education and training requirements.** In Section 2 of the bill draft, it states "For those candidates seeking a limited prescriptive license extension, additional study and training is required, as prescribed by the department by rule." In this current form, the language does require licensed midwives seeking a prescriptive authority license extension to complete additional education and training but lacks any specificity on what additional education and training will be required. We appreciate that the Midwives Association of Washington acknowledges that prescriptive authority would require additional education and training but contend that the requirements must be outlined to ensure practitioners receive the level of education and training needed to safely utilize the proposed prescriptive authority. There is a danger that many common conditions could mimic complex, life-threatening conditions and the provider must have adequate education and training to differentiate one from the other. For example, a pregnant patient prescribed triamcinolone steroid ointment for abdominal itching thought to be pruritic urticarial papules and plaques of pregnancy (PUPPP) could be cholestasis of pregnancy and result in fetal death. Given the lack of specificity in the current language detailing the boundaries of the proposed prescriptive authority, the recommendation in the applicant report of a one-time five-hour continuing education course would be insufficient given the possible latitude and range of conditions that licensed midwives might be able to treat within this proposed prescriptive authority as currently outlined.

	While licensed midwives share an important role in providing care to Washington state patients, their skillsets are not interchangeable with physicians or certified nurse-midwives, who have undergone significantly more extensive medical education and training, have a broader experience requirement, and have successfully completed summative examination of their wide-ranging knowledge. For context, physicians attend medical school for four years, complete residencies ranging from four to seven years, and complete 12,000 to 16,000 patient care hours. Certified nurse-midwives are Advanced Registered Nurse Practitioners (ARNPs), whose educational background includes 2-4-year nursing programs that comprise advanced coursework in physiology, health assessment, and pharmacology. ARNPs must then complete a nurse-midwifery graduate program, with specific training to provide care across the reproductive lifespan, in order to become licensed as a certified-nurse midwife. CNMs also predominantly practice in hospital settings with the support of a fully supplied and staffed hospital. In comparison, licensed midwives complete a three-year educational training program overviewing gestational parents, newborns, and a wide range of associated health topics that isn't intended to provide the level of thoroughness of a physician's education and training, and participate in at least 100 births prior to licensure. Licensed midwives also typically practice in birth centers and patient's homes, rather than a clinical environment. They may not have access to facilities to offer clinical follow-up of patients for whom they have prescribed treatments. While this level of education and training is sufficient under the current scope of practice for licensed midwives, the lack of comprehensive medical training underscores the WSMA's recommendations to outline more specificity and sideboards in statute to ensure patient safety. Simply providing counseling on related reproductive health care issues does not automatically translate to the level of education and training required to prescribe, perform procedures such as IUD implantations, and formulate overarching medical decisions. The WSMA cannot make recommendations on what level of education and training would be sufficient without further details relating to our first two concerns outlined above. We suggest that the applicants refine their proposal to focus on the drugs, procedures and treatments that they are seeking. Failing that, we urge the Department to limit the scope of the proposed prescriptive authority in order to determine whether the current language provides adequate education and training requirements. Attempts to increase access to care will only be meaningful if the providers delivering the care have the adequate education and training. The WSMA and our physician and physician assistant members value our collaboration with licensed midwives and recognize their significance in caring for our state's residents. Licensed midwives are an asset to patients and the entire health care provider community and so we look forward to working with the Department and other stakeholders to remedy these concerns. Thank you again for the opportunity to provide comment on the sunrise review proposal. Should you have any questions, please don't hesitate to contact WSMA's Associate Director of Legislative and Political Affairs, Alex Wehinger at alex@wsma.org. We appreciate your consideration.

Louisa Severn LM, CPM	I write in support of the proposed expansion of the Licensed Midwife's scope of practice to include limited prescribing of contraceptives and contraceptive devices, common antibiotics for swift, appropriate, barrier free treatment of common perinatal ailments such as mastitis and urinary tract infections. I practice in a more rural part of Washington where access to these medications invariably involves unnecessary ER visits and longer than optimal wait times to begin treatment, risking more significant illness, hospitalization and potential morbidity. Allowing LMs like to manage these common and readily treated issues will lessen strain on already strained systems. It will further allow us to take better care of the vast numbers of Medicaid patients we already do, in ways that remove some of the existing barriers to reproductive healthcare and contraceptive access. I appreciate your consideration
Shira Israel	I am a licensed midwife client with a due date of this fall. I intentionally searched one of the few black midwives in Washington. As a black woman it is important for me to get care from someone that looks like me. As a mom with other children I would love to get all of my pregnancy needs met by my midwife but unfortunately I have to see other providers to help prescribe meds for me and this makes it hard for me to get the meds in timely manner. I urge the sunrise review to expand licensed midwife scope of prescribing for common pregnancy illnesses. Thank you!
Kristin Eggleston, LM, CPM	Thank you for the opportunity for a sunrise review and for leaving comments. I work in rural eastern WA, primarily between Yakima and Richland. There are relatively few midwives and few OB practices in this area. All are generally very busy and patients can have a difficult time getting in to see one or to see one they prefer. Compounding the trouble with this, is the fact that I cannot treat common and mild needs within my own practice. This means I have to send my patients periodically out to see a very busy OB or CNM practice and my patients have to pay extra. They have to pay extra because they may not be registered with that practice or that practice may not be in network or the co-pay is simply greater than the cost of the non-routine visit with me. Thankfully I've been in practice for a decade now so I have some relationships with other providers. For new LMs, however, this can be tricky. I also have used licensed CNMs operating a Telehealth practice in order to get my patients seen and treated. None of this ideal for the patient, their family, or for the practitioners. I particularly feel that having antibiotic and family planning prescriptive authority will make a huge difference to my patients. I can't wait to have the training I'll need to be able to expand my scope and be fully competent in these new areas.
Merlene S. Converse, for Kaiser Permanente	Dear Secretary Shah and Department of Health team, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of Washington Options, Inc. in concert with our Permanente Medical Groups (collectively "Kaiser Permanente"), appreciate the opportunity to provide feedback to the Washington State Department of Health on the sunrise review for expanding the scope of practice for licensed midwifery.

	Kaiser Permanente is an integrated health care system that covers and cares for more than 760,000 members in Washington State. We are committed to delivering affordable, coordinated, and high quality care and coverage that supports not only our members but also the communities we serve. We have reviewed the sunrise review application materials for licensed midwifery. The current proposal and draft legislation do not provide an adequate outline of the necessary educational guardrails to ensure that the expanded scope of practice provides patient safety. We therefore do not support the proposal as written to expand the scope of practice to include prescribing antibiotics and implanting contraceptives. Patient safety must be the highest priority Supporting a collaborative relationship with all type of midwives improves patient care, especially if the midwives are licensed and meet educational standards. Therefore, licensed midwives (LMs) having prescription authority for some medications is appropriate, especially if this allows for improved and safer immediate patient care in the entire pregnancy continuum—antepartum to postpartum. It is important for the patient's broader health care team to know if patients are receiving care from midwives so that the team may support safety for those patients and collaborate if higher risk medical conditions are present. Licensed midwives have had legal authority to practice in Washington State for over 20 years. They already are legally permitted to use a number of drugs for pregnancy, delivery and newborn care. Below, we outline specific concerns with the sunrise review application that need to be addressed in the draft legislation. We support contraception services when LMs have completed appropriate training. Access to contraception is critical, and the concept of over-the-counter access to birth control is supported by the American College of Obstetricians and Gynecologists. Therefore, we support extending prescriptive authority to licensed midwives for these services. It is important to note, however, that the FDA currently has restrictions around providing subdermally implanted contraception (Nexplanon) and requires a mandatory 2-hour training provided by Merck. Before expanding the scope of practice, it would be important to make sure that LMs have access to this training. Intrauterine devices (IUDs) are different because there is not a required training program in the United States to be an IUD provider. This training happens during required educational training programs such as an OBGYN residency or a certified nurse midwife (CNM) training practicum. The sunrise application outlines limited amount of training and observed insertions indicated in this document which do not match the requirements, for example, in the several programs that hold trainings globally for low- and middle-income countries (LMIC). In those countries, the majority of reproductive health care is provided by nurses who have completed IUD training programs that can be 4-5 days long, and include practice and sign off on a simulation model, and then a minimum of 10 observed insertions. So, even though there is no data stating the adequate amount of training for an IUD provider, the amount of training stated in the application is concerning when compared to the level of training in other countries. Antibiotic prescribing needs additional guardrails based on the type of medical condition The applicant group proposes to add prescriptive authority for antibiotics. We recognize that there are situations in pregnancy and postpartum in which this is necessary (e.g., a positive screening for asymptomatic gonorrhea or chlamydia).

	However, the draft legislation should establish guardrails for higher risk conditions that require antibiotics. For these higher risk conditions, we recommend that the patient be evaluated by an OBGYN or a clinician with higher level of formalized training. We thank you for the opportunity to provide comments on this sunrise review for licensed midwifery. Please do not hesitate to contact us with questions.
Kim McCaulou, for Washington Academy of Family Physicians	On behalf of the Washington Academy of Family Physicians (WAFP), thank you for the opportunity to comment on the Department of Health's sunrise review addressing midwifery scope of practice. We write to state our agreement with the concerns raised by the Washington State Medical Association in their July 16, 2021 letter. The contributions of licensed midwives to the healthcare needs for low-risk pregnant people experiencing healthy pregnancies are undeniable; they provide a valuable service in the community. Washington's health care system must have providers who care for patients at all levels of need and complexity. The WSMA provides several examples of complications that may occur in the prenatal and postpartum period in their letter, noting a need for additional definition of prescriptive authority and treatable conditions in the proposal. We agree the proposal would benefit from less ambiguity in these areas to ensure the definitions are consistent with the level of education and training licensed midwives achieve. The WSMA also raises concerns with the permissive language related to the drug types included in the proposed prescriptive authority, and we agree the proposed language is too broad. Overall, we want to ensure patients receive care from health care providers who have the training and skills best suited to assess and manage each patient's need. Licensed midwives meet the needs of a subset of patients in the health care system, but their education and training are not as extensive as certified nurse-midwives or physicians. Without additional specificity in the proposal, the prescriptive license and scope of care proposed would create a mismatch between the licensed midwives' education/training and the complexity of their patients' needs. Thank you for your consideration of our comments. Please reach out to WAFP's Executive Vice President, Kim McCaulou at kim@wafp.net if you have questions.
Lindsay Trant, for Pharmacy Quality Assurance Commission	The Pharmacy Quality Assurance Commission (PQAC) thanks the Department of Health for the opportunity to provide remarks on the Sunrise Review: Midwifery Scope of Practice Expansion Draft. PQAC appreciates the Midwives' Association of Washington State for their initiative to further advance their profession's scope of practice, education, and training through the sunrise review process. We understand that enhancing the reproductive health of individuals is instrumental to improving population's health for Washingtonians and nationwide. After review of the bill request #1639.1/21 draft, PQAC has identified the following areas of concerns: • Section 2(2)(e) – For those candidates seeking a limited prescriptive license extension, additional study and training is required, as prescribed by the department by rule.

	o Comment: It is unclear how comprehensive the proposed study and trainings are. PQAC recommends any proposed bill specifically identify minimal standards for the additional study and training (e.g., pharmacology, pharmacokinetics, pharmacodynamics) such as the minimum educational requirements for midwives in RCW 18.50.040(2)(b). • Section 4 – A midwife licensed under this chapter who has been granted a limited prescriptive license extension by the secretary may prescribe, obtain, and administer medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal nonhormonal family planning methods, as prescribed by rule. o Comment: PQAC requests clarification: will those midwives granted with a limited prescriptive license extension be the only midwives allowed to prescribe? If so, is that prescriptive authority restricted to those drugs and devices outlined in WAC 246-834-250 and RCW 18.50.115, or will they have broader authority to prescribe? o Comment: PQAC recommends that if this bill creates two tiers of licenses, that there be a specific identifier on those midwives' credentials who have been granted a limited prescriptive license extension. This will ensure pharmacy licensees are able to determine if the person writing the prescription has the authority to do so. o Comment: PQAC has identified that the appropriate and necessary statutes have not been amended in order for midwives to have prescriptive authority as outlined in H1639.1/21. For midwives to obtain prescriptive authority, amendments should be made to the Legend Drug Act, chapter 69.41 RCW. Specifically, RCW 69.41.030(1) and 69.41.010(17)(a) would need to be amended to further align midwives with others health care professions under the Legend Drug Act. In addition, if the intent is for midwives to obtain the ability to prescribe controlled substances then amendments should be made to the Uniform Controlled Substances Act, chapter 69.50 RCW. Specifically, RCW 69.50.101(mm)(1) would need to be amended. Section 4 – The secretary, after consultation with representatives of the midwife advisory committee, the pharmacy quality assurance commission, and the Washington medical commission, may adopt rules that authorize licensed midwives to ((~~purchase and use~~)) <u>prescribe, obtain, and administer</u> legend drugs and devices in addition to the drugs authorized in this chapter. o Comment: Under the language of 1639.1/21, PQAC is unsure when it will be consulted by the secretary of health. Specifically, will PQAC be consulted when rules are adopted to identify medications and therapies for the prevention and treatment of common prenatal and postpartum conditions, and hormonal nonhormonal family planning methods for those who possess the limited prescriptive license extension? We also encourage the Midwifery Advisory Committee to ensure appropriate checks and balances are in place to supervise prescribing midwives. In addition, we would encourage the Secretary of Health to ensure that every licensee is registered with the Prescription Monitoring Program (PMP) if controlled substances are prescribed.

	PQAC appreciates the opportunity to comment on the Sunrise Review: Midwifery Scope of Practice and supports further collaboration on amendments to the applicant's report to ensure patient safety, health, and welfare.
Mary Lawlor, for National Association of Certified Professional Midwives	I am the Executive Director the National Association of Certified Professional Midwives (NACPM). I am writing to you today to support the request by the Midwives Association of Washington State to review the proposal to increase the options for Licensed Midwives (LM) in the State to include limited prescription authority for contraception and medications and therapies for several common conditions in pregnancy and postpartum for those midwives with appropriate training. In the U.S., consumers far too often encounter barriers to accessing needed health care, which can result in poor outcomes and unnecessary complications and suffering. Licensed Midwives in Washington State are well positioned to ameliorate effects of the perinatal care provider shortage and fill critical gaps in service. Adding contraception, devices, medications and therapies for conditions not infrequently encountered by people during their reproductive years to the LM scope of practice would avoid delays in accessing care and complications that can arise from untreated conditions such as UTIs and mastitis. It would avoid unwanted pregnancies in the interim while additional care providers are being sought out for contraception. These are conditions and situations for which LMs are already trained and qualified to identify and provide counseling for. Being able to prescribe for these same conditions and situations is a logical and important next step in ensuring access to timely, quality care for people already enrolled with Licensed Midwives. There are precedents in Washington State for this expansion of LM services; for example, LMs are currently authorized to obtain and administer antihemorrhagics to address excessive postpartum bleeding and IV antibiotics to treat Group B Strep during labor, two conditions that can arise during care necessitating treatment that midwives have been trained to provide. The proposal addresses another set of similar services that LMs can be trained to provide and that would protect and advantage the clients in their care. We at NACPM appreciate your attention to and consideration of this matter, and we urge the Washington State Department of Health to review this proposal.
Eloisa Cary, LM, CPM	I have been practicing for about 15 years in the Whatcom county community. I have cared for over 1000 mothers and continue to run a high-volume practice. I am writing to make a brief comment on my opinion that it is essential to have the limited prescription authority listed in the proposed legislation. Clients need to be able to easily obtain birth control and basic appropriate prescriptions without challenges and obstacles during this vulnerable time of pregnancy and especially immediately postpartum when they are trying to get into great new family members into their lives. So often I see repeat clients because I haven't been able to get to a provider to obtain birth control because the challenges of low income moms not having transportation just makes it too difficult. I also have seen the majority of low income moms with breast-feeding issues struggle through pain and nipple trauma because they may not have the additional resources to obtain a prescription to heal something as simple as I wounded nipple. This problem will be so easily solved if they could receive the proper care from their midwife while in office or at a home visit not requiring additional trips and added work. I'm sure we, as midwives, could all write pages about this but the

	bottom line is the support we could provide with additional prescriptive authority would hugely impact pregnant and postpartum women in our care, especially the low income population.
Nancy Leavitt	Please accept this email in favor of this legislation that would allow midwives to prescribe birth-control and a small spectrum of medication for postpartum and pregnancy.
Susan Rainwater	I would like to express my support of the Sunrise Review regarding the review of midwives scope of practice. I am fortunate to be the proud mother of four amazing children. When I was seven months pregnant with our first child, I made the decision to switch from receiving my prenatal care by an OBGYN to a licensed midwife, with the intention of having a planned out of hospital birth. Despite the anxiety of changing care in my third trimester, I was confident and comfortable with my lovely team of midwives who were receptive to my planned wishes for a natural birth. My daughter then arrived at a freestanding birth center and we then went on to have three successful home births, with this same team of midwives. Making that difficult decision all those years back was one of the best decisions I could have ever made. During these years of having my four children, who were all only a few years apart, my team of midwives were my main primary health care providers. They spent 10-11 months with me during each of my four pregnancies, which ended up spanning almost ten years of my life. Throughout these ten years, my partner and I changed jobs and therefore, had changes to our medical insurance coverage. Thankfully, our team of midwives accepted each form of our insurance, but we often found ourselves having to search for new primary health care providers throughout these years. In the midst of each of my pregnancies, my midwives explained their limitations in not being able to prescribe basic antibiotics for common urinary tract infections (which are extremely common throughout pregnancies), mastitis complications, or contraceptive prescriptions at my postpartum visits. Being a pregnant mother and having additional little ones, makes it extremely difficult to seek out new health care providers for these simple and basic conditions. And after the birth of our fourth child, I found myself in a new city (because we had just moved a few months prior to the birth), with three other children at home, and no primary health care provider that I could simply contact for these needs. It would be such a tremendous benefit to allow licensed midwives to address these concerns immediately and directly with their patients who are already receiving their care. It is incredibly difficult to seek out a new provider, schedule additional appointments, arrange transportation, having to take a newborn and all siblings to a separate medical appointment, and pay the additional co-payments for these appointment(s), when the concern could have been addressed and handled by my trusted midwife who knows me, my health care history, and my family. I wholeheartedly support this Sunrise Review of the midwifery scope of practice. The ongoing love and care that I received by my team of midwives throughout my birthing years were invaluable.
Catriona Munro	I am writing to state my support of the proposed increased prescriptive authority of licensed midwives in Washington state. The proposed changes - with appropriate training - can only improve outcomes and client satisfaction by creating a more seamless experience, which in turn will increase the likelihood of clients obtaining the care and services they require.

Rebecca Podszus, Health Care Authority	The following is the Health Care Authority's (HCA) response to the Washington State Department of Health's (DOH) Sunrise Review request on anesthesiologist assistants, optometrists, and midwives scopes of practice. (The department is only including the comments on the midwifery proposal here.) **Midwife scope of practice** We reviewed the bill draft (H-1639.1) and additional materials included in DOH's request. This legislation modernizes gender language and allows limited prescription authority for those with appropriate training. While licensed direct-entry midwives in our state are not currently permitted to prescribe most contraceptives or infection treatments, their testing and education counseling related to these conditions, medications, and devices are typically within their scope of practice. If this legislation were to pass, it would have some systems impacts. Apple Health managed care plan contracts may need to be updated, and fee-for-service plan billing guides would also likely need to be updated. However, systems changes would be limited because maternity services are reimbursed as bundled payments rather than individual services. These plans' pharmacy systems may also need to be updated to allow for billing of certain drugs prescribed by midwives (that are not allowed under the provider's current scope of practice). Additionally, HCA would need to check if any changes were required in the ProviderOne system. While PEBB Program and SEBB Program plans did not foresee any significant operational impacts, two plans requested that ambiguities around training in the current bill draft be addressed. As currently drafted, they do not support the bill. The plans would like to ensure that required training related to the increased scope of practice for midwives ensures patient safety. For example, training should address: • Implanted contraceptives • Potential and actual risks, and how to weigh risks and benefits of any treatment • Human physiology and how treatments can affect other organ systems • When a patient should be seen by a prescribing medical professional with higher training This legislation may positively impact clients. Increasing the scope of practice for midwives will likely increase access to some services for clients in rural or marginalized communities. Greater access to care may result in more positive outcomes for childbearing people in our state. Licensed midwives already attend more than 5 percent of total births in Washington State, which is greater than the national average, and this legislation has the potential to increase that percentage. However, we have the same concerns mentioned by the PEBB Program and SEBB Program plans regarding training and preparation for midwives who, under this legislation, would perform procedures and prescribe medications for which they may not have been trained. Regardless of the potential for increased care access, we want to ensure that licensed midwives caring for our clients have the level of training needed to provide quality care. **Conclusion**

	HCA recognizes the potential for all three proposals to positively impact access to care for the Washington residents we serve; however, we do have specific concerns about the quality of care that might result from expanding the scope of practice of both optometrists and midwives, when the training requirements for the additional practices are not specifically delineated . Two PEBB/SEBB plans appear to echo those concerns in pointing out the need for more robust training requirements for midwives, and that they could not support the legislation as currently drafted. If you have any questions about HCA's position on this issue, please contact me at rebecca.podszus@hca.wa.gov.

Appendix E – Curriculum Excerpts from Bastyr Pharmacology and Gynecology Courses

Excerpt of Syllabi provided by Department Chair & Associate Professor, Department of Midwifery

BASTYR UNIVERSITY – Winter 2021
Syllabus Excerpt
MW4310 Pharmacology and Treatments

Syllabus Introduction

Course Overview

- **Course Description**
  This course includes information about allopathic medications and immunizations relevant to midwifery practice and the midwife's professional and legal responsibilities regarding the use of medications.

  Course Topics
  1. Introduction to pharmacology, pharmacokinetics, pharmacodynamics, indications, therapeutic effects, side/adverse effects, contraindications, and methods of administration.
  2. The principle of "Informed Consent" applied to the midwife's legal, ethical, and professional responsibilities regarding drug/treatment use.
  3. Teratogenesis specific to using drugs, herbs (brief introduction – more information in other courses), or other ingestible treatments during pregnancy, lactation, and for the fetus/newborn.
  4. Antimicrobial drugs used in pregnancy and lactation.
  5. Vaccines and immunoglobulins relevant to midwifery practice.

- **Major Course Educational Objectives**
  Upon the successful completion of the course, the student will be able to:
  1. Describe the midwife's ethical and professional responsibilities as applied to the recommendation, administration, and monitoring of medications, including the use of informed consent / refusal and incorporating pharmacovigilance into midwifery practice.
  2. Define terms essential to an understanding of pharmacokinetics, pharmacodynamics, administration, and U.S. regulation of allopathic medications.
  3. Describe the unique physiology of pregnancy, postpartum, and newborns that impact pharmacokinetics and pharmacodynamics, including issues regarding teratogenesis.
  4. Identify medications commonly taken by pregnant and lactating people and demonstrate an understanding of the important and relevant information both the consumer and midwife should know about these medications.
  5. Describe the classes and potential risks of antimicrobials (including antibiotics, antivirals, antifungals) currently recommended for treating common physical conditions during the childbearing period & for newborns.
  6. Discuss basic concepts relevant to and recommendations for use of vaccines and immunoglobins during pregnancy, postpartum, and the newborn period.
  7. Compare and contrast the direct-entry midwife's legal authority and obligations regarding the use of medications in Washington State with other states / provinces.
  8. Identify trustworthy drug information resources (both online and in print).

- **MEAC Competencies addressed in this course:**

COMPETENCY #1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.

The midwife has the knowledge and/or understanding of:
2. principles of community-based primary care using health promotion and disease prevention and control strategies
3. direct and indirect causes of maternal and neonatal mortality and morbidity and strategies for reducing them
6. methods of infection prevention and control, appropriate to the service being provided
9. principles of health education
11. relevant national or local programs or initiatives (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country or locality)
12. the concept of alarm (preparedness), the protocol for referral to higher health facility levels, and appropriate communication during transport [emergency care]

The midwife:
24. is responsible and accountable for clinical decisions and actions
26. acts consistently in accordance with standards of practice as defined by national and local professional midwifery organizations
28. uses standard/universal precautions, infection prevention and control strategies, and clean technique
32. uses shared decision-making in partnership with women and their families; enables and supports them in making informed choices about their health, including the need or desire for referral or transfer to other health care providers or facilities for continued care when health care needs exceed the abilities of the midwife provider and their right to refuse testing or intervention
33. works collaboratively with other health care workers to improve the delivery of services to women and families

The midwife has the skill and/or ability to:
36. engage in health education discussions with and for women and their families
37. use appropriate communication and listening skills across all domains of competency
38. assemble, use, and maintain equipment and supplies appropriate to setting of practice
39. document and interpret relevant findings for services provided across all domains of competency, including what was done and what needs follow-up according to current best practices

COMPETENCY #3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

The midwife has the knowledge and understanding of:
19. safe, locally available non-pharmacological methods for the relief of common discomforts of pregnancy
23. basic principles of pharmacokinetics of drugs prescribed, dispensed or furnished to women during pregnancy
24. effects of **prescribed medications**, ultrasound, street drugs**, traditional medicines**, and **over-the-counter drugs** on pregnancy and the fetus
25. effects of smoking, alcohol abuse and illicit drug use on the pregnant woman and fetus

The midwife has the skill and/or ability to:
57. dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., **antibiotics**, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition

- **Prerequisite Knowledge**
  Consistent with the pre-requisite courses required for admission to the Bastyr University Department of Midwifery MSM program and the courses scheduled to be taken before this course begins. Students or others who audit or "sit-in" will be evaluated on an individual basis regarding their pre-requisite knowledge.

BASTYR UNIVERSITY
COURSE INFORMATION FOR STUDENTS
Pharmacology & Treatments - Winter Quarter 2021

Week	Date	Topics	Activities & Assignments	Points= 200	Due Dates
1	1/4-10 **Onsite**	Course Orientation	Attend class & participate		**1/7 1-5pm**
		Consumer Info Packaging	OTC pkg scavenger hunt discussion	5	1/7
		Pharm Fundamentals: vocabulary, pharmacokinetics, pharmacodynamics	Pharm terms in-class activity Readings, Study Questions & Quiz A	10	Due Sun
		Teratology Intro	Lecture by instructor		
2	1/11-17	Pharmacology & Physiology of Pregnancy, Postpartum, Newborns Teratology & FDA Risk Categories	Readings, Study Questions & Quiz B	10	Due Sun
3	1/18-24	Common Meds in Pregnancy Medication Research	Readings, Study Questions & Quiz C	10	Due Sun
		Online Drug Resources for Clients	Part 1: post online search results Part 2: post a comment or question	20 5	Due Wed Due Sat
4	1/25-31	FDA Regulation of Medications Medication Administration Principles Medication Documentation	Readings, Study Questions, & Quiz D	10	Due Sun
			Fill out Med Abbreviation Table		before class
			Wk5 Med Info Sheet Groups-submit draft		Due Sun
5	2/1-7 **Onsite**	Review & Looking Ahead	Attend class & participate		**2/4 1-5pm**
		Medication Abbreviations	Class activity with abbreviations worksheet		At onsite
		Medication Counseling for Midwives	Clinical scenarios activity in class		At onsite
		Med Info Sheet Presentations	Med Info Sheet - week 5 groups	50	At onsite
6	2/8-14	Pharmacovigilance: adverse reactions, allergies, storage/stability, med errors	Readings, Study Questions, & Quiz E	10	Due Sun
7	2/15-21	Antimicrobial (Antibiotic) Therapy, …Resistance, & Allergies	Readings, Study Questions, & Quiz F	10	Due Sun
8	2/22-28	Immunity & Immunogenic Agents Vaccinations: Pregnancy, PP, Newborns, & Healthcare Providers	Readings, Study Questions, & Quiz G	10	Due Sun
			Wk9 Med Info Sheet Groups-submit draft		Due Wed
9	3/1-7 **Onsite**	Review Weeks 6, 7, 8	Attend class & participate		**3/4 1-5pm**
		Prescriptive Authority introduction	Instructor lecture		At onsite
		Med Info Sheet Presentations	Med Info Sheet - week 9 groups	50	At onsite
10	3/8-14	Regulations & Prescriptive Authority for Midwives	Post State MW regulations	16	Due Fri
		Course Assessment	Do Course Assessment		

11	3/15-19	Final Exam	Exam online (cumulative Week 1-10)	30	Exam open Mon-Fri

BASTYR UNIVERSITY - Fall 2020
Syllabus Excerpt
MW4305 Gynecology

- **Course Description**

  Offered in first quarter concurrent with Midwifery Care Health Assessment, this course includes an overview of female reproductive anatomy and physiology from menarche through menopause, including an introduction to health concerns such as sexuality, fertility/infertility, contraception, unwanted pregnancy, and diagnosis and treatment of gynecological problems and RTIs.

  Course Topics

  1. Anatomy and physiology of the female reproductive system
  2. Puberty & the menstrual cycle
  3. Preconception counseling
  4. Unplanned and/or undesirable pregnancy
  5. Sexual history and counseling
  6. Contraception
  7. Diseases/abnormalities of the reproductive system & breasts, including effect on pregnancy
  8. HIV/AIDS

- **Major Course Educational Objectives**

  At the completion of this course, the student will be able to:

  1. Describe the anatomy and physiology of the female reproductive system.
  2. Describe physiology and symptoms of menstruation.
  3. Explain growth and development related to sexuality, sexual development and sexual activity.
  4. Describe indicators and methods for advising and referral of dysfunctional interpersonal relationships, including sexual problems and gender-based violence
  5. Demonstrate knowledge of preconception factors likely to influence pregnancy outcome.
  6. Describe factors involved in decision-making regarding unplanned and/or undesirable pregnancies and resources for counseling and referral.
  7. Describe the physical and psychosocial components of human sexuality and skill in obtaining a sexual history, identifying indications of common problems and using methods of counseling.
  8. List factors relating to steroidal, mechanical, chemical, physiological and surgical contraception methods.
  9. Describe the signs and symptoms and demonstrate skill in the appropriate diagnosis, intervention and need for referral for diseases and/or abnormalities of the reproductive system and breasts.
  10. Describe the etiology and epidemiology of HIV/AIDS, transmission & risk reduction strategies, clinical manifestations and treatment.

- **Major Course Competencies**

  MEAC Competencies addressed in this course:

  COMPETENCY # 1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.

The midwife has the knowledge and/or understanding of...
10. National and local health services and infrastructures supporting the continuum of care (organization and referral systems), how to access needed resources for midwifery care
11. Relevant national or local programs or initiatives (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country or locality)
14. Policies, protocols, laws and regulations related to therapeutic abortion (TAB) care services
15. Human rights and their effects on health of individuals, including but not limited to: health disparities, domestic partner violence and female genital mutilation [cutting]
16. Advocacy and empowerment strategies for women
18. Unique healthcare needs of women from distinct ethnic or cultural backgrounds, or a variety of family structures and sexual orientations
19. Culturally sensitive care

The midwife:
29. Behaves in a courteous, non-judgmental, non-discriminatory, and culturally appropriate manner with all clients
31. Maintain the confidentiality of all information shared by the woman; communicates essential information among other health providers or family members only with explicit permission from the woman and in situations of compelling need
32. Uses shared decision-making in partnership with women and their families; enables and supports them in making informed choices about their health, including the need or desire for referral or transfer to other health care providers or facilities for continued care when health care needs exceed the abilities of the midwife provider and their right to refuse testing or intervention

The midwife has the skill and/or ability to:
36. Engage in health education discussions with and for women and their families

COMPETENCY # 2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

The midwife has the knowledge and/or understanding of...
1. Growth and development related to sexuality, sexual development and sexual activity
2. Female and male anatomy and physiology related to conception and reproduction
3. Cultural norms and practices surrounding sexuality, sexual practices, marriage and childbearing

4. Components of a health history, family history and relevant genetic history
6. Health education content targeted to sexual and reproductive health (e.g., sexually transmitted infections, HIV, newborn and child health)
7. Basic principles of pharmacokinetics of family planning drugs and agents
8. Natural family planning methods
9. All currently available methods of family planning, including medical eligibility criteria and appropriate timeframes for method use
10. Methods and strategies for guiding women and/or couples needing to make decisions about methods of family planning

11. Signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country
13. Indicators and methods for advising and referral of dysfunctional interpersonal relationships, including sexual problems, gender-based violence, emotional abuse and physical neglect
14. Principles of screening methods for cervical cancer, (e.g., Pap test, and colposcopy) and interpretation of test results

The midwife has the skill and/or ability to:
15. Take a comprehensive health and obstetric, gynecologic and reproductive health history
17. Perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman
19. Request and/or perform and interpret selected screening tests including, but not limited to: screening for HIV, STIs and Pap tests
21. Dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) locally available and culturally acceptable methods of family planning
22. Advise women about management of side effects and problems with use of family planning methods
23. Take and order cervical cytology (Pap) test
24. Use the microscope to perform simple screening tests including, but not limited to: amniotic fluid ferning, candida, trichomonas, and bacterial vaginosis

COMPETENCY # 3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

The midwife has the knowledge and/or understanding of...
1. Anatomy and physiology of the human body
2. The biology of human reproduction, the menstrual cycle, and the process of conception
4. Signs and symptoms of pregnancy
5. Examinations and tests for confirmation of pregnancy
6. Signs and symptoms and methods for diagnosis of an ectopic pregnancy
9. Manifestations of various degrees of female genital mutilation (cutting) and their potential effects on women's health, including the birth process
10. Factors involved in decisions relating to unintended or mistimed pregnancies
11. All currently available methods of therapeutic abortion (TAB) and their medical eligibility criteria
12. Pharmacotherapeutic basics of drugs recommended for use in medical abortion
32. Signs, symptoms and potential effects of conditions that are life-threatening to the pregnant woman and/or her fetus, including but not limited to:
    e. syphilis

The midwife has the skill and/or ability to:
40. Draw blood and collect urine and vaginal culture specimens for laboratory testing
54. Identify variations during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for:
    c. ectopic pregnancy
    e. genital herpes

56. Inform women who are considering therapeutic abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining therapeutic abortion, and to support women in their choice
58. Provide individualized care according to the needs and desires of each woman

COMPETENCY #5: Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.

The midwife has the knowledge and/or understanding of:
2. The normal process of involution and physical and emotional healing following SAB or TAB
4. Signs and symptoms of SAB or TAB complications and life-threatening conditions (e.g., persistent vaginal bleeding, infection)
15. Approaches and strategies for providing special support for adolescents, and victims of gender-based violence (including rape)
19. Care, information and support that is needed during and after SAB or TAB (physical and psychological) and services available in the community

The midwife has the skill and/or ability to:
35. Educate mother on care of herself following a SAB or TAB, including rest and nutrition and how to identify complications such as hemorrhage

COURSE INFORMATION FOR STUDENTS
Gynecology - Fall Quarter 2020

All Sunday due dates unless otherwise specified

WK	DATE	Topics:	Assignments:	Due Date
1	**9/14-9/20 Onsite**	Anatomy of the reproductive system Feminist healthcare	Assignment of STI topics Participation in onsite	Onsite: 9/16
2	**9/21-9/27**	Anatomy of the pelvis and breast	Assigned readings Online discussion (extra credit) Quiz 1- Material from Weeks 1 and 2	Discussion: Sunday Quiz: Sunday
3	**9/28-10/4**	Menstrual cycle and reproductive endocrinology	Assigned readings Online discussion	Select topic: Tues Discussion: Sunday
4	**10/6-10/11**	Vaginitis Reproductive Cancers	Assigned readings Quiz 2- Material from weeks 3 and 4	Sunday
5	**10/12-10/18 Onsite**	Vaginitis Cervical Cancer Screening Herbal treatment of gyn issues	Participation in onsite Guest speaker Case studies	Onsite: 10/14
6	**10/19-10/25**	Unplanned pregnancy Abortion care	Assigned readings Values Clarification Exercise A	Sunday

7	**10/26-11/1**	Sexually Transmitted Infections Urinary Tract Infections	Assigned readings Quiz 3 - Material from week 6 & 7 Values Clarification Exercise B	Quiz: Sunday Exercise: Sunday
8	**11/2-11/8**	Birth control methods Abnormal uterine bleeding	Assigned readings Upload entry to class study guide Quiz 4 - Material from week 8 Values Clarification Exercise C Reminder: first STI presentations due next week	Study guide: Wed Quiz: Sunday Exercise: Sunday
9	**11/9-11/15 Onsite**	Contraception Reproductive Health Inequity STI presentations	First half of STI presentations Case Study Contraception review Participation in onsite	Onsite: 11/11
10	**11/16-11/22**	Preconception care Infertility Human Sexuality	Assigned readings Values Clarification Exercise D	Exercise: Friday
11	**11/23-11/29**	Lesbian, bisexual, queer and transgender health Female genital cutting	Assigned readings Online discussion Quiz 5 - Material from weeks 10 and 11	Discussion: Sunday Quiz: Sunday
12	**11/30-12/6**	HIV	Assigned readings Quiz 6 - Material from week 12	Sunday
13	**12/7-12/11 Onsite**	STI presentations HIV Course Review	Second half of STI presentations Participation in onsite	Onsite: 12/19