MEETING
of the
CERTIFIED NURSE-MIDWIFE ADVISORY COUNCIL
of the
KANSAS STATE BOARD OF HEALING ARTS
Thursday, December 2, 2016

I. CALL TO ORDER - ROLL CALL

The Certified Nurse-Midwife Council of the Kansas State Board of Healing Arts (KSBHA) met on Thursday, December 2, 2016, at the KSBHA offices. The meeting was called to order at 2:10 p.m. by Kelli Stevens, General Counsel, KSBHA. The following Council members attended:

Kent Bradley, M.D.	present
Cara Busenhart, PhD, CNM, APRN	present
Cathy Gordon, RN, MSN, FNP-BC, CNM	present
Joel Hutchins, M.D.	present
Chad Johanning, M.D.	by phone
Manya Schmidt, CNM, APRN	present
Tarena Sisk, CNM	by phone

Staff members present were: Kelli Stevens, General Counsel; Stacy Bond, Assistant General Counsel, Jennifer Cook, Legal Assistant to General Counsel. Also present were: Diane Glynn from KSBN, Rachelle Colombo from KMS, Bob Williams from KAOM, Kendra Wyatt from NBC, and Dodie Wellshear from KAFP.

I. APPROVAL OF MINUTES

The minutes of September 20, 2016 were approved with a minor correction to one date that was listed as "2015" instead of "2016." (Hutchins/Gordon)

II. OLD BUSINESS- Continued regulation development

a. Ms. Stevens summarized the 2 decisions of the Board which were made at the Board meeting on October 14, 2016. The Board determined that a prior cesarean delivery was not within the definition of a normal, uncomplicated pregnancy and a TOLAC/VBAC was not an uncomplicated delivery. Additionally, the Board approved the abbreviation, "CNM-I" for the new license. She also informed the Council that she visited with representatives from BCBS of Kansas to inquire about any potential third-party payor issues with the new license. BCBS conveyed that they did not see any potential issues and said they would just need to include the new license in their credentialing system. Ms. Stevens also had a conversation with a KanCare representative who indicated they did not foresee particular problems with the new license. Kendra Wyatt commented that she believed there would ultimately be problems with using the CNM-I title in the KanCare system.

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Later in the meeting, the CNM members of the Council expressed that it was troublesome that they were not introduced or asked to address the Board at the October 14, 2016 Board meeting. The physician members were asked to address the comments of Dr. Wickstrom, who presented to the Board at the request of the CNM members of the Council. Ms. Bond explained that it was staff's understanding that Dr. Wickstrom was speaking on behalf of the CNM members of the Council. Ms. Stevens also acknowledged that while comments to the Board were not originally anticipated, it would have been better to at least introduce all members of the Council.

b. The Council reviewed the latest staff revision to the draft Definitions regulation, K.A.R. 100-74-1, particularly the inclusion of a definition of "minor vaginal laceration" to provide guidance on what types of lacerations could be repaired within the statutory scope of this new license. **The Council members agreed that a second degree laceration could be repaired and noted that an episiotomy goes beyond a first degree laceration. Staff will revise the draft accordingly.**

c. The Council reviewed the latest staff revision of draft K.A.R. 100-74-8 Scope of practice; limitations. One of the revisions was to prohibit a licensee from providing "clinical services" to a patient with a prior cesarean delivery to comport with the Board's determination. Ms. Busenhart asked that the Council revisit the issue of a prior cesarean delivery with respect to antepartum care. Ms. Stevens pointed out that the current draft language would preclude licensees from providing any care to a patient with a prior cesarean, even prenatal care. Ms. Busenhart noted that in county health departments, nurse-midwives often provide prenatal care and then delivery is done by a physician at a hospital, for example Wyandotte County Health Department and K.U. Hospital. The Council discussed whether a prior cesarean delivery is inherently a complicated pregnancy or just a complicated delivery. Ms. Gordon described how they measure the patient's scar and pay attention to where the placenta is during prenatal care. The Council discussed how care may be different for a patient with a classical c-section that has been performed emergently or in patients coming from other countries such as Mexico. Those patients are usually delivered early (36 to 37 weeks) by a repeat cesarean to avoid the possibility of them going into labor. **The Council reached a consensus and recommended that the draft regulation be edited to only prohibit intrapartum (labor and delivery) care to patients with a prior cesarean delivery and that antepartum care be specifically included in the scope.**

The Council also recommended that the term "labor and delivery" be replaced with "intrapartum care" to be clinically accurate.

Ms. Busenhart inquired about the fact that the general scope is not articulated. Ms. Stevens explained that the regulation will refer back to the scope in the new statute.

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d. The Council reviewed the revisions to the draft regulation for Duty to refer or transfer care (unnumbered) that added in "consultation" language. The Council discussed the practical implications of the language "refer for consultation or transfer care." Ms. Busenhart suggested the word "confer" be included as that is often all that is needed to determine if there is something in the patient's history or present condition which creates a risk which would put the patient's care outside the scope of this license. The Council discussed the difference between a "consultation" and "conferring." Dr. Bradley opined that "confer" denotes a less formalized process than a "consultation." Dr. Bradley expressed that when he gives a "curbside" consult, he does not always recall the specifics and there is no documentation on his part. The Council discussed when documentation is required. Ms. Stevens noted that the draft regulation on patient records requires a written report of all "consultations." **The Council agreed that some form of documentation should be required when a licensee "confers" with another practitioner.** This could even be in email. **Ms. Gordon suggested that there be definitions of "confer" and "consult." Ms. Busenhart indicated that "or continue" needed to be added after the language permitting the licensee to "resume" providing clinical services. The Council members all agreed on these recommended revisions.**

The Council also discussed whether the consultation, etc. needed to be to an Obstetrician. Dr. Bradley opined that it should not be limited as the appropriate consultation may be by an Endocrinologist or other specialist depending on the patient's condition. The other Council members concurred.

e. The Council reviewed the draft regulation, Assessment of patient for identifiable risks (unnumbered). Gestational age was added to the list of factors. The Council agreed that gestational age greater than 42 weeks was a risk and that labor at 20 weeks was pre-term, so gestational age should be a general factor listed. The Council also recommended that "pregnancy induced hypertension" be replaced with "gestational hypertension."

f. The Council reviewed the draft regulation K.A.R. 100-74-10, Transfer protocol requirements. The Council noted that the "prespecified hospital" for transfer needs to be a hospital with an OB unit. The Council discussed and then recommended deleting the recent revision addition of a patient form to indicate choice of hospital. The Council noted that this was usually part of giving informed consent, and the patient's preference may not be the best choice. **Language regarding patient choice will be deleted and language regarding informed consent will be added for the Council to review.**

g. The Council reviewed the draft regulation, Identifiable risks requiring transfer of care of patient (unnumbered). Dr. Bradley suggested, and the rest of the Council agreed, that the word "premature" be deleted from the condition, "current pre-term premature rupture of membranes" as it is redundant.

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h. The Council reviewed the draft regulation, Identifiable risks requiring transfer of care of newborn (unnumbered). In responding to a question from a KSBHA member, the Council members discussed and all agreed that an Apgar score of six or less at five minutes of age was a condition requiring transfer and that an Apgar of seven at five minutes was not. **The Council agreed that "any green emesis" should be deleted as that was not inherently a condition of concern. Ms. Gordon suggested adding "failed CCHD" as a condition and the Council discussed and decided it should be added and that cardiac arrhythmia also still be kept in the regulation.**

i. Ms. Busenhart asked the Council to revisit the scope of practice draft regulation, K.A.R. 100-74-8. She noted that there are many common conditions that are not inherent in the statutory scope of practice which are routinely treated as part of regular prenatal care. Some of these include UTIs, sinusitis, vaginitis, and Group B Strep. The Council discussed that often a primary care practitioner won't treat a pregnant woman and refers them to the practitioner providing prenatal care. **The Council all agreed and recommended that routine primary care which is part of prenatal care needs to be articulated in the scope of practice.**

j. The Council requested to review the regulations with recommended revisions from this meeting as well as the whole set of regulations so they could see the entire regulatory scheme. Staff will ensure that the Council receives the regulations and has adequate time to review them. The Council expressed that the time they had before this meeting was too short. Questions were asked about the next steps. Ms. Stevens said she will provide the KSBHA with an update at their meeting on December 9th, particularly on the issue of prenatal care of patients with prior cesarean deliveries. Both Boards may need to hold special meetings to consider content approval since the KSBN meeting is on December 12th, and that is too short of a timeframe.

III. ADJOURNMENT

The meeting adjourned at 4:15 p.m.

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