Department of Public Health Hearing regarding the proposed amendments to 105 CMR

130.000 and 105 CMR 140.000

This letter is in response to the proposed regulation changes to Birth Center Regulations. As the owner of the only existing free-standing birth center ( Seven Sisters Midwifery) and a

CNM provider for more than 40 years in Massachusetts I would like to suggest these changes.

# Remove the clinical background requirement for the Administrative Director. (105 CMR 140.902 A)

* Regulations should align with AABC, which does not require the administrative director to be a clinician.
  1. The national regulations state: “The birth center shall appoint an administrative director and a clinical director. Depending upon the structure of the organization, the administrative and clinical directors may be the same person. The administrative director shall be responsible for implementing and overseeing the operational policies of the birth center.”
* While clinicians may serve as Administrative Directors in some birth centers, the language proposed by DPH would preclude birth centers from hiring qualified *administrators* with public health, non profit, and business backgrounds, (e.g., Nashira Baril, MPH – Founder and Director of Neighborhood Birth Center would not be allowed serve in this role).
* Also, allow the same person to serve as medical and administrative director if they meet the requirements of both roles.

# Broaden the definition of a birth assistant beyond “Registered Nurse with L&D experience.” (105 CMR 140.902 C-2)

* Regulations should align with AABC, which states: “The birth center shall have at least two persons who are currently certified in basic life support and neonatal resuscitation on premises and immediately available during each delivery.”
* Requiring RNs with L&D experience massively shrinks the hiring pool– which will be immensely challenging in a time of statewise nursing shortages.
* I believe that RNs that have acute care ie ICU or cardiac intensive care will be acceptable. You need a RN that can start an IV and is good in an urgent situation.
* I feel that a birth assistant may not have the urgent care experience that is required in the rare but possible events that happen out of hospital.

# Remove “abortion” from the list of procedures birth centers are precluded from providing, allowing providers to offer medical or procedural abortions that are within their clinical scope of practice. (105 CMR 140.906 B-1)

* Birth centers do and can provide abortions– both medical and procedural– throughout the nation. This included Cambridge Birth Center and North Shore Birth center when they were open.
* CNMs now have procedural abortion as part of their scope of practice following the ROE Act.
* DPH and MassHealth must honor reproductive justice and make sure that people can access and pay for abortion care in trusted community clinical settings.
* In conjunction, MassHealth needs to remove “abortion” from “non covered services” from freestanding birth centers in 130 CMR 457.000

# Allow birth center providers to send clients home with medications as appropriate and within provider scope of practice. (105 CMR 140.906 B-4)

* There are a variety of instances where a provider in a birth center may need to send a client home with medication for that client to self-administer. Regulations should be updated to allow for these practices where consistent with provider regulations and standards of practice.
* Recommendation is to strike 105 CMR 140.906 B-4 which is unnecessary as the regulations set forth in section F of “140.347: Pharmacy Services by Clinics without Clinic Pharmacies” would apply to birth centers.

Also change the requirement for a bedside neonatal warming devise.

We have the warmer and it has never been used in over 4 years and > 650 births. It is very expensive, never used and unnecessary.

Thank you for considering these suggestions. Ginny Miller CNM

Owner of Seven Sisters Midwifery and Freestanding Community Birth Center