

**QUARTERLY MEETING OF THE
ARKANSAS STATE BOARD OF HEALTH**

July 26, 2018

MEMBERS PRESENT

Catherine Tapp, MPH, President
Nathaniel Smith, M.D., MPH, Secretary
James Zini, D.O., President Elect
Terry Yamauchi, M.D.
Perry Amerine, O.D.
Greg Bledsoe, M.D.
Marsha Boss, Pharm. D
Lawrence Braden, M.D.
Glen "Eddie" Bryant, M.D.
Alan Fortenberry, P.E.
Beverly Foster, D.C.
Phillip Gilmore
Anthony Hui, M.D.
Lee Johnson, M.D.
Thomas Jones, R.S.
David Kiessling, D.P.M.
Mike Riddell, M.D.
Susan Weinstein, DVM
Susan Ward-Jones, M.D. (via phone)
Robbie Thomas-Knight, Ph.D. (via phone)

NOT PRESENT:

Miranda Childs-Beebe, D.D.S.
Vanessa Falwell

GUESTS PRESENT

Stephanie Williams, Deputy Dir. for Public
Health Programs
Namvar Zohoori, MD, Chief Science Officer
Robert Brech, General Counsel
Vicki Pickering, Department Administrative Law
Judge
Reginald A. Rogers, Deputy General Counsel
Renee Mallory, Center Dir. for Health Protection
James Bledsoe, M.D., Chief Physician Specialist
Don Adams, Dir., Center for Local Public Health
Randyl Marshall
Samantha Minster, ACH
Amy Vanhooser, ABM
Christy Sellers, Dir., Center for Health
Advancement
Dr. Richard McMullen, Ph.D., Center for Local
Public Health
Dr. Glen Baker, Dir., Public Health Lab
Steve Carter, Chief Financial Officer
Tanya Smith, Midwifery Board
Amanda McKay, ABM
Margaret Owens, ABM
Halee Burchfield, ABM
Haley Gilliam, ABM
Abigail Burchfield, ABM
Josiah Burchfield, ABM
Elijah Burchfield, ABM
Emily Gillispie, ABM
Selma Gillispie, ABM
Kadie Edwards, ABM
Kim Jacob, MAB
Shea Childs, MAB
Brittany Oaks, ABM
Rowan Pore, ABM
Connor Oaks, ABM
Wesley Oaks, ABM
Mariah Resseano, ABM
Kristin Jimenez, ABM
Miles Jimenez, ABM
Levi Jimenez, ABM

Chelsea Cameron, ABM/MAB
Kris Montes, ABM
Gabieller Thraillkel, MAB
Cora Crain, ABM
Jenny Knight, ABM
Appathurai Balamurugan, ADH
Craig Wilson, ACHI
Dr. William Greenfield, ADH
Rhonda Kitelinger, ADH
Shelly Matthews, ADH
Mylon Boston, ADH
Ericka Lindsey, ADH
Chelsey Mueller, ADH
Landrey Mueller, ADH
Merritt Mueller, ADH
Sutton Mueller, ADH
Sondra Rodocker, Arkansas Family Doulas
Haley Ortiz, ADH
Bradley Planey, Family Health Branch Chief,
ADH
Connie Melton, Branch Chief, Health Systems
Licensing & Regulation
Kelli Kersey, ADH, Section Chief
Corinthia Blanks, ADH
Rhonda Brown, ADH, Section Chief
Environmental Health
Shirley Louie, Dir., Center for Public Health
Protection
Marisha DiCarlo, Ph.D., Dir. Health
Communications
Meg Mirivel, Public Information Specialist
Brandy Sutphin, Senior Epidemiologist, CHLP
Epidemiology
Kristyn Vang, ADH
Michelle R. Smith, ADH
Mike Wilson, ADH
Gary Wheeler, ADH
Dawn Porter, ICDR
Charvis Won, ADH
Emma Carlson, ADH
Hannah Branton, COPH
Caleb Coleman, UAMS COPH
Genie Davis, ADH
Angelica Chavez, ADH
Stephanie Wolmarans, ABM
Kesha Chiappinelli, The Zaffino Law Firm
Sean Reedy, ADH
Dr. Dirk Haselow

Abby Holt, Cancer Research Administrator,
CPHP Health Statistics
Bethany McLaughlin, Legal Specialist, Legal
Services
Anna Hurst, Law Clerk, Legal Services

MEETING OF THE ARKANSAS STATE BOARD OF HEALTH

The quarterly meeting of the Arkansas State Board of Health was held Thursday, July 26, 2018, in the Arkansas Department of Health Public Health Laboratory Building in Little Rock, Arkansas.

CALL TO ORDER

The meeting was called to order at approximately 10:05 a.m. by President Catherine Tapp, with Dr. Robbie Thomas-Knight and Dr. Susan Ward-Jones participating by teleconference.

APPROVAL OF MINUTES

Dr. James Zini entertained a motion for approval of the April 26, 2018, Quarterly Minutes. Motion made to accept the minutes, seconded by Dr. Perry Amerine, O.D.

Dr. Amerine requested clarification on the minutes regarding the Lay Midwives' completing risk assessments to the same extent as a licensed physician or a nurse practitioner at a Local Health Unit. Mr. Robert Brech explained that Certified Nurse Midwives can provide those risk assessments if they have a doctoral or nursing degree.

Dr. Susan Weinstein stated there was a typographical error under Licensed Lay Midwives. The motion to amend to correct the typographical errors carried.

Dr. Nathaniel Smith stated that he had two letters from Governor Asa Hutchinson recognizing two Arkansans, Dr. Robert Hopkins and Dr. Jose Romero. Dr. Smith presented a proclamation to the Board in honor of Dr. Weinstein. Dr. Zini entertained the motion for approval regarding the proclamation, seconded by Mike Riddell, M.D. Motion passed.

OLD BUSINESS

There was no discussion of old business.

NEW BUSINESS

Massage Therapy Technical Advisory Committee

Ms. Kelli Kersey reported that Massage Therapy Technical Advisory Committee appointments end on September 30, 2018. There are six licensed massage therapists and one establishment owner recommended for appointment. Three of those recommended are currently active within the Committee, and it would be their second term. Dr. Weinstein entertained a motion for approval of new and reappointment of existing members for the Committee, seconded by Dr. Zini. Motion passed.

Midwifery Advisory Board Member Nominations

Ms. Rhonda Brown sought approval for the nomination of Traci Kiernan D.C. to be a four-year term member of the Advisory Board. Alan Fortenberry, P.E. made a motion for approval of the new nomination, seconded by Beverly Foster, D.C. Motion passed.

Independence and Jefferson County Health Officers

Namvar Zohoori, M.D. sought approval for the appointment of Independence County Health Officer, Jordan Weaver, M.D. and the reappointment of Jefferson County Health Officer, Horace L. Green, M.D. Mike Riddell, M.D. made a motion for approval regarding appointment and reappointment; seconded by Dr. James Zini. Motion passed.

Appointment Master Plumber Representative

Dr. Richard McMullen filled in for Mr. Bob Higginbottom. Dr. McMullen sought approval of appointments of Greg Brasher, Master Plumber Representative; Justin Goins, Consumer Representative; and Phillip Fruechting, ADH Representative. Dr. Weinstein made a motion for approval regarding appointment and reappointment, seconded by Thomas Jones, R.S. Motion passed.

Adoption Forms

Mr. Brech introduced Mr. Shane Carter to the Board. Mr. Carter reached out to State Representative Deborah Ferguson before the 2017 Arkansas legislative session. She was instrumental in getting Act 519 of 2017 passed and, Mr. Brech wanted her to be recognized. Mr. Brech stated that he previously reviewed a set of adoption forms dealing with birth parents, which allowed them to redact their names from the adoption file as long as they filled out the relevant forms. On August 1, 2018, in accordance with the Act, both an adopted child who is at least 21 years of age and the child's guardian may obtain the child's adoption file. Mr. Brech requested the Board approve the adoption file request forms and noted that, upon such approval, the forms will be put on the website for public use. Dr. Robbie Thomas-Knight made a motion to accept the adoption forms with a special thanks to Mr. Carter, Representative Ferguson and Mr. Brech; seconded by Nathaniel Smith, M.D. Motion passed.

Ms. Tapp inquired about the number of parents that have redacted their names, and Mr. Brech stated there have been a couple dozen.

OTHER BUSINESS

Administrative Updates

Ms. Stephanie Williams filled in for Ms. Ann Purvis and announced that the Department is preparing for the upcoming legislative session. A biennium budget has been prepared, and the most significant changes relate to the number of authorized Department positions and the elimination of the Department's Cessation Service Program. The new biennium budget is set according to a budget snapshot from the last biennium budget in April 2016, and aside from the

lower number of positions, the two are similar. The Department prepared a request to renew its contract with National Jewish Health, which was designated as its vendor by the Legislative Council. The Department made its presentation, but there was no support to continue utilizing the vendor, although there was support for continued cessation services. The Council agreed to approve the Department's contract request regarding National Jewish Health for a six-month period, giving the Department time to develop and transition to a new model for cessation services. The plan is to develop a call center in-house that will triage calls and link them to services. The Department intends to link local resources that may be available in the community, as well as develop cessation resources in its local health units.

The Department is now offering birth certificate issuance through its Local Health Units with sites in the State where Arkansans can access copies of those vital documents.

Last week, the Department hit a milestone for the WIC Program. Arkansas is the first state to implement a statewide electronic WIC system.

Ms. Williams noted that Dr. Weinstein helped the Department recruit a new replacement, Dr. Laura Rothfeldt, to serve as the Arkansas Department of Health's Public Health Veterinarian.

2016 Licensed Lay Midwife Statistical Report

Ms. Rhonda Brown pointed out that the 2016 Annual Licensed Lay Midwives statistical report was presented to the Board for review. The updated report contains the 2016 data and was compiled by the Women's Health section staff. The report has been reviewed and approved by the Midwives Advisory Board and the Department of Health.

Dr. Thomas-Knight questioned how the numbers compared to the other states and why the antepartum referrals were so high. Ms. Joni Yarnell, Certified Nurse Midwife, responded that the Department does not have data from other states because that data is not published. However, there are published studies on antepartum referrals include clients of midwives who need physicians or other healthcare providers to evaluate the patient. The published rates are consistent across the State, and are reassuring to the Department that the midwives are identifying potential problems according to the rules and recognizing the need for the referral.

Dr. Amerine requested Dr. Riddell share his thoughts based on his experience in the field. Dr. Riddell responded that this is a collective experience from the Department, and noted that about one out of three women who seek home birth are risked or referred out and then more than ten percent go into labor and are not able to complete home delivery. Based on previous review, the most common reason for antepartum transport was due to Cephalopelvic Disproportion, which is not an emergency condition. There were a few emergency conditions and Dr. Riddell stated he does not have those statistics. Dr. Riddell pointed out that he remembers looking at some disciplinary measure from the Department regarding several incidents of shoulder dystocia at home that did involve a death, and the basic maneuvers for shoulder dystocia were not implemented. Dr. Riddell stated that the Board wants a safe outcome for both mother and the baby, and suggested that the Department have a standardized script for the midwives to use to counsel their home birth clients that includes research, options and documentation. Dr. Amerine further inquired about death statistics. Dr. Smith responded that Arkansas has had one perinatal death per year for the last three years according to this report, a rate of about four per thousand

perinatal deaths. Dr. Smith questioned how that compared with the Department's overall perinatal death rate in the state. Dr. Riddell responded that he does not have those statistics. Joni Yarnell, CNM stated that the Department was working on a report comparing these numbers to numbers from across the state. Dr. Smith stated that overall for the U.S., the rate was less than one per thousand and that the numbers presented today would be compared to the overall Arkansas rates. President Tapp stated that when the reports are ready they will be sent out to the Board.

Yearly Update on Arkansas Acute Stroke Task Force

Dr. Appathurai Balamurugan updated the Board regarding the Acute Stroke Task Force, which was created by the Board pursuant to Act 663 of 2005. Arkansas was once first in the nation regarding stroke deaths, but now is fifth. Dr. Balamurugan pointed out that he is the outgoing chair for the Stroke Task Force and introduced Dr. Cygnet Schroeder, Medical Director for Blue Cross Blue Shield, as the new chair. Dr. Schroeder stated that she is a physician from Fort Smith, and she specializes in physical medicine specifically pertaining to rehabs and strokes. Dr. Schroeder reported that the Stroke Task Force coordinates efforts to address the debilitating impact of stroke in Arkansas and supports a statewide approach with the Arkansas Stroke System of Care, including collaboration between Emergency Medical Services, hospitals, and community education. The Stroke System of Care was launched in the southwest region and now has implemented statewide. The southwest part of the state consists of 14 hospitals and 15 EMS services. Dr. Schroeder expressed that the program is built upon the successes that the Department has had. Starting in the fall of 2017, the Department's Stroke/STEMI Section launched a program to help common standard of care. This occurred in EMS and includes adherence to patient care and guidelines, such as performing pre-hospital screens or applying a stroke band, so those patients can be identified across the continuum of care. Therefore, data can be collected, performance will improve, and gaps or potential problems can be easily identified. Dr. Schroeder stated that EMS helped to determine the appropriate destination in critical care transfers. For hospitals this includes demonstrating in the evidence-based standards on acute stroke performance, so the Department works with hospitals to help them achieve all this. Based on criteria set forth by the Department, the national fast practice guidelines ensure that the hospital will demonstrate its ability to provide patients the best acute stroke care possible. Dr. Schroeder stated that the hospital has to complete the application for the Department, a safe visit, a hospital review, and a tour. There are fourteen (14) participating hospitals designated by the Department. The hospitals are primarily located in the northwest region of the state. The Department's Stroke/STEMI Section has a vendor that provides free web-based education to all health care providers across the state in managing acute stroke patients. Dr. Schroeder pointed out that another area of emphasis is the Community Education component, using subcommittees to increase knowledge and awareness of stroke, heart attack and usage of 911, when a problem is suspected, and partnering with the Department to implement the "Dial Don't Drive," campaign, targeting communities with the greatest need.

Dr. Amerine questioned when the Stroke Task Force was founded. Dr. Balamurugan stated it was founded around 2008, a couple of years after the legislation was passed. Dr. Amerine stated that there were some beneficial things that could be enhanced for the quickness of care and delivery of care. Dr. Balamurugan responded that there are two sets of guidelines and protocols; one is for EMS and the other is for the hospitals. Last year Mr. Balamurugan presented about nine community pilots and presented the results to the Board. The Stroke Task Force was able

to decrease the first medical contact, which are all based on the American Heart and the American Urology Association guidelines. Dr. Amerine stated that the Board is here to protect the public health and the people of Arkansas. Dr. Amerine explained that assessing those regulations and implementing those regulations made a difference. Dr. Schroeder stated that the last statistics from the American Heart Association showed that patients who receive appropriate stroke care within the window of opportunity are twice as likely to have better outcome.

Rules and Regulations Governing the Practice of Licensed Lay Midwifery in Arkansas

Mr. Brech pointed out there are two petitions to amend the Lay Midwifery Rules that went into effect on June 1, 2018. The first dealt with Registered Nurses who are also Licensed Lay Midwives using and obtaining oxygen for the infant and dealing with the morals clause in the application that was inserted on June 1, 2018. The second one dealt with the risk assessments and the VBAC (Vaginal Birth After Caesarean) issue. Mr. Brech stated that the Board has not reviewed a petition like this and normally the Department would present the Rules to the Board as a draft and the Board would need to approve in order to move forward. The drafts today are being presented by individuals and the process would remain the same. The Board has three options: option one is the Board can approve, and then go for public comment and then the administrative procedure; option two is that the Board can amend these Rules and then send them out for public comment and start the process; and option three is that the Board can deny the petition.

Ms. Martha McBride, a Licensed Lay Midwife and Registered Nurse, stated that the first issue is a lack of provision in the regulation permitting all the midwives to obtain oxygen to be available during births. The second issue is the lack of a provision for obtaining oxygen, potentially endanger the nursing licenses of the midwives who are also Registered Nurses. Ms. McBride stated that the third issue relates to certain language regarding sworn oaths, in both the initial license application and license renewal forms, which has the strong potential to create an environment of intimidation and unobtainable expectations upon the midwives by the Department. Ms. McBride pointed out that the latest version of the rules and regulations require all Licensed Lay Midwives to become certified in neonatal resuscitation, which is appropriate. Ms. McBride stated that Section 400 (2) does permit midwives to employ a prescription drug or device in an emergency and under certain conditions. However, the regulations do not contain legal provisions for the midwives themselves to obtain and carry medical grade oxygen, which may prevent them from fulfilling the requirements set forth by the Department. As the regulations stand, every birthing client has to obtain her own prescription for oxygen and then has to go to a medical supply house and pick up her own cylinder of oxygen to have for an out-of-hospital birth. Ms. McBride stated that the midwives are absolutely trained and qualified to use oxygen in an out-of-hospital setting. The Neonatal Resuscitation Provider's (NRP) certification course that the midwives take is the same as the course which nurses, doctors, and paramedics take. Ms. McBride stated that the midwives must take the entire course. The NRP course consists of 11 lessons. Participants are required to complete all lessons to receive their card. Ms. McBride pointed out that each health care provider's scope of practice is defined by his/her state licensing Board. A special consideration portion for the course specifically addresses babies born outside of the hospital setting and states that a different strategy is needed to resuscitate babies born outside the hospital. Therefore, Ms. McBride stated that there is not a need for excessive protocol to be added into the regulations on this matter. The protocol exists within the neonatal resuscitation course and that is kept updated regularly. Ms. McBride stated

that she spoke with officials in Northwest Arkansas to see how this situation was handled with emergency responders. Each county or fire district has a Medical Director that outlines protocol based on current certification practices they function under the Medical Director of local EMS services. Under that authority the trained individuals are able to obtain, carry and use oxygen. Our Midwifery Program already has a similar structure in place because midwives have practice protocols within the regulations. The regulations require the training to use the oxygen, including the restriction of when midwives can do so. These protocols are referenced and outlined in the NRP Certification. Ms. McBride proposed changes to the Rules and Regulations, under Section 302.07.3, subsection (c) to state that the Licensed Lay Midwives must advise the client that the newborn may need supplemental oxygen during the immediate post-partum phase of delivery. The Licensed Lay Midwife may obtain oxygen from a supplier of medical grade oxygen in Arkansas. Also, changes to 302.07.3 (c) would need to state that oxygen is for the use of neonatal resuscitation, as it is outlined by a NRP Certification Course and approved by North American Registry of Midwives (NARM). This wording mirrors the renewal requirement language which is in 202 (c). Ms. McBride stated that the ideal picture would be that the Licensed Lay Midwives would be able to go to their local medical supply store and use their Midwifery License number to set up an account and be able to obtain and fill their portable oxygen tank. Ms. McBride stated she would like language put into the rules and regulations that provides a legal pathway for midwives to obtain, carry, and use oxygen. As it currently stands under the Controlled Drug and Devices Act, unless there is permission from the Department, every single birthing mother out of the hospital setting has to get her own individual prescription. Dr. Yamauchi questioned whether there would be a change if an individual does not go through the certification to use the oxygen. Ms. McBride stated that if the midwives did not get the certification they would not get their Midwifery License because it is part of the requirements for all. Also, if the midwives do not get the resuscitation training, the midwives do not get a Midwifery License. The Department requires all midwives to be trained in resuscitation and now the Department needs to give them the tools to do so, and it was missed in the rules and regulations. Before, the midwives were only required to have infant and adult CPR, and that training does not require one to use oxygen. But now the midwives have a new requirement and in order to fulfill that task, the midwives have to be able to obtain oxygen. Dr. Eddie Bryant questioned if there would be any requirement regarding the length of time that the oxygen had to be used. Ms. McBride stated that was in the protocols of the neonatal resuscitation and the Rules and Regulations, require a report anytime midwives do any resuscitation, whether mild or actually having to perform resuscitation, ensuring that there is accountability. Ms. McBride reported that Registered Nurse (RN) licenses are endangered by the lack of the oxygen provision. A couple items in the newest version of the regulations address scope of practice for midwives, stating that if a licensed Registered Nurse attends a birth and oxygen was present that was not obtained by prescription to that mother, then the Department reserves the right to take disciplinary action against the midwives and also refer them to the Nursing Board.

Ms. McBride stated that the third issue related to additions to the sworn oaths that the midwives must sign. The document the midwives are required to sign now is unlike what any other health care providers are signing. The midwives regulations contain actual practice protocols. The questionable wording added to this oath could have strong potential to create an environment of intimidation by the Department with far-reaching consequences. Ms. McBride stated that there is a section that she is concerned about that reads, "...and I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices." Ms. McBride suggested that the Board strike the one sentence from the oath so that the midwives are

not responsible for what other midwives do. Each midwife should only be responsible for her own actions, not the actions of others.

Dr. Amerine stated that in 1987, there was a three-page statute that the legislature passed authorizing the State Board of Health to license lay midwives. The Board was created by the legislature and reports to the legislature. Dr. Amerine stated that the legislature intended that lay midwives exist for the people of Arkansas. The statute states that only the Department of Health physicians have the right to support and advise midwifery. There is no mention of obstetric standard of care like in the Optometry statute. The recent revision to the Rules and Regulations was a collaborative effort and were approved by the Board. The State Board of Health, a legislative creation, has delegated the authority to the Department to regulate Midwifery. Dr. Amerine stated that at the last quarterly meeting there were documents from the Department that needed changes from the midwifery point of view. On the standard of care everyone has to have standard protocol in order to get the job done in any facility. Dr. Amerine pointed out that the Board has people showing us rules and regulations to consider to approve, deny or to amend. He suggested that it is a process problem. Dr. Amerine stated that he is not in a position to approve, deny or amend the rules and regulations and believes the only option available is the review and amendment process. Dr. Amerine made a motion to form a subcommittee of the Board to consider the ideas and listen to all parties. Mr. Brech responded to let the Board know that typically if a rule needed further study; it would go to a subcommittee. In this case, the Board would need to either deny the request or agree to open up the amendment process. Mr. Brech stated that the process goes through two legislative committees, gets the Governor's approval, and then has to go to public comment. Dr. Amerine believes that the Board does not have enough time to review what has been given. Dr. Amerine made a motion to deny until the Board gets further review. Mr. Brech responded with recommendation that if the Board is uncomfortable with going forward, then the Board could possibly have a fourth avenue, with Ms. McBride's approval; which is to deny the request and form a subcommittee of the Board and to study it.

Dr. William Greenfield responded about the issue regarding oxygen and the Registered Nurse and how it impacts the Board. He stated that our charge is regulating Licensed Lay Midwives, so when you get to issues of the impact of different licensure that is beyond the scope of what our mission actually is. Dr. Greenfield pointed out that a comment was made that Licensed Lay Midwives are required to be Certified Professional Midwives (CPMs). That is the case going forward, but as it stands right now, not all Licensed Lay Midwives are CPMs. Additionally, in terms of management of oxygen and administration of oxygen, the purview of the Licensed Lay Midwife is to manage low risk pregnancies. Dr. Greenfield stated that there was no discussion regarding the process of monitoring oxygen, noting that the Board should consider the potential of moving into a medical model of care in its deliberations. Dr. Riddell questioned Dr. Greenfield about whether improper oxygen levels can lead to potential blindness. Dr. Greenfield stated that it is typically beyond the scope and that was a detailed question. He did not know the duration time. President Tapp stated that the Board should decide on an option as Mr. Brech described at the beginning. Dr. Riddell stated that when it came time to revise the regulations, he was glad that Dr. Zohoori has some scientific knowledge and had assembled a group with different area of expertise. Dr. Riddell believed that Dr. Zohoori and his committee deserved a round of applause and believed it was as neutral as possible. Ms. McBride stated in the interest of time this conversation be continued in a subcommittee. Dr. Amerine made a motion to create a subcommittee that combines members of the Arkansas Board of Health, members of the

Arkansas Department of Health, a member of the Midwifery Advisory Board who is a, consumer and non-affiliated member of the Advisory Board on this committee. Dr. Amerine stated that Dr. Zohoori and the Midwifery Advisory Board have done a great job to get a good product out there but it needs some refining around the edges. Dr. Amerine pointed out that there are a couple of complaints about the risk assessment and believes it is easy to develop a document where the person makes a choice stating that she has been informed and is willing to take the risk, whether there is oxygen, or pelvic exam at the risk assessment. Dr. Riddell questioned how this was going to affect future tweaking of regulations. President Tapp stated that this could be a Pandora's Box and it would be determined in the future. Dr. Smith pointed out that if the committee is able to focus on the specifics that Ms. McBride brought forward it would enable the Board to give her an answer. Dr. Lawrence Braden seconded Dr. Amerine's motion to form a subcommittee. Dr. James Zini asked if all this entails is the Board setting up a committee to discuss it with all the parties involved. Dr. Smith pointed out that the subcommittee would not be making that decision but would be coming to the full board with the recommendations. Dr. Anthony Hui stated that when these documents were created, it went through the whole process before the Board was to approve the final version as a regulation. President Tapp stated that the Board needs to make a decision. The vote was eight (8) in favor and opposed nine (9). The motion to form a sub-committee failed. Dr. Amerine moved to proceed through the Administrative Procedures Act and Dr. Braden seconded the motion. The vote was nine in favor and opposed seven, Motion passed to move forward.

Ms. Kesha Chiappinelli pointed out that she is an International Board Certified Lactation Consultant, an Attorney and former JAG Office for the US Air Force. She stated that she has been working on the midwifery issues for about two years, as a member of the Birth Rights Bar Association and state representative for the midwives. Ms. Chiappinelli pointed out that she is here on behalf of her clients who are consumers. She stated that these ladies are subject to these rules, the patients have had children pursuant to the rules and will again in the future. Ms. Chiappinelli explained that she made her petition pursuant to statute 25-15-204 of the Administrative Procedures Act because although the Department had three or more years to work on this, the consumers only had 30 days. The rule-making process was flawed in many respects, in which an extension of the rule-making period was denied. She stated that the midwives were not given notice of important steps of the process, so that the consumers could take part in the rule making procedure. Ms. Chiappinelli sent comments during the public comment period but the agency did not respond. The patients want to address the ability to undergo labor with the midwives after having cesarean birth and to know with specificity what the regulations require of the consumers when a risk assessment takes place with the Department of Health Nurse at the Local Health Units. Part of the problem is that the rules do not mention vaginal exams and have vague language in the rules that could be interpreted to include such exams. There is a lot of media coverage about this issue. There were three women that were forced and coerced to have vaginal exams at the Local Health Unit. They bravely told their stories to local news stations, including NPR and were most recently interviewed by VICE News. Ms. Chiappinelli stated that the complaints stem from the 1990s to the present and there is no complaint mechanism by which these women can report such instances. Ms. Chiappinelli pointed out there has been no investigation regarding the ladies' stories to her knowledge. Also, the other reason why we are here in this forum is because Arkansas is the only state that has chosen to write practice protocols into the rules and regulations. When a woman decides how she wants to give birth and she is looking to hiring a Licensed Midwife, she needs to be able to pick up those rules and regulations, with practice protocols in them, and know what the practice

protocols will require of her. The midwives do not doubt that the Department has the power to promulgate these rules, and the Department can also determine a midwife's scope of practice, but it is their position that the Department has to conform to constitutional standards in the exercise of that authority. Ms. Chiappinelli pointed out that patients are competent adults in this country. The patients have the right to refuse medical treatment, certainly something as invasive as a vaginal exam.

Ms. Chiappinelli pointed out that Ms. Tanya Smith is the most knowledgeable person regarding this subject. She is a local International Cesarean Awareness Network Chapter Leader, and she is an International Board Certified Lactation Consultant (IBCLC) and current member of the Midwifery Advisory Board. Ms. Smith pointed out that she is here as a concerned citizen and not for the Midwifery Advisory Board; many of the women that have complaints about the regulations are her friends. Ms. Smith stated that Section 104, Scope of Practice, number 5(a), was added by the consumers. The consumers also added language that specifically states that vaginal exams and tests or procedures could be refused. As the Board is aware, the forced vaginal exams have been occurring for many years and the evidence that the patients were given regarding the vaginal exams requirement is outdated. Ms. Smith stated that the consumers were told that pelvimetry was the reason for these exams, so three specific reviews to pelvimetry were included, which concluded that there is not enough evidence for any form of routine pelvimetry including clinical pelvimetry. Ms. Smith stated that the second change concerns Section 302.01, regarding the risk assessments. The consumers requested that paragraph two be stricken, the review of systems be stricken, and the addition of which consists of regarding physical exams. The rationale is that risk assessments be comprehensive enough to review of systems. However, the language is vague and open to misinterpretation. Ms. Smith pointed out that the regulations already state that the purposes of these visits are to ensure that the client has no potentially serious medical conditions and no medical complications to home birth. The consumers believe that comprehensive risk assessments are redundant in lists 302.01 and 302.02. Ms. Smith explained that the regulations be clear to patients ensuring the awareness of what to expect when a risk assessment is completed. She stated that the third change concerns Section 303.02, which requires antepartum services at or near the initiation of care, and asked that the Pap/HPV test be stricken. Ms. Smith explained that the rationale is the Pap test is additional and unnecessary testing that is irrelevant to pregnancy because the abnormal Pap is not treated during pregnancy. Ms. Smith advised that the rules could direct midwives to recommend a Pap if it had not been done in the last three years. Ms. Smith stated that the last one, which is probably a contentious issue, relates to Vaginal Birth After Cesarean (VBAC) and the other is Trial of Labor After Cesarean (TOLAC). Ms. Smith requested that the Board strike through previous cesarean delivery replaced with the criteria listed in order to make it as safe as possible for Arkansas citizens. The consumers would like to preclude a classical incision, more than three (3) cesareans and inter-delivery interval of twelve (12) months or less. She stated the rationale is that of the 33 states with licensure or statutory authority for the legal practice of CPMs, 23 allow Licensed Midwives to attend VBAC at home, two of those having practical requirements. Arkansas is one of the seven that does not permit VBAC. Ms. Smith pointed out that the concern is uterus rupture at a rate 0.3 to 0.5% and this does not account for 19.5% repeat cesareans. Midwives are already trained to observe for deviations in labor and this could happen during a TOLAC or a non TOLAC. Ms. Smith recommended that this be regulated similar to other states such as Texas and Tennessee, which require documentation on low transverse incision. The patients should be able to choose which manner of delivery and birth locations are acceptable to them even if that choice includes home birth after previous cesareans. Dr. Greenfield stated the

Midwifery model is based on low-risk client care and licensing lay midwives for patients at low risk for developing complications. The risk assessments are developed to identify what conditions put patients at high risk. Dr. Greenfield pointed out that there are not many providers across the state are willing to provide risk assessments and it has been acknowledged that the Department is able to provide those services. Dr. Greenfield stated that the backup protocols for nurse practitioners were relevant to the rules and regulations, which were discussed extensively the last time the Board met regarding nurse practitioners and how they practice are not relevant to the rules and regulations that cover midwifery practice and the midwives. Dr. Greenfield stated that the pelvic exams do provide an opportunity to access some things that otherwise could not be detected. Regarding cesarean section, the absolute risk of having a uterine rupture is low; however, he believes that the Board needs to consider a few things as discussed: vaginal birth after cesarean section, and trial of labor after cesarean delivery to have the effort to have that done regardless of whomever the provider is, whether a physician, certified nurse midwife, licensed lay midwife, VBAC at home is not safe. Dr. Greenfield explained that uterine rupture can range from a small separation to a catastrophic event, which is a life or death situation for the mother and child. Dr. Greenfield stated that the risk of uterine rupture for a client who has had a cesarean section is twenty-two times greater. The risk of maternal mortality doubles. Dr. Greenfield stated that the Board has taken three years with input from members of the Department, members of the Midwives Advisory Board, and community. Those recommendations all went into the process of developing the rules and regulations that have come before the Board. Ms. Chiappinelli questioned whether the clinic nurses worked for the same department that formulated the rules and regulations. Ms. Chiappinelli questioned whether the Informed Refusal Form has to be respected by the clinic nurses since the nurses have their own protocol. Dr. Greenfield stated that the Informed Refusal Form was put in place for those Licensed Lay Midwives who have certain credentialing; it does not dictate for all the nurses in the clinic. There are different nurses who function in different roles. When nurses complete the assessments, the nurses will comment on whether the patient has opted to refuse, and or the patient does have the opportunity for Informed Refusal. Based on the level of certification that the Licensed Lay Midwives have, the midwives then have certain obligations. The Licensed Lay Midwives with the highest level of certification and must duly note what the patient actually refused. Dr. Marsha Boss questioned how many Licensed Lay Midwives have Midwifery Education, Regulation, and Association (MERA) Bridge and how many do not. Ms. Chiappinelli pointed out that around 30 have MERA Bridge and five do not. Ms. Chiappinelli stated that if the clinic nurses can respect the ability of the client to exercise Informed Refusal and respect that form, which is also in rules and regulations, the nurses should be able to respect the practice protocols that are in the regulations. Ms. Deb Phillips pointed out that she is a Licensed Midwife in Arkansas as well as a CPM and holds her MERA Bridge Certificate. Ms. Phillips stated that since the rules and regulation went into effect in June, the women are going to the clinic and refusing the vaginal exams. The women received letters stating that the assessment was not completed because the patients refused vaginal exams. The midwives filled out an Informed Refusal Form on them and that is supposed to be covered. Dr. Greenfield pointed out in his professional opinion, for patients that have an abnormal Pap smear, a biopsy should be recommended. Dr. Amerine clarified that the patients do have the right to deny and made a motion that the four points be declined; seconded by Dr. Smith. Following questions from Board members, Dr. Hui and Dr. Riddell, Dr. Greenfield stated that he would not recommend vaginal delivery for a patient with an active herpetic outbreak and that American College Obstetricians and Gynecologists (ACOG) recommends patients who desire a TOLAC be

at a facility that can provide an immediate cesarean delivery. Dr. Amerine restated his motion. President Tapp stated that the motion to decline the four points passed.

Public Health Science/Program Updates

Dr. Dirk Haselow explained that Hepatitis A is considered an uncommon infection. Typically in the State of Arkansas there have been between five and ten cases a year. Since February 2018, the Department has identified 65 cases, very closely linked in the northeast corner of the state, primarily in Clay and Greene Counties. Dr. Haselow stated that the risk factors for acquiring Hepatitis A are through food when there is fecal contamination of a food product, and individuals that are sick may give it to close contacts within a household. This outbreak appears to be different and many states are burdened by this outbreak far more so than Arkansas. Tennessee has a few hundred cases, Kentucky has 700 cases, Michigan has 700 cases, and Hawaii had 1,000 cases last year. Dr. Haselow explained that on the basis of these clusters of cases, the outbreaks have occurred in some cases among food workers in Clay County and in some among people with other risk factors. Newly identified risk factors for this type of outbreak include injection of recreational drugs and high-risk sexual behaviors. Among these groups, the Department has had seven different clinics to try and provide vaccine to target this risk of infection. The Department started today to issue a more aggressive recommendation for individuals in Greene County to be vaccinated: anyone between the ages of 19-60, which includes the entirety of the Department's case count in Greene and Clay Counties. Dr. Haselow stated that the Department hopes to deliver 4,000 vaccines in a short period of time in order to get ahead of this outbreak. Dr. Boss asked whether if it is a two shot regimen. Dr. Haselow answered that it was, and stated that the Department is offering the first and then, if interested, the second shot. Dr. Haselow explained that the Department has performed a lot of outreach through the communication programs, through Facebook, interviews, social media, and has instituted guidelines to ERs throughout the State. Dr. Haselow explained that not all hepatitis viruses are related. The viruses are in some cases not even spread the same way. Hepatitis A is spread through food transmission and only from person to person; there is no important animal reservoir. Dr. Zini questioned whether the virus is transmitted via commercial food vendors or primarily people to people. Dr. Haselow answered that the Department has had seven food workers involved in this outbreak at this point in time. The Department has not confirmed that any of them have played a part in ongoing transmission. The Department is not aware of anyone that has acquired this directly from food consumption. Dr. Haselow stated that it is hard to figure out because Hepatitis A has a long incubation period, which can be three weeks or three months.

President's Report

President Tapp did not have a President's report.

Director's Report

Dr. Smith recommends attending Public Health Grand Rounds. The Department has a one hour conference every Thursday morning. All of the State is invited, and it is "piped out" to many other places. The next meeting will feature Dr. Zohoori. Dr. Smith wanted to say thanks for indulging the lab as a meeting place, and stated that he wanted the opportunity for the Board of Health members to see the public health lab. It is a tremendous resource to us in the state to

accomplish the Department's mission. Mr. Reginald Rogers mentioned that the cancer registry meeting would be held immediately after this meeting. Meeting adjourned at approximately 12:39 p.m.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'N. Smith', with a horizontal line extending to the right and a small flourish at the end.

Nathaniel Smith, M.D., MPH
Director and State Health Officer
October 25, 2018