Grand Valley Holistic Homebirth

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Informed Disclosure and Consent for Midwifery Care

State Required Sections appear underlined

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Welcome! Thank you for considering Grand Valley Holistic Homebirth for your maternity care and birth. If you are reading this document, it means you are learning more about what your options in childbirth really are. Here you will get a short introduction to the different types of midwives and their history in the United States. You can also read about my educational background, the philosophy of my midwifery practice, the services I offer, potential reasons for transfer of care, my accessibility, the grievance process, and the ever important privacy policy and informed consent to care forms which we need you to sign before we begin care. There are two copies of the signature pages, so that we both have a copy. Some of the information given here is mandated by the state, and will be underlined to reflect its significance.

I. Midwifery in the USA

Midwives have served birthing women for all of the world's known history, and they continue to do so in most countries around the world today. Around the turn of the 19th century in the United States, Midwives were vilified, persecuted and driven out of the profession by medical doctors working in hospitals.

By 1921, 30-50% of women now gave birth in hospitals. Midwifery care continued only in very rural and poor communities where doctors tended not to go. Women inclined towards the healing services mostly became nurses, serving under doctors.

In 1925 Mary Breckenridge founded the Frontier Nursing Service of Kentucky, and the American phenomenon of “Nurse Midwifery” was born. Nurse midwives have fought for many years with modern medical men for credibility and autonomy to practice their profession. They provide a valuable service to women, offering more options in the hospital, as well as birth centers. Some few Nurse midwives practice home birth, but their training is usually in hospitals or birth centers so that is where they feel comfortable practicing. Nurse Midwives are trained in the medical model because they must first become nurses, and later they do an advanced program to also become Midwives.

By 1950, 80% of births in the United States took place in hospitals. By 1960, 97% of births took place in the hospital. Native Americans were forced into hospital care and often sterilized in Reservation hosptials without their consent. African American “granny midwives” continued to practice in smaller numbers, quietly serving in rural communities.

In 1971, Ina May Gaskin began to attend births as a “lay midwife,” and in 1975 she published her book “Spiritual Midwifery,” which sparked a resurgence in home birth all over the United States for privileged white women. Lay midwives began springing up, learning from their experiences, from each other and from medical books. Eventually training programs began to start up and the quality of education began to improve. The school I attended, Midwives College of Utah, was founded in 1980.

By the 1990's these midwives began to organize, developing national associations. The Certified Professional Midwife (CPM) credential was created to establish a nationwide standard of education for direct entry midwives. Direct entry midwives train as midwives from the outset, instead of as a nurse first and a midwife second. The Midwifery Education Accreditation Council (MEAC) was formed in 1991 to begin accrediting schools. These modern midwifery institutions teach The Midwives Model of Care, which combines an understanding of modern medicine with alternative health care and respect for the birth process as a naturally occurring rite of passage in a woman's life that is low risk for most women, most of the time. Home birth Midwives today only care for low risk women at home, referring higher risk clients to Nurse Midwives and Physicians in hospitals. They are trained to recognize complications before they become emergencies, transferring care proactively, and are also trained to handle common complications at home as needed.

The midwifery movement today is well and alive, striving to educate more midwives and provide safer, affordable options for low risk women desiring home birth. Black women in the U.S. are 3-4 times more likely to die of childbirth related causes. Midwifery model care needs to be more available to women of color in our nation, and MEAC schools are actively striving now to make this model of care more accessible by improving educational access and training to BIPOC communities. The intent is to shift the quality of maternity care to be available to ALL women in the United States who desire respectful care.

Midwifery in Colorado

Birth at home with a midwife has been legal in Colorado since 1993. There are currently 2 Types of Midwives legally available in Colorado.

1 - CNM: Certified Nurse Midwives

CNM's are trained first as nurses in a hospital setting. They then go on to earn a Masters degree in Midwifery so that they can serve as a woman's sole maternity provider. Nearly all CNM's in Colorado practice in the hospital setting. There is currently one local birth center run by CNM's (Bloomin Babies in Grand Junction). CNM's also perform Well Woman care, offer birth control, and are able to accept Medicaid. They provide a wonderful service for those women who prefer to give birth in the hospital or birth center..

2 – RM/CPM: Registered Midwives, also known as “Direct Entry Midwives”

A direct entry midwife differs from a CNM in a number of ways. They are not required to train as a nurse first (although there are some nurses who choose to train as direct entry midwives). Second, direct entry midwives train specifically for out of hospital birth in birth centers and in homes. CPM’s are not trained in the hospital setting or allowed to practice as midwives in the hospital. If a home birth client is transported to the hospital for care, her midwife can act as her doula once there, but not as her midwife. Direct Entry Midwives registered by the state of Colorado are known as RM's (Registered Midwives). Most RM's in Colorado also carry the credential of CPM (Certified Professional Midwife), a nationally recognized credential.

RM's and CNM's are trained differently and have a different scope of practice. RM's are primarily trained to handle low risk births and the range of possible complications and emergencies in a home birth setting. CNM's have a wider scope of training, including the ability to perform Well Woman Care, write prescriptions and administer contraceptives. They work in collaboration with Doctors who handle high risk patients and complicated cases. They provide high quality childbirth care in the hospital and birth center setting. If you develop complications in your pregnancy, we can arrange to transfer your care to a CNM or a Doctor.

II. Education:

Anna Gilmore is the lead midwife at Grand Valley Holistic Homebirth, LLC. She is a Colorado Registered Midwife (RM)/Certified Professional Midwife (CPM). This means that she specializes in assisting women to give birth at home. She earned this credential by completing her Associates of Science in Midwifery degree through Midwives College of Utah (MCU), which is a MEAC accredited school (Midwifery Education Accreditation Council). MCU is one of the longest running (founded in 1981) and most highly attended midwifery colleges in the United States. Anna is a member of the Colorado Midwives Association as well as a former board member of the Utah Midwives Organization and the Colorado Midwives Association.

Anna completed her didactic work at MCU over 3 years (2014-2017) earning a total of 81.50 credit hours. She then completed her clinical experience over an additional 2 years (2017-2019, by apprenticing within several different midwifery practices in Utah along the Wasatch front. She attended over 75 births at 7 different birth centers as well as in clients' homes. After completing her clinical training requirements in 2019, she sat for the national certifying exam for direct entry midwives in 2020, and passed with flying colors. She continues to collaborate with local midwife Tawnya Renee Schiebel (RM, CPM) who practices mainly in Montrose. Student/Assistants are a part of the GVHH practice.

Anna is current in her Neonatal Resuscitation (NRP) Certification, as well as her CPR/AED certification. She has never had a licence, certification or registration revoked by any local, state or national health care agency.

"My first experiences with birth were with my own babies, who were all born at home. While expecting my fifth child, I felt inspired to become a midwife, committing to whatever it took to make that happen, so that other women could have similar opportunities for wonderful birth experiences. I trained as e a childbirth educator through ICEA (International Childbirth Education Association), and a childbirth mentor through Birthing From Within, as well as a Doula (a woman who attends women at birth, but with none of the medical responsibility) before beginning formal midwifery school in 2014, after the birth of my sixth baby. I went on to bring one more child into the world during my schooling. It seems a daunting task to be a midwife and raise a large family, but training with Utah midwives allowed me to mingle with many other midwives doing exactly that, some with even more children than myself!"

-Anna

III. Philosophy

Our role during your prenatal care is to empower you to learn about your options, let you make the decisions that are best for your family, and then support you. Be prepared for relaxed appointments in our cozy Grand Junction office, plenty of time to ask all your questions, and sound nutritional advice! Coaching you on how to eat during pregnancy is how we nourish both you and your baby and prepare your body for the rigors of childbirth. Lab work gives us feedback on how you are doing and what to do next. We treat every client as a potential student of midwife by sending you home with a home prenatal care kit where you can check in with your body and your baby in between appointments, or be empowered for a high quality telehealth call if needed. We teach you throughout your pregnancy and encourage you to take charge of your own family's health care.

We have 2 intentions during your labor and birth.

1: Support and empower you

2: Guard the safety of you and your child

To guard your safety, there are at least two of us present at the birth. We don't hesitate to escalate to higher levels of care when needed. When transport is needed we strive to change birth settings before it becomes an emergency. To support and empower you we coach your partner and/or your doula on how to support you physically during labor. During your prenatal care we will discuss your birth plan so that you can make the choices that are meaningful for you. You choose who will be there. You choose to labor on land or in water. You choose who catches. You choose when and who cuts the cord. You choose who gets to weigh your new baby. You choose what you want done with your placenta. You choose what procedures are performed on yourself and on your child. Our job is to support you in your choices within the confines of safety.

We provide home visits during the first week after your baby is born. You can stay tucked in bed with your new baby, while we come to you! I make certain you get all of the newborn screenings offered that would be done in the hospital including the CCHD, the hearing screen, and the metabolic screen. We visit you in your home on day 2, and again on day 7. We are qualified to offer basic newborn care for the first 6 weeks. You can call us to consult, or come in for an office visit as often as needed for up to 6 weeks postpartum for you and/or your baby. We support your feeding goals for your baby, and refer you to solid community resources (such as WIC) and lactation consultant support as needed.

Every woman has the right to make her own choices regarding her body and her birth. You should have access to evidence-based, unbiased information during your pregnancy and birth in order to make informed decisions. Good nutrition is an essential component of healthy pregnancy, birth, postpartum, self-care and child-rearing. We hope you gain some helpful strategies while in our care.

Bringing a child into the world can be a sacred, humbling, rite of passage for a woman and her partner. We

believe you should be able to choose to give birth where you feel most safe. Ideally, you should be attended only by those you feel comfortable and safe with, so as to allow the process of birth to unfold without emotional inhibition or fear of judgment. Being allowed into the presence of a birthing woman is a privilege, and it should be guarded such that you feel honored, respected, and safe.

Ultimately, the primary care provider for an unborn child is the Mother. The role of a midwife is to support you in giving yourself and your child the best possible emotional/spiritual, nutritional and physical support possible during your pregnancy.

We consult with a network of other birth professionals, including other Registered Midwives, Certified Nurse Midwives, Obstetricians, Chiropractors, Naturopaths, specialists (in the case of co-care), Lactation consultants, and ChildBirth Educators.

We offer you information, encourage you to read, take classes and do internet research yourself, because you have many decisions to make. Your decisions will be yours, and not ours. We expect you will sometimes choose differently than we might. Our job is to provide the best information we can to help you make informed decisions outside of our personal preferences. The decisions you will make during pregnancy and childbirth are but a prelude to the many decisions you will need to make for your family in the future.

There are no guarantees in life or in birth. Each of us must make the decisions which we believe to be best for us, because ultimately, we will be the ones to live with the consequences of those decisions. At Grand Valley Holistic Homebirth, our role is to support and empower you throughout your journey.

IV. What Services We Offer

We offer prenatal, labor, birth and postpartum services to healthy, low-risk women who wish to birth vaginally at home.

Prenatal Care:

Appointment Schedule:

- Once a month until you reach 28 weeks
- Every 2 weeks from 28 weeks to 35 weeks
- Weekly from 36 weeks to delivery

At each appointments we will:

- Obtain vital signs
- Check urine dipstick test for protein and glucose (after 24 weeks)
- Assess for
    - Signs of complications
    - Your emotional/psychological well-being
    - Nutritional status
    - Fundal height
    - Gestational age of your baby
    - Baby's presentation and position (when you are far enough along
    - Baby's activity
    - Baby's heart tones.

Prenatal visits are a time for you to ask questions and for the midwife to share knowledge with you that will help you prepare for your baby's birth, your postpartum recovery, assistance with nutrition for you and your baby, etc. Appointments are typically a one hour office visit, and you are welcome to bring your partner or your children along, or you can use it as a time to treat yourself to self care time.

We are required to perform or obtain certain laboratory test results during your care, unless you sign a refusal of consent. These tests include:

- Indirect Coombs test at 28 and 36 weeks, if indicated (for Rh- mothers)
- Hemoglobin or Hematocrit at 28 and 36 weeks
- *In addition, a one-hour Glucose Tolerance Test with a minimum of a 50 Gram glucose loading dose shall be offered at 26-28 weeks.*

After your baby is born, the state recommends that your baby receive a shot of vitamin K. Anna is currently applying for authority to administer vitamin K, and waiting for the state to process her application. If for some reason, she is unable to provide this service to you by the time your baby is born, you can take your baby to a pediatrician, or to Tawnya Scheibel (The Montrose Midwife) to have the shot administered.

After your baby is born, the state recommends that the baby be screened for heart defects with a pulse oximeter. This is a completely non-invasive test that measures the baby's oxygenation levels with a pulse oximeter. If we are unable to perform this test when your baby is born, we will refer you to a pediatrician or to Tawnya Scheibel (The Montrose Midwife) to have this test performed.

If your blood is Rh negative, the state recommends that you receive a shot of Rho(D) immune globulin, often referred to as "Rhogam." Anna is currently applying for authority to administer Rhogam, and waiting for the state to process her application. If for some reason she is unable to provide this service to you by the time your baby is born, you can go to your family doctor, an obstetrician, a CNM or to Tawnya Scheibel (The Montrose Midwife) to have the shot administered.

I am not legally allowed to care for women with the following conditions:

- Diabetes mellitus or a diagnosis of gestational diabetes in the current pregnancy
- Hypertensive Disease (blood pressure greater than 140/90 when at rest)
- Pulmonary Disease or Cardiac Disease that interferes with activities of daily living
- A history of Thrombophlebitis or Pulmonary Embolism
- Hematological or Coagulation Disorders (leukemia, sickle cell anemia)
- Seizures controlled by medication **if** the client has seized in the last year
- Hepatitis B, HIV positive or AIDS
- Current use of psychotropic medications if client is not under the care and monitoring of a physician during pregnancy
- Current substance abuse of drugs or alcohol
- Rh sensitization (positive antibody titre)
- Incompetent cervix
- Previous uncontrollable postpartum hemorrhage
- A woman with a previous delivery of an infant who was premature or stillborn, or a neonatal death associated with maternal health conditions (such as hypertension, Diabetes, Rh sensitization, clotting disorders)
- A woman with a previous delivery of an infant with a major genetic anomaly unless there is a normal prenatal screening to rule out genetic anomalies, or an intervening normal pregnancy
- VBAC unless certain specific conditions are met

What Safety Equipment I DO and DO NOT Carry

While I DO carry equipment in case of emergencies, there are certain things we cannot provide except by transporting you to a hospital as quickly as possible.

<u>I do NOT carry the following:</u>

Pain relieving medications
An electronic fetal monitor (we use a doppler for intermittent monitoring instead)
Vacuum or forceps (for extracting a stuck baby)
Blood bank (for a transfusion in case of hemorrhage)
An operating room and surgical staff for emergency cesareans
A Ventilator
IV Fluids

<u>I DO carry the following:</u>

Blood pressure cuff
Thermometer (to check for fever in the mother which could indicate uterine infection)
Fetoscope and Doppler (for monitoring baby's heart tones)
Oxygen with adult and infant masks
Bulb Syringe and DeLee trap (for clearing mucus from the baby)
Neonatal Resuscitation equipment
Pitocin, Methergine and Misoprostol (for stopping a postpartum hemorrhage)
Suturing Equipment
Lidocaine (to numb the area during suturing)

Assistants

A home birth is safer with more than one set of skilled hands. We strive to provide at least 1 midwife and one one trained assistant (preferably two) to help the process run more smoothly and to better handle an emergency. Assistants all train in BLS (Basic Life Support) as well as NRP (Neonatal Resuscitation). It is intended that their experiences in GVHH will lead to completion of their future certification as midwives.

V. Transfer of Care

For the sake of the health and safety of both you and your baby, there are certain situations in which we may need to transfer your care before, during, or after your baby's birth.

During your pregnancy (Antepartum Care):

If any of the following conditions or the conditions listed above in section IV become manifest, We will need to refer you to an appropriate care provider. If the condition resolves and they refer you back to us then we can continue care together.

- If you turn out to be carrying twins or higher order multiples
- If your baby presents as anything other than vertex at the onset of labor
- If you continue to have hyperemesis (extreme nausea and vomiting) after your 24thweek of gestation
- If you develop or manifest hypertension
- If you show signs and symptoms of preeclampsia
- If you develop seizures
- If there is vaginal bleeding after 20 weeks
- If you manifest signs and symptoms of urinary infections or STDs
- If you have a temperature in excess of 101 degrees for more than 24 hours accompanied by other signs of significant infection or which does not resolve in 72 hours
- Any lab results indicating a need for medical treatment
- Severe anemia
- Too much or too little amniotic fluid
- Suspected death of your baby (can't find fetal heart tones)
- Significantly decreased fetal movements
- A gestation that lasts longer than 42 weeks
- Rupture of Membranes for longer than 12 hours with Group B strep or longer than 18 hours without Group B strep
- Premature labor (before 37 weeks)
- Active herpes
- Intrauterine growth retardation
- Suspected abnormality of the pelvis

Once any of the conditions provided above are noted, We are not permitted to resume care for you until a qualified health care provider assesses you and determines that you are not exhibiting signs or symptoms of increased risk of medical, obstetrical, or neonatal complications, or problems during the completion of the pregnancy, labor, delivery, or the postpartum period, and are not exhibiting signs and symptoms of increased risk that the infant may develop complications or problems during the first six weeks of life.

During the Birth (Intrapartum Care):

We are required to transport for any of the following conditions:

- Inappropriate bleeding (other than the “bloody show” prior to delivery)
- Signs of placental abruption (including continual lower abdominal pain and tenderness)
- Prolapse of the cord
- Any meconium staining without reassuring fetal heart tones, moderate or greater meconium staining regardless of the status of fetal heart tones
- Significant change in maternal vital signs (fever, high pulse with decrease in blood pressure, or a higher than safe blood pressure)
- Failure to progress in labor
- Fetal heart rate below 110 or above 160 between contractions
- Protein or glucose in the urine
- Seizures during labor
- An atonic uterus
- Retained placental fragments
- Vaginal or cervical lacerations requiring repair

In addition, if for any reason you decide you want to be in the hospital, we will transport according to your wishes.

After your birth (Postpartum care):

The following are conditions we would need to arrange for consultation or transport:

- If there is maternal blood loss of more than 500 cc
- If you have a fever over 101 degrees on any of the 2nd through 10th days postpartum
- If you cannot void (urinate) within 6 hours after the birth
- If the lochia (postpartum period) is abnormal (such as foul smelling or excessive)
- If you exhibit signs of clinically significant depression (not just the baby blues)

VI. Accessibility

Anna can be reached during business hours 8-5 PM Monday – Friday.

Please keep all non-emergency calls to business hours. You are always welcome to leave a text message. She will see a text message sooner than a voicemail.

Anna Gilmore 970-216-7849

If for some reason you are unable to get through to Anna on my phone, you can call her husband's phone. Leave a voicemail and a text so that our phones will give us an alert.

John Gilmore 970-589-6849

Prenatal appointments are held in our office in Grand Junction. Call or text Anna to schedule. Initial Consultation is free. Please let us know asap if you cannot make an appointment or if you will be late.

We have arrangements with Tawnya Schiebel (The Montrose Midwife) and Jaime Doty (San Juan Midwifery) to be back-up midwives if something unforeseen prevents Anna from attending your birth. They are both excellent midwives with years of experience with women in this area.

Tawnya Schiebel (The Montrose Midwife) 970-258-0596

Jaime Doty (San Juan Midwifery) 308-636-6184

VII. Grievance Process

If you ever have concerns or complaints, please bring it to my attention first, so that I can address it. I am continually learning and improving, and I want to hear all types of feedback, including negative feedback, so that I have the opportunity to learn from it and try and resolve any conflicts. Grand Valley Holistic Homebirth, LLC does not carry malpractice insurance or liability insurance for the practice of direct-entry midwifery.

Signing this disclosure statement does not constitute a waiver of any right the client has to seek damages or redress from the undersigned direct-entry midwife for any act of negligence or any injury the client may sustain in the course of care administered by the undersigned direct-entry midwife.

The practice of direct-entry midwifery is regulated by the Department of Regulatory Agencies:

DORA-Colorado Department of Regulatory Agencies
1560 Broadway #1545, Denver, CO 80202
303-894-7855
http://dora.colorado.gov

Violation of the Direct-Entry Midwives Practice Act may result in revocation of registration and of the authority to practice direct-entry midwifery in Colorado.

If for some reason a client has a complaint which they feel must be escalated to a higher authority than the state (DORA), there is an accountability process that can be pursued with NARM. NARM (the North American Registry of Midwives) is the national organization which oversees the licensing of Certified Professional Midwives (CPM's) and has the power to suspend and revoke that credential.

NARM will not simultaneously pursue investigation of a midwife who is already facing a regulatory investigation (an investigation by DORA in Colorado) or civil or criminal litigation. If those proceedings are taking place, it is the responsibility of the complainant to notify NARM within 90 days of the conclusion of those proceedings so that they can begin their accountability process.

To pursue a complaint with NARM you must make it in writing and mail it to:

NARM Accountability
Shannon Anton
PO Box 128
Bristol, VT 05443

A complaint against a CPM or CPM applicant may only be made by a client, or a party with direct knowledge of the cause for concern. Complaints must be received by NARM within 18 months of the end of the course of care prompting the complaint.

OVERVIEW OF THE NARM GRIEVANCE MECHANISM AND POLICIES

1. Complaints must be filed within eighteen months of occurrence or conclusion of care.
2. All complaints shall be kept confidential.
3. A written complaint to the NARM Board initiates the Grievance Mechanism, which begins with peer review at the most local level possible. Peer review in response to such a written complaint utilizes the NARM Complaint Review process. If prior to the written complaint to NARM, this complaint was addressed by a local peer review process and resolution was not reached, the written complaint to NARM initiates the Grievance Mechanism. The NARM Board then refers the complaint to the Accountability Committee.
4. The Accountability Committee shall identify a local review committee made up of the midwife's peers (at least two (2) CPMs, one of whom will chair, and may include one consumer) at the appropriate local level. The NARM Grievance Mechanism may be a face to face meeting or conducted by teleconference, to be determined at the discretion of the NARM Accountability Committee. A complaint against a CPM applicant may be reviewed by a committee of NARM Board members.
5. Upon receipt of a complaint, the Accountability Committee Chair will respond to the complainant with a letter stating that the complaint has been received and will ideally be heard in the review committee within 90 days. 6. The CPM or applicant is notified of this pending action, and, within one week of notification, the CPM (or applicant and preceptor) must submit to the Accountability Committee a complete copy of the client chart and the CPM's own practice guidelines. The chart is then passed on to the local review

committee chairperson. 7. The opposing sides are each invited to supply written or verbal testimony for the review. Written testimony must be sent from witnesses directly to the local committee chair. Copies of all written material are supplied to the local level chairperson for dissemination to 1) the CPM (or applicant and preceptor), and 2) review committee members, at least two weeks before the review. The local review committee chair is also responsible for coordinating the details of the review committee meeting time and location and will notify the involved parties at least 30 days in advance. 8. Complainant must respond within two weeks of being notified by the NARM Grievance Mechanism Chairperson with attempts to establish a date for the Grievance Mechanism session. If the complainant does not continue participation in the process, the complaint will be dropped and will not reflect on the CPM or applicant in question.

The Proceedings

I. All participants are required to sign a statement of confidentiality. If the session is via teleconference, this will be established prior to the call and reaffirmed verbally at the opening of the session.
II. The complaint shall be read aloud along with the agenda. The agenda will be drawn from a list of proceedings and the material to be presented.
III. Written testimony will be read and verbal testimony given by the complainant. The midwife may be present during this time.
IV. Complainant is excused from the proceedings.
V. The midwife in question will present the case. Then the CPM (or applicant) is excused. VI. The review committee discusses the case, writes a synopsis, and makes recommendations to the Accountability Committee.
VII. The Accountability Committee derives appropriate action after the synopsis and recommendations are considered. NARM's intention in the Grievance Mechanism is to provide educational guidelines and support where appropriate. Punitive action is only taken when educational avenues have failed and further action is deemed necessary. Actions are limited to the following possibilities:

a. Midwife is found to have acted appropriately and no action is taken against the CPM. If the review process has not resolved the dispute, concerned parties are urged to seek professional mediation.
b. Midwife is required to study areas outlined by the Accountability Committee. The committee will involve the midwife in identifying areas needing further study. Upon completion of the assigned study, the midwife will submit a statement of completion to the Accountability Committee.
c. Midwife is placed on probation and given didactic and/or skills development work to address the areas of concern. The midwife must find a mentor, approved by NARM, to follow the assigned studies and lend support in improving the areas of weakness. The mentor will report to the Accountability Committee regarding the progress and fulfillment of the probation requirements. While on probation, the midwife may be required to attend births with a more experienced midwife assisting.
d. Midwife's certification is suspended, and the CPM is prohibited from practicing as a primary midwife for a period of time during which the CPM is mentored by another midwife and focuses on specific areas of study. The mentor midwife will report progress to the Accountability Committee. Upon completion of required study and/or experience, the CPM is reinstated. If a midwife on suspension is found to be in deliberate violation of suspension guidelines, this CPM risks certificate revocation.
e. In the case of dishonesty, refusal to inform, negligent or fraudulent action of self-interest in which the certified midwife or applicant compromised the well being of a client or client's baby, or non-compliance with the Grievance Mechanism, this CPM's certificate must be revoked, or the CPM application must be denied. Midwives with revoked certificates may reapply for certification after two years. This application must include the full fee. Prior to recertification all outstanding complaints must be resolved, including the completion of previous Grievance Mechanism requirements. A midwife with a denied application may reapply after meeting all requirements resulting from the review process.
f. If the case involves the abuse of a controlled substance, the certified midwife (or applicant) in question will be required to participate in a rehabilitation program in addition to the above possible outcomes. Proof of participation and release will be necessary for full certification reinstatement, or for an applicant to continue in the CPM application process.

VIII. The midwife in question is notified of findings and appropriate action taken.
IX. The complainant is notified of action taken regarding the midwife. If no action is taken, a compassionate approach is taken to honor the complainant's perspective.

VIII. Client Responsibilities:

- Honesty regarding all issues and a signed contract with a commitment to all provisions in the contract.

- Parents take an active role in their care and well-being through nutrition, exercise, attendance at prenatal visits and healthy lifestyle. We ask all homebirth clients to not smoke or use recreational drugs.

- Preparation of home for the birth and all birth supplies organized by 36th week of pregnancy.

- Willingness to transport to the hospital at the request of the midwife.

- A care provider selected for your newborn.

- Honor the financial agreement.

IX. Informed Consent to Care

I (we) have voluntarily chosen to engage the care of a midwife through Grand Valley Holistic Homebirth, LLC for prenatal care, labor and delivery and postpartum care. It is our intent to labor at home until such a time as we either want or need to transfer to a hospital, or the labor culminates in the out-of-hospital birth of our baby.

_____, _____

I (we) have made this decision after being informed that in the natural course of childbearing, which is a normal human function, medical problems can unpredictably and suddenly arise which may present a hazard to myself and my unborn/newborn child. I understand that equipment for dealing with these potential problems is most readily available in the labor and delivery complex of an acute-care hospital where the intrapartal events would be under the supervision of a medical doctor.

_____, _____

I (we) understand that risk is always present in life, including childbearing, regardless of the intrapartal location, due to unforeseeable complications and/or human error.

_____, _____

I (we) are aware that certain risks are greater in a medical setting (i.e. unwanted interventions and/or interference with physiological nature of the birth process that cause complications and lead to unnecessary surgery, hospital-acquired infections, drug and anesthetic reactions, medication errors, and other iatrogenic & nosocomial complications, etc) and certain risks are more prevalent in a domiciliary (home) setting (i.e. no immediate access to blood transfusions, delay in being able to respond to immediate surgical needs such as but not limited to emergencies of acute fetal distress, premature separation of the placenta, maternal hemorrhage, etc).

_____, _____

I (we) hereby state that I (we) are aware of the nature and the magnitude of risks assumed by choosing domiciliary (home) care and that we are willing to assume primary responsibility for the consequences of this decision, holding the midwife harmless except in cases of gross negligence.

_____, _____

I/We have read and understand the above Informed Disclosure and Informed Consent documents.

Client: _____ Date: _____

Partner: _____ Date: _____

Midwife: _____ Date: _____

Notice of Privacy Practices

As a client in our practice, you have the right to:

• Request access and corrections to your record
• Request an accounting on how your information has been used and who it was released to in the course of your care
• Request that all communications be confidential
• Complain about a perceived violation of privacy- to Grand Valley Holistic Homebirth LLC, to the Colorado Department of Regulation Agencies (DORA), and to the North American Registry of Midwives (NARM)
• Decline any of the following authorizations (all of which are optional):

Please initial ONLY the following which you agree to (if any):

_____ I agree to allow student midwives and apprentices associated with Grand Valley Holistic Homebirth llc to use my records, with name removed, for verification of skills with the North American Registry of Midwives (NARM)

_____ I agree to allow my records to be used, with my name removed, in peer review with professional colleagues.

_____ I agree to allow a photo of my baby, with my baby's name, and birth weight to be posted to Grand Valley Holistic Homebirth LLC social media page or website

_____Grand Valley Holistic Homebirth, LLC has my permission to disclose my protected health information with the following family members or friends:

_____

_____

_____

_____

Situations that require no permission to use or disclose your records and are routine in our practice are:

Consultations, referral or transfer of care

Sharing a chart with a back up midwife

Lab or Ultrasound orders

Insurance claims we make on your behalf

Situations related to public benefit: reporting victims of abuse, neglect, domestic violence, legal proceedings, national security, and law enforcement. Any other transactions which involve treatment, payment or healthcare operations

In addition to the above policies, our practice follows the following protocols to protect your privacy:

1. When sending written information (mail, email, fax) we: Confirm the address, phone or fax number

2. When sending written information (mail, email, fax) we: Include a cover letter with instructions for the recipient to contact us and destroy the contents if they are not the intended recipient.

3. When sending written information (mail, email, fax) we: We send the minimum information necessary to achieve the goal of communication (if we call you concerning lab results and have to leave a message, we will ask you to call us back instead of leaving personal details)

4. We speak quietly if we ever need to discuss a client in public areas of our office so as to not be overheard by others.

5. We refrain from incidental conversations concerning clients among colleagues that are not necessary for treatment, keeping things on a need-to-know basis.

6. We do not discuss private client information with people outside our practice, even if they are mutual friends/acquaintances.

Notice of Security Practices

In compliance with guidelines from HIPAA we follow the following security policies in our practice:

1. Client Records are Stored with encrypted cloud storage instead of on a local computer. In this way it cannot be compromised with a stolen computer or lost phone.

2. Passwords for all electronic devices associated with our practice are kept secret.

3. All electronic devices associated with our practice log off after 3-5 minutes without use, and are only accessible again with a secret password.

4. We only share protected information with other entities (Colleagues, Insurance Companies, Labs, etc.) who are also HIPAA compliant.

5. Any discarded records are first shredded before being composted, burned, thrown away or recycled.

6. Once a year our security and privacy practice guidelines are reviewed and updated as part of our Risk Analysis Management Plan.