FLORIDA | Council *of* Licensed Midwifery

Agenda Outline

October 3, 2016

9:00 am

Call in Number: 1(888)670-3525
Participant Passcode: 7133577864

The meeting will be called to order at 9:00 am or soon thereafter.

Call to Order: **Melissa Conord-Morrow, LM, Chair Roll**
Call: **Kama Monroe, Executive Director**

Review of Minutes from Previous Meeting:

1. December 10, 2015, General Business Meeting Minutes

General Business:

2. Preparing Annual Report
   (a) DH-MQA 5011

3. Non-Matriculating Student Agreements
   (a) Declaratory Statement

4. Discussion of Letter from The American Congress of Obstetricians and Gynecologists

Rule Discussion

5. 64B24-7 Midwifery Practice
   (a) 64B24-7.004 - Risk Assessment
   (b) 64B24-7.007 - Responsibilities of Midwives during the Antepartum Period
   (c) 64B24-7.008 - Responsibilities of Midwives during the Intrapartum
   (d) 64B24-7.009 - Responsibilities of Midwives during the Postpartum

Reports:

6. Annual Report Draft

7. Executive Director's Report

8. Application Liaison –

9. Budget – Kathy Bradley

10. Community and Consumer Relations - Kathy Bradley

11. International Relations –

12. Laws & Rules and Other Agency Action – Susan (Robyn) Mattox

13. Unlicensed Activity – Susan (Robyn) Mattox, L.M.

14. Healthy Weight Initiative – Melissa Conord-Morrow

15. Counsel Report – Linda McMullen, Esq.

Old Business

New Business

Adjourn

FLORIDA | Council of Licensed Midwifery

DRAFT
December 10, 2015

Conference Call
Call in Number: 1(888)670-3525
Participant Passcode: 3608975369

Melissa Conord-Morrow, LM
Chair

Susan "Robyn" Mattox, LM
Vice Chair

Claudia J. Kemp, JD
Executive Director

Section I: The meeting was called to order by Ms. Mattox, Vice Chair, at approximately 9:08 a.m. Those present for all or part of the meeting included the following:

General Business started: 9:08 a.m.

MEMBERS PRESENT
Susan Robyn Mattox, LM, Vice Chair
Charlie Young, LM
Tania Mondesir, RN, LM
Dana Barnes, MD
Robert Pearson-Martinez, MD
Kathy Bradley, Consumer Member

STAFF PRESENT:
Claudia J. Kemp, Executive Director
Daisy King, Program Administrator
Alexandra Meredith, Regulatory Specialist II

MEMBERS EXCUSED
Melissa Conord-Morrow, LM, Chair
David S. Stewart, MD

MEMBERS UNEXCUSED
Stephanie Wombles, CNM

COUNSEL
Not present was Linda McMullen, Assistant General Counsel
DOH Office of the General Counsel

COURT REPORTER
Tallahassee Court Reporting
850-222-5491

Please note the minutes reflect the actual order agenda items were discussed and may differ from the agenda outline. Minutes from this meeting can be found online: http://www.floridahealth.gov/licensing-and-regulation/midwifery/meetings/index.html

General Business started: 9:07 a.m.

1. APPROVAL OF MINUTES

October 14, 2015 – Full Council Meeting

Minutes of the October 14, 2015 General Business Meeting were reviewed, with corrections being noted on page four, line 51 instead of 46 weeks it should be 6 days, line 52, instead of 46 weeks it should also be 6 days. After these corrections, Ms. Bradley made the motion to accept the minutes seconded by Dr. Pearson-Martinez. Vote: unanimous

Approval of Minutes ended: 9:18 a.m.
Annual Report started: 9:18 a.m.

2. **GENERAL BUSINESS**

2015 ANNUAL REPORT OF MIDWIFERY PRACTICE FORM (final draft)

Discussion:
Discussion presented of attendance of council members and rule support for attendance. Rules and regulations for guidelines of what constitutes excused and unexcused absences to be sent to council members for clarification by the Executive Director.

Ms. Mattox made the motion to accept the annual report, seconded by Ms. Bradley.
Vote: unanimous

3. RULE DISCUSSION

Rule 64B24-7, F.A.C., Midwifery Practice

Discussion of the rules tabled to next meeting, February 8, 2016, to present language.

Rule Discussion ended: 9:51 a.m.
Reports started: 9:51 a.m.

4. REPORTS

Executive Director's Report

Report given by Ms. Kemp on Healthiest Weight Initiative. All board websites will be updated to highlight the Healthiest Weight "Maintain Don't Gain Holiday Challenge". Last year 1,700 Floridians participated in challenge. 67% maintained weight throughout holidays with 26% losing at least 3 pounds.

Application Liaison

Ms. Barnes nominated Ms. Mattox to serve as the Application Liaison. Ms. Barnes made the motion to accept nomination, seconded by Ms. Bradley.
Vote: unanimous

Budget

The budget discussion was led by Ms. Bradley, the budget liaison. No significant changes to report at this time.

Community and Consumer Relations

Discussion led by Ms. Bradley. Discussion of packet to include copy of rules and language changes to be provided to Midwives to be passed out to the community for educational purposes. The material will be collected and placed on a future agenda for discussion.

Data Collection

Ms. Barnes nominated Ms. Mattox to serve as the Data Collection Liaison. Ms. Barnes made the motion to accept nomination, seconded by Ms. Bradley.
Vote: unanimous

International Relations

Ms. Barnes nominated Ms. Mattox. Ms. Barnes made the motion to accept nomination, seconded by Ms. Bradley.
Vote: unanimous

Laws & Rules and Other Agency Action

Discussion led by Ms. Mattox. Other agency action reported was AHCA's opening rules and language changes in regards to midwifery. AHCA will be looking at opening rule regarding risk assessment.

Unlicensed Activity

Discussion led by Ms. Mattox. There have been no reports on complaints filed against midwives practicing without a license. Discussion proceeded on how to file a complaint against a midwife practicing without a license.

Healthy Weight Initiative

Discussion tabled to next meeting, February 8, 2016.

Counsel Report

Report tabled to next meeting, February 8, 2016.

5. **OLD BUSINESS:** None

Old Business ended: 10:15 a.m.
New Business started: 10:15 a.m.

6. **NEW BUSINESS:** Mrs. King advised of renewal period being mandatory reporting of continuing education in order to renew as well as process of online and paper renewal process.

Discussion presented by Ms. Mattox to bring the consideration for the board to make rules on a future agenda. The discussion continued on creating reporting method for licensed midwives on cases with an adverse outcome.

NEXT MEETING DATE –
Next meeting is a conference call on February 8, 2016. Council requested the meeting be face to face. The Board staff will send out possible locations for consideration if meeting is approved for face to face.

ADJOURNMENT

New Business concluded at: 10:26 a.m.
The Council adjourned at 10:26 a.m.

STATE OF FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

LICENSED MIDWIFE ANNUAL REPORT

Report data from July 1 through June 30 of each year. Reports are due no later than July 31..

SECTION 1: PRACTICE INFORMATION

Midwife Name: _____ License#: _____

Practice Name: _____

Address: _____

_____

Phone Number: _____ Email: _____

SECTION II. CLIENT CARE SERVICES (include data for the report year only)

Section number									Total(s)
2	A	Total number of initial OB clients seen by you (include those accepted into care and not accepted into care):							
	B	Total number of maternity clients accepted for care in the reporting period:							
	C	Total number of deliveries you performed during reporting period:							
	D	Total number of licensed midwife student assigned to the practice during the reporting period							
	E	How many delivered at: Home:		Birthing Ctr:		Hospital:			
	F	Number of Planned: Breech:		Twins / Multiples					
	G	Number of Planned VBAC: # of Primary VBAC:		# of Subseq. VBAC:					
	H	Number of VBAC Successfully Delivered by you: # of Primary		# of Subseq:					
	~~H~~ I	Number of water births:							
	~~I~~ J	Number of mothers requiring sutures:							
3	A	Number of mothers transferred antepartum (for medical reasons):							
	B	Number of mothers transferred intrapartum:							
	C	Number of mothers Transferred postpartum: (medical reasons)							
	D	Number of Newborn Transfers							
4	A	Number of Fetal Deaths / Stillborn (midwife delivery only)							
	B	Number of Fetal Deaths / Neonatal (within 7 days of life)							
	C	Number of Maternal Deaths (please submit separate report)							

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): List each transfer separately. Do not list names. Attach separate sheet as needed

Date	Reason For Transfer	GA at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum Transfers from all sheet (3-A)

(3-B) INTRAPARTUM TRANSFERS: List each transfer separately. Do not list names. If needed, attach separate sheets as needed.

		MOTHER		INFANT		
DATE	**REASON FOR TRANSFER**	**Delivery Method**	**Complications?**	**BIRTH WEIGHT**	**Admitted to NICU? If yes, reason and # of days**	**Neonatal Death?**

Total Intrapartum Transfers from all sheets (3-B)

(3-C) MATERNAL POSTPARTUM TRANSFERS: **(List each transfer separately. Do not list names.)**

Date	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers from all sheets (3-C)

(3-D) NEWBORN TRANSFERS: **(List each transfer separately. Do not list names.)**

Date	Reason For Transfer	Birth Weight	APGARS	Admission to NICU? If yes, # of days	Outcome

Total Newborn Transfers from all sheets(3-D)

SECTION IV - DEATHS

(4-A) STILLBIRTH **(midwife delivered only)**

Date	Cause of Death	Death Was:			Birth Weight	Gestational Age
		Before Labor	During Labor	During Delivery		

Total Number of Fetal Death/Stillborn (4-A)

(4-B) FETAL DEATH/ NEONATAL DEATH (Deaths within seven days of life following midwife delivery of a live infant)

Date	Cause of Death	Site of Death	Birth Weight	Age at death
			Total Number of Fetal/Neonatal Deaths (4-B)	

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT FOR EACH INCIDENT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name: _____

Signature: _____

Date: _____

Please mail your completed Annual Report to:

Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way
Bin C-06
Tallahassee, FL 32399-3255

Or Fax to: (850) 921-6184

STATE OF FLORIDA
DEPARTMENT OF HEALTH
COUNCIL ON LICENSED MIDWIFERY

IN RE: PETITION FOR DECLARATORY STATEMENT OF STACY KLINE

_____/

FINAL ORDER ON PETITION FOR DECLARATORY STATEMENT

On or about December 2, 2015, Petitioner filed the attached Petition for Declaratory Statement with the Department of Health (Department) pursuant to § 120.565, Fla. Stat. (2015), and Fla. Admin. Code R. chapter 28-105. The Petition asks the Department for an interpretation of § 467.009, Fla. Stat. (2015). The Notice of Petition for Declaratory Statement was initially published on December 15, 2015, in Vol. 41, No. 241, in the Florida Administrative Register. An amended notice was published on December 18, 2015, in Vol. 41, No. 244, Florida Administrative Register. No comments were submitted for the Department's consideration subsequent to the filing of the Petition and the notices.

FINDINGS OF FACT

1. Petitioner, Stacy Kline, is a licensed midwife in Dunedin, Florida, qualified to act as a preceptor for student midwives.

2. The Department is responsible for adopting standards for and approving midwifery training programs.

3. Petitioner seeks to act as a preceptor and teach and train student midwives enrolled in an out of state midwifery training program, specifically Midwives College of Utah.

4. Midwives College of Utah has not been approved by the Department as a midwifery training program in Florida.

CONCLUSIONS OF LAW

1. The Department has authority to issue this Order pursuant to § 120.565, Fla. Stat. (2015), and Fla. Admin. Code R. 28-105.

2. The Petition filed in this cause is in substantial compliance with the provisions of § 120.565, Fla. Stat. (2015), and Fla. Admin. Code R. Rule 28-105.

3. The purpose of a declaratory statement is to resolve a controversy or answer questions concerning the applicability of statutes, rules or orders which an administrative agency enforces, adopts, or enters. Citizens of the State ex. rel. Office of Pub. Counsel v. Fla. Pub. Serv. Comm'n, 164 So. 3rd 58, 59 (Fla. 1st DCA 2015).

4. § 467.009(4), Fla. Stat. (2015), provides that a student midwife shall undertake the care of 50 women in each of the prenatal, intrapartal and postpartal periods while under the supervision of a preceptor. § 467.003(12), Fla. Stat. (2015), defines a "preceptor" as any Florida licensed physician, midwife, or certified nurse midwife with a minimum of 3 years of professional experience who directs, teaches, supervises, and evaluates the learning experience of a student midwife. Fla. Admin. Code R. 64B24-4.007, provides that the training program shall provide the student midwife with a variety of potential preceptor role models to choose as a preceptor, and that no preceptor shall be assigned more than two students during any clinical experience.

5. § 467.207, Fla. Stat. (2015), provides that a license is required to practice midwifery in Florida unless the practitioner is a student enrolled in an approved midwifery program.

6. § 456.065, Fla. Stat. (2015), provides that the unlicensed practice of a health care profession or the performance or delivery of medical or health care services to patients without a

valid, active license to practice that profession, or an exemption from the licensure requirement, is strictly prohibited and constitutes a felony of the third degree, punishable as provided in § 775.092, § 775.083, or § 775.084, Fla. Stat. (2015).

7. The Department hereby grants the petition and answers the request for Declaratory Statement to state that, based on the foregoing statutes and rules, acting as a preceptor for a student enrolled in an unapproved, out of state midwifery training program is not authorized by § 467.009, Fla. Stat. (2015). Further, providing midwifery services under the supervision of a preceptor as a student midwife enrolled in an unapproved, out of state midwifery training program constitutes the unlicensed practice of midwifery.

This Order shall become effective upon filing with the clerk of the Department of Health.

DONE AND ORDERED this 4TH day of February, 2016.

DEPARTMENT OF HEALTH

MICHELE TALLENT
Interim Deputy Secretary for Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party adversely affected by this Final Order is entitled to judicial review pursuant to § 120.68, Fla. Stat. (2015). Review proceedings are governed by the Florida Rules of Appellate Procedures. Such proceedings must be initiated by filing a notice of appeal with the Clerk of the Department of Health and a copy of the notice of appeal, accompanied by the filing fee, with the district court of appeal in the appellate district where the party resides or the First District Court of Appeal. The notice of appeal must be filed within thirty (30) days of the filing of this Final Order.

Copies furnished to:

Stacy Kline
459 Wilkie Street
Dunedin, FL 34698

Claudia Kemp, Executive Director
Council on Licensed Midwifery
Florida Department of Health
4025 Bald Cypress Way, Bin C-00
Tallahassee, FL 32399

Marjorie Holladay, Chief Attorney
Joint Administrative Procedures Committee
Room 680 Pepper Building
111 W. Madison Street
Tallahassee, FL 32399-1400

Linda McMullen, Senior Attorney
Office of General Counsel
Florida Department of Health
4052 Bald Cypress Way, Bin A-02
Tallahassee, FL 32399

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been furnished by U.S. Mail, electronic, or interoffice mail to each of the above-named persons this 4th day of February, 2016.

Shannon Revels

Agency Clerk
Florida Department of Health

The American Congress of Obstetricians and Gynecologists

District XII Florida

April 21, 2016

Melissa Conord-Morrow, LM, RN
Chair, Council of Licensed Midwifery
Florida Department of Health
4052 Bald Cypress Way, Bin #C06
Tallahassee, FL 32399-3256

Dear Melissa:

As Chair of the American Congress of Obstetricians and Gynecologists (ACOG) District XII Florida, I have, as always, continued to follow the actions of the Florida Department of Health's Council of Licensed Midwifery. At our February District Advisory Council Meeting, our members received an update on the status of the Council and the profession of midwifery in general. During this meeting, we were informed of rulemaking activity impacting the profession. ACOG would like to continue being an informed and involved partner because we are interested in the healthcare of all women in our state. We would like to request permission to have representation at the next Council meeting to discuss our experiences throughout the State as they relate to the practice of licensed midwifery.

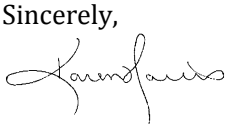
Some of the inquiries I have received, and would appreciate input on prior to our participation in the next Council meeting, include questions regarding the following:

1. What new rules will the Council contemplate that may address adverse incidence reporting?
2. How can ACOG District XII be more involved in discussions relative to the Council?
3. How are adverse outcomes in out of hospital births tracked? Physicians and our CNM colleagues all have such a reporting mechanism, and Boards that review these cases.
4. We would like to understand the how and why of transfer arrangements for patients who need hospital care. We would like to build a collaborative arrangement that is in the best interests of our pregnant patients.

We look forward to any feedback you and your staff can provide as well as an opportunity to speak at the next meeting.

Thank you for your work on behalf of healthy babies in Florida!

Sincerely,



Karen E. Harris, MD, MPH
Chair, ACOG District XII

6816 Southpoint Pkwy, Suite 1000, Jacksonville, FL
Main: (904) 309-6265 Fax: (904) 998-0855
info@acogdistrict12fl.org

64B24-7.004 Risk Assessment.

(1) For each patient, the licensed midwife shall assess risk status criteria for acceptance and continuation of care. The general health status and risk assessment shall be determined by the licensed midwife by obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances along with social and psychological factors. The licensed midwife shall risk screen potential patients using the criteria in this section. If the risk factor score reaches 3 points the midwife shall consult with an appropriate physician ~~who has obstetrical hospital privileges~~ or advanced registered nurse practitioner/certified nurse midwife or specialist in the area of concern and if there is a joint determination that the patient can be expected to have a normal pregnancy, labor and delivery the midwife may provide services to the patient. When a client has a risk score of 3 or higher and has previously had a physician, advanced registered nurse practitioner/certified nurse midwife or an appropriate specialist consultation for the identical risk factors in a prior pregnancy with no current changes in health or risk factors another consultation is not required.

(2) The licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the cumulative risk score reaches three points or higher and the patient is not expected to have a normal pregnancy, labor and delivery, the midwife shall transfer such patient out of his or her care. The midwife may provide collaborative care to the patient pursuant to Rule 64B24-7.010, F.A.C.

(3) The risk factors shall be scored as follows:

	Score
(a) Socio-Demographic Factors.	
1. Chronological age under 16, or older than 40.	1
~~2. Residence of anticipated birth more than 30 minutes from emergency care.~~	~~3~~
(b) Documented Problems in Maternal Medical History.	
1. Cardiovascular System	
a. Chronic hypertension.	3
b. Heart disease ~~Maternal~~	3
c. Heart disease assessed by a cardiologist which places the mother or fetus at no risk.	1
d. Pulmonary embolus.	3
e. Congenital heart defect	3
(i) Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk.	1
2. Urinary System	
a. Renal disease.	3
b. History of pyelonephritis	1
c. Pyelonephritis	3
3. Psycho-Neurological	
a. History of psychotic episode adjudged by psychiatric evaluation and which required use of drugs related to its management, but not currently on medication.	1
b. Current mental health problems requiring drug therapy.	3
c. Epilepsy or seizures in the last two years.	3
d. Required use of anticonvulsant drugs.	3
e. During the current pregnancy, drug or alcohol addiction, use of addicting drugs.	3
f. Severe undiagnosed headache.	3
(4) Endocrine System	
a. Diabetes mellitus.	3
b. History of gestational diabetes.	1
c. Current thyroid disease.	
(i) Euthyroid.	1
(ii) Non-Euthyroid	3
5. Respiratory System	
a. Chronic bronchitis.	1
(i) Current or chronic or with medication.	3
(ii) Without medication or current problems.	1
b. Smoking.	
(i) 10 or less cigarettes per day.	1
(ii) More than 10 cigarettes per day.	3
c. Evidence of active tuberculosis	3

d. asthma

(i) History of Asthma without medication or recent event in the last 3 years 1

(ii) Asthma with medication or a documented asthma attack in current pregnancy 3

6. Other Systems

a. Bleeding disorder or hemolytic disease. 3

b. Cancer of the breast in the past five years. 3

7. Documented Problems in Obstetrical History

a. Expected Date of Delivery (EDD) less than 12 months from date of previous delivery. 1

b. Previous Rh sensitization. 3

c. 5 or more term pregnancies. ~~3~~ 2

d. Previous abortions.

(i) 3 or more consecutive spontaneous abortions. 3

(ii) Two consecutive spontaneous abortions or more than three spontaneous abortions 1

(iii) 1 septic abortion 3

e. Uterus.

(i) Incompetent cervix, with related medical treatment. 3

(ii) Prior uterine surgery 3

(iii) Prior uterine surgery followed by an uncomplicated vaginal birth. 2

f. Previous placenta abruptio. 3

g. Previous placenta previa. 1

h. Severe pregnancy induced hypertension during last pregnancy. 2

(i) Postpartum hemorrhage apparently unrelated to management. 3

(8) Physical Findings of Previous Births

a. Stillbirth occurring at more than 20 weeks gestation or neonatal loss (other than cord accident). 3

b. Birthweight.

(i) Less than 2500 grams or two or more previous premature labors without a subsequent low risk pregnancy and full term appropriate for gestational age (AGA) infant. 3

(ii) Less than 2500 grams or two or more previous premature labors with one or more full term AGA infant(s) subsequently delivered, after a low risk pregnancy. 1

(iii) More than ~~4000~~ 4635 grams. ~~Or~~ 10.0 pounds 1

c. Major congenital malformations, genetic, or metabolic disorder. 3

9. Maternal Physical Findings

a. Gestation

(i) Of more than 22 weeks in the patient's first pregnancy (nullipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3

(ii) Of more than 28 weeks if the patient has had at least one previous viable birth (multipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3

(iii) of more than 42 weeks 0 days 3

b. Prepregnant ~~weight is not within the range of the following weights by height:~~ BMI ~~2~~

(i) equal to or greater than 40 3

(ii) between 35-39 ~~2~~

~~Without Shoes~~	~~Prepregnant Minimum Weight in Pounds~~	~~Prepregnant Maximum Weight in Pounds~~
~~56~~	~~83~~	~~143~~
~~57~~	~~85~~	~~146~~
~~58~~	~~86~~	~~150~~
~~59~~	~~89~~	~~153~~
~~60~~	~~92~~	~~157~~
~~61~~	~~95~~	~~161~~
~~62~~	~~97~~	~~166~~
~~63~~	~~100~~	~~170~~
~~64~~	~~103~~	~~175~~
~~65~~	~~106~~	~~180~~
~~66~~	~~110~~	~~185~~
~~67~~	~~113~~	~~190~~
~~68~~	~~117~~	~~196~~
~~69~~	~~121~~	~~202~~
~~70~~	~~124~~	~~208~~
~~71~~	~~128~~	~~212~~
~~72~~	~~131~~	~~217~~
~~73~~	~~135~~	~~222~~

c. Evidence of clinically diagnosed pathological uterine myoma or malformations, abdominal or adnexal masses.	3
d. Polyhydramnios or oligohydramnios.	
(i) Prior pregnancy.	2
(ii) Current pregnancy.	3
e. Cardiac diastolic murmur, systolic murmur grade III or above, or cardiac enlargement.	3
f. Unexplained vaginal bleeding	3
g. Abnormal weight change defined as less than 12 or more than 50 pounds at term.	2
i. Any other severe obstetrical, medical or surgical problem.	3
j. Thromboembolism in current pregnancy	
10. Current Laboratory Findings	
a. Hematocrit/Hemoglobin.	
(i) Less than 31% or 10.3 gm/100 ml.	1
(ii) Less than 28% or 9.3 gm/100 ml.	3
b. Sickle cell anemia.	3
c. Pap smear suggestive of dysplasia.	3
d. Evidence of active tuberculosis.	3
e. Positive serologic test for syphilis confirmed active.	3
f. HIV positive.	3
g. Laboratory evidence of Rh sensitization.	3
11. Current Fetal Findings	
a. Non reassuring fetal surveillance	3
b. Intrauterine Growth Restriction (IUGR)	3
(c) Genetic or congenital abnormalities or fetal chromosomal disorder	3

(4) The following risk factors are shall be an exclusion and are not eligible for Licensed Midwife delivery at home. Midwife may provide care with a collaborative management plan for prenatal care only or planned hospital delivery.

a. Residence of anticipated birth more than 30 minutes from emergency care.
b. Non-cephalic presentation at term
c. Twins or multiple fetuses
d. Severe congenital abnormalities or chromosomal disorder in the fetus, which places neonate at risk at birth
e. Pre-eclampsia in current pregnancy
f. Placenta previa persistent after 36 weeks
e. Diabetes requiring insulin management or uncontrolled diabetes
f. Gestational Age > 42.6 weeks
g. Gestational Age < 37.0 weeks

Rulemaking Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.004, 59DD-7.004,
Amended 9-11-02, 2-2-06, 4-1-09.

64B24-7.007 Responsibilities of Midwives During the Antepartum Period.

1. (1) The licensed midwife shall require every patient to have the following minimum antepartum care. However, unless otherwise noted as required, after thorough counseling, discussion and informed consent the mother refuses one or more components of care, and the midwife determines that care may safely proceed, the midwife may continue providing care, appropriately documenting any refusal in the health record.

(a) Require each patient to have a complete history and physical examination when care is started, unless documented from previous care which includes:

1. Pap smear, pelvic exam and breast exam if appropriate.
2. Serological screen for syphilis.
3. Gonorrhea and chlamydia screening.
4. Blood group including Rh factor and antibody screen.
5. Complete blood count (CBC).
6. Rubella titer.
7. Urinalysis with culture.
8. Sickle cell screening for at risk population.
9. Screen for hepatitis B surface antigen (HBsAG).
10. Screen for HIV/AIDS.
11. BMI

(b) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.
(c) Provide counseling and offer screening related to the following when appropriate:

1. Neural tube defects.
2. Group B Streptococcus.
3. ~~CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.~~ Early Aneuploidy and Neural tube Defect Screening

4. Nutritional counseling.
5.Childbirth preparation.
6.Risk Factors.
7..Common discomforts of pregnancy.
8..Danger signs of pregnancy.

(d) Follow-up screening:

1. Hematocrit or hemoglobin levels at 28 and 36 weeks gestation.
2. Diabetic screening between 24 and 28 weeks gestation.
3. Antibody screen for Rh negative mothers, at 28 weeks gestation. Counsel and encourage RhoGAM prophylaxis. In those clients declining RhoGAM prophylaxis repeat antibody screen at 36 weeks.
4. Ultrasound after 20 weeks to assess fetal anatomy, well being and placental location, as appropriate
5. Fetal Bio Physical Profile after 41 weeks gestation

(e) Require prenatal visits every four to 6 weeks, as appropriate until 28 weeks gestation, every two weeks to three from 28 to 36 weeks gestation and weekly from 36 weeks until delivery.

(2) The following procedures and examinations shall be completed and recorded at each prenatal visit:
(a) Weight.
(b) Blood pressure.
(c) Urine dip stick for protein and glucose each visit with leukocytes, ketones, and nitrites as indicated.
(d) Fundal height measurements.
(e) Fetal heart tones and rate.
(f) Assessment of edema and patellar reflexes, when indicated.
(g) Indication of weeks' gestation and size correlation.
(h) Determination of fetal presentation after 28 weeks of gestation.

(i) Nutritional assessment.
(j) Assessment of subjective symptoms of PIH, UTI and preterm labor.
(3) An assessment of the Expected Date of Delivery (EDD) and gestational age shall be done by 20 weeks, if practical, according to:
(a) Last normal menstrual period.
(b) Reference to the statement of uterine size recorded during the initial exam.
(c) Hearing fetal heart tones at eleven weeks with a Doppler unit, if one is available, and patient gives consent.
(d) Recording of quickening date.
(e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.
(f) Hearing the fetal heart tones at twenty weeks with a fetoscope.
(4) If a reliable EDD cannot be established by the above criteria, then the licensed midwife shall encourage the patient to have an ultrasound for EDD.
~~(5) The midwife shall refer a patient for consultation to a physician with hospital obstetrical privileges if any of the following conditions occur during the pregnancy:~~
~~(a) Hematocrit of less than 30% at 37th week gestation or hemoglobin less than 11gms/100 ml.~~
~~(b) Unexplained vaginal bleeding.~~
~~(c) Abnormal weight change defined as less than 12 or more than 50 pounds at term.~~
~~(d) Non-vertex presentation persisting past 37th week of gestation.~~
~~(e) Gestational age between 41 and 42 weeks.~~
~~(f) Genital herpes confirmed clinically or by culture at term.~~
~~(g) Documented asthma attack.~~
~~(h) Hyperemesis not responsive to supportive care.~~
~~(i) Any other severe obstetrical, medical or surgical problem.~~
~~(6) The midwife shall transfer a patient if any of the following conditions occur during the pregnancy:~~
~~(a) Genetic or congenital abnormalities or fetal chromosomal disorder, which places neonate as risk after birth~~
~~(b) Multiple gestation.~~
~~(c) Pre-eclampsia.~~
~~(d) Intrauterine growth retardation. restriction~~
~~(e) Thrombophlebitis.~~
~~(f) Pyelonephritis.~~
~~(g) Gestational diabetes confirmed by abnormal glucose tolerance test.~~
~~(h) Laboratory evidence of Rh sensitization.~~
~~(7) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and midwife deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall continue with the licensed midwife.~~

Specific Authority 456.004(5), 467.005 FS. Law Implemented 467.015 FS. History–New 7-14-94, Formerly 61E8-7.007, 59DD-7.007, Amended 9-11-02, 7-21-03, 9-18-06.

Rationale for Change:

1. Reduce Redundant language of the rule. Section FIVE (5) is covered under **64B24-7.004 Risk Assessment** and does not need to be repeated in the antepartum section.

2. 7.007 (1) Updated language to assess quality of care, while maintaining patients right to choose or refuse medical care after informed consent.

3. 7.007 (1)a – adding the specification that these items should be done at the start of care, so there is no ambiguity of when these items should occur.

4. 7.007(1)(A)1 – Adding pelvic and breast exams where appropriate. Guidelines for women's health change on a regular basis, as standards are updated. Pap smear should not be required, unless appropriate.

5. 7.007(1)A-11 – Adding BMI to the required history and Physical Exam. BMI is a better way to assess obesity than height to weight ratio, this better aligns the language with current standards.

6. 7.007(1)C – 3 – is an update to the current language and screening standards.

7. 7.007(1)D – 4. Ultrasound screening after 20 weeks is standard for care to rule out problems with the fetus and placenta – which may make an out of hospital birth risky for mother or baby. Its prudent to screen all mothers, who have given informed consent for fetal abnormality and placental location. Thi sis will also rule out the possibility of surprise multiples at term.

8.7.007(1)D - 5 – Fetal Surveillance after 41 weeks, to check on fetal wellbeing in a post date pregnancy. When a baby is doing well, a pregnancy should be allowed to continue until natural labor starts.

9. 7.007 (1)E – adding flexibility to number of weeks between appointments allows for scheduling and patient preference. A visit every 4 weeks may not be needed in early pregnancy, or due to scheduling may need to occur in week 5 or more. The language should allow for the flexibility and acknowledge the need for patients to choose to be seen on alternative schedules.

64B24-7.008 Responsibilities of Midwives During Intrapartum.

(1) Upon initial assessment, the midwife shall:

(a) Determine onset of labor.

(b) Review patient's prenatal records.

(c) Assess condition of the mother and fetus.

(d) Assess delivery environment.

(e) Perform sterile vaginal examinations to initially assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

(2) Throughout active labor the midwife shall:

(a) Maintain a safe and hygienic environment.

(b) Provide nourishment, rest and support as indicated by patient's condition.

(c) Monitor, assess and record the status of labor and the maternal and fetal condition.

(d) Measure the blood pressure 2 hours unless significant changes or symptoms require more frequent assessments.

(e) Take the patient's pulse every 2 hours while membranes are intact and temperature is normal, then every hour after rupture of membranes.

(f) Take the temperature every 2 hours, or more frequently if maternal condition warrants, and every hour if elevated to 100º F or above.

(g) Estimate fluid intake and urinary output at least every 2 hours.

(h) Assess for hydration and edema at least every 2 hours

(3) The midwife shall assess and record the status of labor as follows:

(a) Measure the frequency, duration and intensity of the contractions every ~~half hour and~~ 2 hours, more frequently if indicated or when a change is noted.

(b) Observe and record vaginal discharge as indicated or if change occurs.

(c) Monitor fetal heart tones during and following contractions to assess fetal condition according to the following schedule after admission to care for labor:

1. Every hour during the latent phase.
2. Every 30 minutes during the active phase of the first stage.
3. Every 15 minutes during transition.
4. Every five minutes during the second stage.
5. Immediately after the appearance of amniotic fluid in the vaginal discharge.

(d) ~~Palpate the abdomen for the position and level of the presenting part.~~ Perform sterile vaginal examinations as needed throughout labor, and with the start of second stage to assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes as appropriate and if patient consents to additional exams.

(4) Risk factors shall be assessed throughout labor to determine the need for physician consultation or emergency transport. The midwife shall ~~consult, refer or~~ transfer to a physician ~~with hospital obstetrical privileges~~ if the following occur during labor, delivery or immediately thereafter:

(a) If one of the following Risk factors occurs in the intrapartum– the midwife shall consult with a physician:

(1) Premature rupture of membranes, meaning rupture occurring more than ~~12~~ 18 hours before onset of ~~active labor.~~ regular contractions.

(2) Failure to progress in active labor:

a. 1. First stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara.

b. 2. Second stage: more than 2 hours without progress in descent.

c. 3. Third stage: more than 1 hour.

(b) If any one of the risk factors occurs in the intrapartum – the midwife shall transfer the patient to a hospital, unless delivery is imminent, in which case the midwife shall activate the EMS system and prepare for emergency delivery:

(1) Non-vertex presentation.

(2) Evidence of fetal distress

(3) Abnormal heart tones.
(4) Moderate or severe meconium staining.
(5) Pregnancy induced hypertension which is defined as 140/90, or an increase of 30 mm hg systolic or 15 mm hg diastolic above baseline.
(6) Marked edema of cervix.
(7) Active bleeding.
(8) Prolapse of the cord.
(9) Active infectious process.
(10) Other major medical or surgical problems.

(5) The midwife shall not perform any operative procedure other than:
(a) Artificial rupture of the membranes when the fetal head is engaged and well applied to the cervix in active labor and four or more centimeters dilated.
(b) Clamping and cutting the umbilical cord.
(c) Episiotomy when indicated.
(d) Suture to repair first and second degree lacerations.
(6) The midwife shall not attempt to correct fetal presentations by external or internal version.
(7) The midwife shall use only prescription drugs pursuant to Rule 64B24-7.011, F.A.C.
(8) The midwife shall not use artificial, forcible or mechanical means to assist the birth.