



# FLORIDA | Council of Licensed Midwifery

## Agenda Outline

December 10, 2015

9:00 am

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

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

**Call to Order:** Melissa Conord-Morrow, LM, Chair Roll  
**Call:** Claudia Kemp, Executive Director

### **Review of Minutes from Previous Meeting:**

1. October 14, 2015, General Business Meeting Minutes

### **General Business:**

2. Council of Midwifery Annual Report Information

### **Rule Discussion (draft language will be provided separately):**

3. 64B24-7 Midwifery Practice

### **Reports:**

4. Annual Report Draft
5. Executive Director's Report
6. Application Liaison –
7. Budget – Kathy Bradley
8. Community and Consumer Relations - Kathy Bradley
9. Data Collection –
10. International Relations –
11. Laws & Rules and Other Agency Action – Susan (Robyn) Mattox
12. Unlicensed Activity – Susan (Robyn) Mattox, L.M.
13. Healthy Weight Initiative – Melissa Conord-Morrow
14. Counsel Report – Linda McMullen, Esq.

### **Old Business**

### **New Business**

### **Adjourn**

**FLORIDA** | Council of Licensed Midwifery

DRAFT  
October 14, 2015

Omni Orlando Resort at Championsgate  
1500 Masters Boulevard  
Championsgate, Florida



Melissa Conord-Morrow, LM  
**Chair**

Susan "Robyn" Mattox, LM  
**Vice Chair**

Claudia J. Kemp, JD  
**Executive Director**

1 **Section I:** The meeting was called to order by Ms. Conord-Morrow, Chair, at approximately 9:07 a.m. Those present for all or part of  
2 the meeting included the following:  
3

4 **General Business started: 9:07 a.m.**

5  
6 **MEMBERS PRESENT**

7 Melissa Conord-Morrow, LM, Chair  
8 Susan Robyn Mattox, LM, Vice Chair  
9 Charlie Young, LM  
10 Tania Mondesir, RN, LM  
11 Dana Barnes, MD  
12 David S. Stewart, MD  
13 Kathy Bradley, Consumer Member

6 **STAFF PRESENT:**

Claudia J. Kemp, Executive Director  
Adrienne C. Rodgers, Bureau Chief, Health Care Practitioner Regulation

14  
15 **MEMBERS EXCUSED**

16 Robert Pearson-Martinez, MD  
17 Stephanie Wombles, CNM

18 Dr. Stewart moved that the absences be unexcused since this is the second absence for each. Ms. Maddox seconded.  
19 Vote: unanimous.

20  
21 **COUNSEL**

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

24  
25 **COURT REPORTER**

26 American Court Reporting  
27 Suzette Bragg  
28 407-896-1813

29  
30 *Please note the minutes reflect the actual order agenda items were discussed and may differ from the agenda outline. Minutes from  
31 this meeting can be found online: <http://www.floridahealth.gov/licensing-and-regulation/midwifery/meetings/index.html>*

32  
33 **General Business started: 9:07 a.m.**

34  
35 **1. APPROVAL OF MINUTES**

36 July 13, 2015 – Full Council Meeting

37  
38 Minutes of the July 13, 2015 General Business Meeting were reviewed.  
39 Dr. Barnes made the motion to accept the minutes seconded by Ms. Bradley.  
40 Vote: unanimous

41  
42 **Approval of Minutes ended: 9:12 a.m.**

43 **Rule Discussion started: 9:12 a.m.**

44  
45  
46 **Part 2 through 22: RULE DISCUSSION**

47  
48 2. Rule 64B24-7, F.A.C., Midwifery Practice

49 The council reviewed comments received from: council member Dr. Dana Barnes, MD – Council Member Family Practice Physician  
50 and Midwives Association of Florida; HealthNet Prenatal/Perinatal Health Guidelines; and reviewed the Paper from Midwives  
51 Association of Washington State (MAWS): Indications for Discussion, Consultation and Transfer of Care.

52  
53 **Discussion:**

54 Ms. Mattox handed out a suggested checklist and new format for risk assessment, rule 64B24-7.004, F.A.C., which incorporated the  
55 comments of Dr. Barnes with regard to antepartum care. This handout grouped risk screening by risk factors instead of the current  
56 grouping of systems and history.

57 Ms. Young felt Dr. Barnes' comments were on point, especially in regard to informed refusal and informed consent in rule 7.005,  
58 F.A.C.

1 Dr. Barnes informed the council that her suggestion for “medical consultation for “non-vertex” presentation” should read “medical  
2 consultation for “non-cephalic” presentation.”

3 Discussion commenced regarding Ms. Mattox’s hand out.

4  
5 Ms. Conord-Morrow commented that the existing list in the rule would have to be deleted and the “checklist” format incorporated.  
6 The council agreed to have a single form for the practice.

7 The council discussed the issue of low BMI in pregnancy and recommended adding a consult for BMI less than 18.5 for initial visit  
8 risk assessment.

9 Dr. Stewart commented that excessive weight gain should be a part of 28 week visit evaluation.

10 Ms. Mattox explained that her “checklist” was intended for ongoing risk assessment not specific to a particular visit or period in the  
11 pregnancy.

12  
13 In discussing Risk 2 factors, she stated the current standard is 12 lb up to 50 lb, with high BMI counseled to gain no more than 10 lb.  
14 The council discussed having a second column for the notation of responsibilities, rule 7.007, versus only having risk factors, rule  
15 64B24-7.004, F.A.C., on the checklist and having a number assigned for each factor in the second column. The council discussed  
16 whether the intrapartum and postpartum rules should be included.

17  
18 The question was raised as to whether a separate, inclusive checklist was necessary for intrapartum and postpartum issues. Ms. Mattox  
19 responded that her “checklist” included exclusionary factors for all stages from acceptance and continuation of care through delivery.  
20 The recommendation was amended to add postpartum underneath the exclusionary factors.

21  
22 The current rule 64B24-7.008, F.A.C., for intrapartum care does not have risk factor assigned or list all risks for exclusion. The  
23 question was discussed of what the midwife is supposed to do. Risk factors to be moved into its own section. Responsibilities, section  
24 5, still lists what must be assessed. Should be absolutes, not just consults.

25  
26 Dr. Stewart asked whether thick meconium required transfer while the patient is in labor as he opined most hospitals cannot accept a  
27 transfer patient in labor. He suggested adding that an obstetrical hospital be required for the transfer. Ms. Young said this is on the  
28 emergency care plan. Dr. Stewart requested this new recommendation needs to also have clarification.

29  
30 Ms. Mattox wants to change section 4, combine? Or part of its own?

31  
32 In discussing exclusions, Dr. Barnes said a consult must be required for severe congenital anomaly or chromosomal disorder of the  
33 fetus but may become a 3 depending on the result of the consultation. Dr. Stewart expressed concern about misdiagnosed in utero  
34 regarding viable birth. Ms. Young asked to add for maternal choice on genetic counseling.

35  
36 Ms. Conord-Morrow doesn’t agree with exclusion of the non-cephalic presentation after 36 weeks and suggested it be changed to 37  
37 weeks. She also suggested that non-cephalic presentation after 36 weeks be moved up to a risk factor of 3 and retain the language  
38 about resolution which allows the midwife to continue care.

39  
40 The council found that the risk 3 factors box includes “3 or more consecutive spontaneous abortions listed twice.

41 Dr. Barnes expressed concern about risk 3 factor of an A1c (HbA1c) less than 7. Ms. Mattox said the factor was based on control for  
42 the pre-pregnancy diagnosed diabetic and offered more language about what is well controlled. Dr. Barnes asked to strike A1c as a  
43 predictor of good control using only good glycemic control as more appropriate. Dr. Barnes opined that anyone with a history of  
44 diabetes should receive a consultation. Dr. Stewart asked why choose an A1c of 7 when fetal affects are seen at 6.5 and suggested an  
45 ultrasound would be needed at that point: for example, 28 week glucose and consult and the consult says everything is OK. Dr.  
46 Stewart said he maintains his patients below 6 as he believes any diabetic above 6 is not usually in good control. However, defining  
47 good control is difficult because of patient compliance. Ms. Conord-Morrow said that with a diabetic patient, the midwife must  
48 consult. Dr. Barnes and Dr. Stewart agreed. Ms. Young said remove everything except diabetes. If consult gives ok then the patient  
49 may continue with the midwife.

50  
51 Ms. Modesir asked if the diabetic is already on medication, should diabetes be an exclusionary factor, as opposed to a risk 3 factor,  
52 since patients don’t change their diet and exercise because they are pregnant. Ms. Modesir opined pregnancy would result in less  
53 control and added risk.

54  
55 Dr. Stewart said diabetics are at a high risk for kidney, and other problems, so should they be allowed to return to the midwife or fall  
56 under collaborative management – a 4<sup>th</sup> criteria. Ms. Young said if physician agrees the patient may come back to midwife,  
57 collaborative management is included in standard practice; however, recommendations under the current rule are not binding. Any

1 risk 3 factor should be under a collaborative management plan. The council discussed whether there needed to be an exclusionary  
2 standard.  
3

4 The council discussed that the risk acceptance for care appropriate to be delivered outside of the hospital (extramural) won't be added  
5 by most referral or consulting doctors. The midwives on the council asked if collaboration can be with a specialist and not just an  
6 obstetrician. Dr. Stewart opined that an obstetrician is necessary but the midwife may also bring in a specialist particular to the  
7 pathology involved. Dr. Stewart opined that the phrase "normal labor" leaves a wide gap since the expectation is that every patient  
8 will have a normal labor.

9 Strike "normal pregnancy" and substitute "not at an increased risk for labor complications" and then it wouldn't require the physician  
10 to say it's OK. Ms. Mattox not in favor of any change in the language. If made binding, then most patients would not have an  
11 extramural birth (see ACOG position statement).  
12

13 Dr. Stewart recommended having a council/department liaison speak with the American Congress of Obstetricians and Gynecologists  
14 (ACOG) on the changes being made to the practice of midwifery. If midwives are moving toward what ACOG wants, then ACOG  
15 should move forward in its position. The council requested staff to determine if a meeting between a council member, an ACOG  
16 representative and a department representative could be set up to accomplish this. Dr. Stewart opined that ACOG may have  
17 suggestions for the consultation form/care plan. Dr. Karen Harris is the president and she is aware of the council's interest in setting  
18 up a meeting.  
19

20 Ms. Mondesir asked for automatic consultation with report and specific recommendations as part of the rule.  
21

22 **10:42 Council break**

23 **10:58 Council returned**  
24

25 Discussion ensued as to whether intrapartum, postpartum and newborn care recommendations should be added to a December  
26 teleconference or whether the council should stay later today and complete the recommendations.

27 Council questioned how information regarding new rules or other matters of interest to the profession is disseminated. Ms. Rodgers  
28 informed the council about notification by active campaign or US postal service.  
29

30 Dr. Barnes returned the discussion to the risk 3 factor for hypertension and recommended that it be labeled "hypertension" not  
31 "primary" hypertension. The council concurred. Dr. Barnes also recommended that "Pulmonary Disease or ongoing pulmonary  
32 problems requiring medication or medical management such as asthma or reoccurring bronchitis" be changed to "chronic lung or  
33 pulmonary disease" and delete the remainder of the item.  
34

35 In addressing risk 1 factors, Dr. Barnes recommended taking "Stable on thyroid replacement therapy" and add this factor to risk 3  
36 factor, renaming it "thyroid disease." This change was agreed to by Dr. Stewart, Ms. Conord-Morrow and Ms. Mattox.  
37

38 Ms. Conord-Morrow led a brief discussion of what constitutes a bleeding disorder in current rule language.  
39

40 Dr. Barnes asked if risk 3 factor "Positive serological test for Syphilis confirmed active" meant both latent and active disease, to  
41 which Ms. Mattox replied that she intended it to mean just a positive test for syphilis because the midwife is not competent to  
42 determine resolution of the disease unless there is independent confirmation available.  
43

44 Under risk 3 factor, Dr. Barnes asked to have "incompetent cervix with related medical treatment" modified to "incompetent cervix,"  
45 add history of thromboembolic disease to risk 3 factor, and make thromboembolism in the current pregnancy exclusionary.  
46

47 Dr. Stewart stated that herpes simplex virus active at term should be referred to a physician. Consult should be offered at 36 weeks for  
48 suppressive therapy.  
49

50 Ms. Young asked about redefining the appropriate gestational age for exclusion for LMW delivery in an out of hospital setting. The  
51 current standard is 41 weeks and 46 weeks with a consult required at 42 weeks. The council determined that the only change needed  
52 would be to offer a consult at 41 weeks, leaving out the 46 week requirement, and add in completion of a fetal assessment within the  
53 41st week in the responsibilities rule.  
54

55 Dr. Stewart offered that documented shoulder dystocia at delivery has a significant risk of recurrence (24%) and long term injury.  
56 Dystocia is defined as 60 seconds from delivery of the head to the delivery of the shoulder, and delivery requires any maneuver  
57 requiring assisted delivery. He asked if this should be moved to a risk 2 factor. Discussion ensued.  
58

1  
2 Dr. Stewart began discussion of findings for not eligible for licensed midwifery delivery in an out of hospital setting based on  
3 Intrauterine Growth Restriction (IUGR) and ongoing risk assessments related to unexplained size and date discrepancy of longer than  
4 3 weeks. He recommended that the decision be based on fundal height on more than one visit. Discussion ensued regarding whether  
5 these results should prompt a consult or an MRI. The council recommended that an assessment was sufficient unless the fundal height  
6 was greater than 10% and then a consult should be made.  
7

8 Consumer left meeting at 12:12 pm and returned at 12:18 pm  
9

10 Dr. Barnes summarized the discussion that IUGR is an exclusion, and the midwife's responsibilities are: fundal height discrepancy  
11 greater than 3 weeks is a reason to refer for ultrasound. When weight is below the 10th percentile, this would be a prompt for a consult  
12 with an obstetrician. Dr. Stewart added that growth greater than 90 percentile must prompt a consult.  
13

14 Dr. Stewart addressed risk 3 factor for stillbirth occurring more than 24 weeks gestation and suggested adding pregnancy loss greater  
15 than 16 weeks without previous evaluation should be a consult.  
16

17 The council discussed the increased risk of methylenetetrahydrofolate reductase (MTHFR), a rare genetic defect that can lead to  
18 complications in pregnancy, lupus and coagulopathies. Dr. Barnes suggested additional collaborative care.  
19

20 Dr. Barnes suggested risk 2 factor for pre-eclampsia as history of hypertension.  
21

22 Dr. Stewart initiated discussion on adding a risk factor for ages less than 16 or over 40. The council found no research to support the  
23 older age risk. Dr. Barnes supported including the older age risk due to physical problems related to delivery such as uterine rupture,  
24 etc. Dr. Stewart will look at fetal loss, etc. after a certain age and identify the risk factors.  
25

26 **Break for lunch 12:43 pm**  
27 **Return 1:34 pm**  
28

29 Dr. Stewart stated that the society for maternal medicine published a study showing that pregnancies over the age of 40 have no  
30 standard for management but is included as a risk factor. Advanced maternal age came under discussion. The council determined that  
31 this should be a risk 1 factor and there is no need to do anything different than that already captured in rule.  
32

33 Dr. Barnes suggested for heart disease or cardiac anomaly assessed by a cardiologist, which places the mother or fetus at low risk in  
34 risk 1 factor, change "cardiologist" to "physician" since these are low risk patients. She continued in risk 1 factors and commented  
35 that for history of psychotic episode and judged by psychiatric evaluation and which required use of drugs related to its management,  
36 but not currently on medication, the language is not clear. Ms. Mattox stated the language was meant to pick up mental health issues  
37 that could result in relapse during pregnancy. Dr. Barnes suggested changing the language to read "History or current mental health  
38 disorder (illness) as diagnosed under DMS criteria without medication." She added that "with medication" would require a consult.  
39

40 Dr. Barnes suggested that a history of thyroid disease or asthma not requiring medication could be in risk 1 factor.  
41

42 Dr. Stewart stated that risk 3 factor for sickle cell anemia the word "anemia" should be struck and the word "trait" should be inserted  
43 because all hemoglobinopathies should prompt the offer of genetic screening for the father as well.  
44

45 Rule 64B24-7.001, F.A.C., "Consult" definition should add: formal written communication between midwife and physician licensed  
46 under chapter 458 or 459, F.S., documented in the patient record.

47 Collaborative management means the midwife works in conjunction with the physician

48 Referral – a written communication for a face-to-face appointment for the patient with a physician licensed under chapter 458 or 459,  
49 F.S., if anything of itself is a risk factor 3, but not a three in the aggregate  
50

51 The council agreed to expand the definitions to define the acronym found on the risk factor chart if the full name cannot be made a  
52 part of the checklist.  
53

54 Rule 64B24-7.008, F.A.C., discussion:

55 7.008(1) – no change

56 7.008(2) – no change

57 7.008(3) – pulse and temp taken every two hours

58 – two hours for edema



1 – Fetal heart tones the earlier of every 5 minutes and adjust for contractions (of after every other contraction)

2 [ACOG defines active labor at 6 cm]

3 Rule 64B24-7.008(4), F.S., strike the midwife shall have a “physician consultation or” initiation of transfer process to physician or  
4 hospital should begin immediately upon the diagnosis of (a) thru (o) but if delivery is imminent, then care should be given in the best  
5 interest of the patient and fetus.

6  
7 Dr. Stewart will work on the question of whether the timeframe for a death related to maternal complications captures one year after  
8 the conclusion of the pregnancy.

9  
10 Prolonged rupture is 18 hours of labor; “premature rupture” is defined as occurring before labor ensues. The question was raised  
11 regarding how long can beta strep go without being treated before it becomes harmful to the mom and baby.

12  
13 Strike rule 64B24-7.008(4)(a) and (g), F.A.C.

14  
15 No other changes.

16  
17 Dr. Stewart addressed rule 64B24-7.008(5)(a), F.A.C., for active labor delete “and four centimeters or more centimeters dilated.”  
18 For rule 64B24-7.008(8), F.A.C., the question was addressed whether this included labor and delivery or delivery only.

19  
20 **Break 3:45**

21 **Resumed 4:02**

22  
23 Artificial ruptured membranes discussion resumed.

24 Ms. Conord-Morrow stated that because so much is dependent on active labor, the rules must define this. The final recommendation  
25 was to leave the rule as it currently exists. The council recommended that the midwife shall not use artificial or mechanical means “to  
26 induce labor or assist with birth.” A Foley bulb is still mechanical and has potential for injury. Breast pump is also a mechanical  
27 means of inducing labor but the midwife is not doing the induction, the mom is and that knowledge can be obtained from the internet.

28  
29 For Informational Purposes only: The Notice of Rule Development was published on all rules except for the practice rule. The next  
30 step is to publish a Notice of Proposed Rule, which can result in a letter from JAPC. Upon resolution, the rule would be filed for  
31 adoption with Secretary of State and it would become effective 20 days after that filing. Rule adoption is probably 4 to 6 weeks away.

- 32  
33 3. 64B24-1.004 Terms, Meetings, Quorum, and Absences  
34 4. 64B24-2.001 Licensure to Practice Midwifery  
35 5. 64B24-2.0011 Forms  
36 6. 64B24-2.002 Examination  
37 7. 64B24-2.003 Licensure by Examination  
38 8. 64B24-2.004 Licensure by Endorsement  
39 9. 64B24-3.002 Application Fees  
40 10. 64B24-3.003 Examination Fee  
41 11. 64B24-3.004 Endorsement Fee  
42 12. 64B24-3.005 Initial License Fee  
43 13. 64B24-3.006 Temporary Certificate Fee  
44 14. 64B24-3.007 Active Biennial Renewal Fee  
45 15. 64B24-3.008 Delinquent Fee  
46 16. 64B24-3.009 Reactivation Fee  
47 17. 64B24-3.011 Duplicate License Fee  
48 18. 64B24-3.013 Continuing Education Provider Application Fee  
49 19. 64B24-3.014 Unlicensed Activity Fee  
50 20. 64B24-3.015 Change of Status Fee  
51 21. 64B24-3.016 Inactive Renewal Fee  
52 22. 64B24-3.017 Retired Status Fee  
53

54 The council discussed the clinical experience part of Rule 64B24-4, F.A.C., to make a recommendation on the number of vaginal  
55 sutures that a student should perform 5 documented sutured repairs.

56  
57 The council recommended that an out of state student cannot gain clinical experience with a Florida preceptor. Discussion ensued as  
58 to whether this was unlicensed practice and whether the preceptor should also be disciplined.

1  
2 The council members agreed that there is no definition of “classroom hours” but the classroom hours must be taken in a “brick and  
3 mortar” school.  
4

5 **Rules discussion ended: 4:17 p.m.**

6 **Annual Report started: 4:17 p.m.**

7  
8 **23. 2015 ANNUAL REPORT OF MIDWIFERY PRACTICE FORM (final draft)**

9  
10 **Discussion:**

11 Dr. Barnes – annual report form

12 The council determined that a question regarding the obstetric or maternity hospital should be included.

13 The question arose as to whether initiation of breast feeding should be on the annual report form and whether it should ask  
14 about continuation at 6 weeks, which is the discharge date for patients. The council determined that it should be optional on  
15 breastfeeding information.

16 Timeframe for maternal death – 7 days (ACOG has a committee on maternal deaths and Dr. Stewart will check that date)  
17 Ms. Mondesir stated that birthcenters have a mandated form of their own for reporting purposes. She also requested that questions on  
18 page 3 a and b be on separate pages because birthing centers have more transfers. The council stated the form already provides that  
19 additional sheets may be used to answer the questions.  
20

21 **Annual Report ended: 4:38 p.m.**

22 **Old Business started: 4:38 p.m.**

23  
24 **24. OLD BUSINESS**

25 Unlicensed activity - Ms. Mattox

26  
27  
28 **Discussion from last meeting:**

29 Whether it is appropriate for students to be taken out of country for clinical experience.

30  
31 **Discussion:**

32 Clear that it must be in the State of Florida for purpose of licensing.

33  
34 **Discussion from last meeting:**

35  
36 Students precepting with licensed midwives and not an approved program. There is no definition of “student” in statute or  
37 rule to say the student must be in an approved program. Statute provides definition of student. Rule provides definition of  
38 preceptor. These individuals appear to be engaging in unlicensed practice.  
39

40 **Discussion:**

41 Defined in statute, no need for rule. Staff will do active campaign for midwives and other impacted professions.  
42

43 **Old Business ended: 5:00 p.m.**

44 **New Business started: 5:00 p.m.**

45  
46 **25. NEW BUSINESS: None**

47  
48 **NEXT MEETING DATE** – Board staff to send out December meeting dates for consideration.

49 Next in-person meeting is February 8, 2016. Board staff to send out possible locations for consideration.  
50

51 **ADJOURNMENT**

52  
53 **General Business concluded at: 5:02 p.m.**

54 **The Council adjourned at 5:02 p.m.**  
55



**2015 COUNCIL OF LICENSED MIDWIFERY ANNUAL REPORT**

<b>Council Members</b>	<b>Meeting Dates &amp; Attendance</b>			
	<b>4/11/2015</b>	<b>04/27/2015 (Rules Workshop)</b>	<b>July 13, 2015</b>	<b>October 14, 2015</b>
<b>Melissa Concord-Morrow</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>Dana Barnes</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>Kathy Bradley</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>Robyn Mattox</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>Tania Mondesir</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>David Stewart</b>	<b>Present</b>	<b>Absent</b>	<b>Present</b>	<b>Present</b>
<b>Charlie Young</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>	<b>Present</b>
<b>Stephanie Wombles</b>	<b>Present</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>
<b>Robert Pearson-Martinez</b>	<b>Present</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>



## COUNCIL OF LICENSED MIDWIFERY RULES REPORT –2015

The newly reconstituted Council shouldered a tremendous project and began reviewing all existing midwifery rules and forms in order to clarify, reduce and update the rules governing the practice of midwifery.

Rule Number	The Council reviewed and advised the department on the following rules on April 27, 2015. Rule Title	The notices of rule development on these rules were published:	Notice Published	Adopted	Effective
64B24-1.004	Terms, Meetings, Quorum, and Absences	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-2.001	Licensure to Practice Midwifery	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-2.0011	Forms	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-2.002	Examination	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-2.003	Licensure by Examination	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-2.004	Licensure by Endorsement	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.002	Application Fees	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.003	Examination Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.004	Endorsement Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			

## COUNCIL OF LICENSED MIDWIFERY RULES REPORT –2015

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Rule Number	The Council reviewed and advised the department on the following rules on April 27, 2015. Rule Title	The notices of rule development on these rules were published:	Notice Published	Adopted	Effective
64B24-3.005	Initial License Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.006	Temporary Certificate Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.007	Active Biennial Renewal Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.008	Delinquent Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.009	Reactivation Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.01	Duplicate License Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.013	Continuing Education Provider Application Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.014	Unlicensed Activity Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			

## COUNCIL OF LICENSED MIDWIFERY RULES REPORT –2015

The newly reconstituted Council shouldered a tremendous project and began reviewing all existing midwifery rules and forms in order to clarify, reduce and update the rules governing the practice of midwifery.

Rule Number	The Council reviewed and advised the department on the following rules on April 27, 2015. Rule Title	The notices of rule development on these rules were published:	Notice Published	Adopted	Effective
64B24-3.015	Change of Status Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.016	Inactive Renewal Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-3.017	Retired Status Fee	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-4	Training Programs	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-5.003	Renewal, Inactive Status, Reactivation	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-5.004	Retired Status License	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-6.001	Continuing Education for Biennial Renewal	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-8.002	Disciplinary Action and Guidelines	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			
64B24-8.003	Citations	<a href="#">8/12/2015</a> <a href="#">Vol. 41/156</a>			

**COUNCIL OF LICENSED MIDWIFERY  
RULES REPORT –2015**

**The newly reconstituted Council shouldered a tremendous project and began reviewing all existing midwifery rules and forms in order to clarify, reduce and update the rules governing the practice of midwifery.**



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<b>Rule Number</b>	The Council reviewed and advised the department on the following rule on October 14, 2015 <b>Rule Title</b>	The notices of rule development on these rules were published:	<b>Notice Published</b>	<b>Adopted</b>	<b>Effective</b>
64B24-7	Rule 64B24-7, F.A.C., Midwifery Practice				



## CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The *Core Competencies for Basic Midwifery Practice* include the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited by the Accreditation Commission for Midwifery Education (ACME), formerly the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA).

Midwifery practice is based on the *Core Competencies for Basic Midwifery Practice*, the *Standards for the Practice of Midwifery*, the *Philosophy of the ACNM*, and the *Code of Ethics* promulgated by the ACNM. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers for women and newborns.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the *Standards for the Practice of Midwifery*.

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and the ACNM *Standards for the Practice of Midwifery*.

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report, *Primary Care: America's Health Care in a New Era*,<sup>1</sup> the *Philosophy of the ACNM*,<sup>2</sup> and the ACNM position statement, "Midwives are Primary Care Providers and Leaders of Maternity Care Homes."<sup>3</sup> Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of and referral to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents. The concepts, skills, and midwifery management processes identified

below form the foundation upon which practice guidelines and educational curricula are built. The core competencies are reviewed and revised regularly to incorporate changing trends in midwifery practice. This document must be adhered to in its entirety and applies to all settings for midwifery care, including hospitals, ambulatory care settings, birth centers, and homes.

## **I. Hallmarks of Midwifery**

The art and science of midwifery are characterized by the following hallmarks:

- A. Recognition of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes
- B. Advocacy of non-intervention in normal processes in the absence of complications
- C. Incorporation of scientific evidence into clinical practice
- D. Promotion of woman- and family-centered care
- E. Empowerment of women as partners in health care
- F. Facilitation of healthy family and interpersonal relationships
- G. Promotion of continuity of care
- H. Health promotion, disease prevention, and health education
- I. Promotion of a public health care perspective
- J. Care to vulnerable populations
- K. Advocacy for informed choice, shared decision making, and the right to self-determination
- L. Integration of cultural humility
- M. Incorporation of evidence-based complementary and alternative therapies in education and practice
- N. Skillful communication, guidance, and counseling
- O. Therapeutic value of human presence
- P. Collaboration with other members of the interprofessional health care team

## **II. Components of Midwifery Care: Professional Responsibilities of CNMs and CMs**

The professional responsibilities of CNMs and CMs include but are not limited to the following components:

- A. Promotion of the hallmarks of midwifery
- B. Knowledge of the history of midwifery
- C. Knowledge of the legal basis for practice
- D. Knowledge of national and international issues and trends in women's health and maternal/newborn care
- E. Support of legislation and policy initiatives that promote quality health care
- F. Knowledge of issues and trends in health care policy and systems
- G. Knowledge of information systems and other technologies to improve the quality and safety of health care
- H. Broad understanding of the bioethics related to the care of women, newborns, and families
- I. Practice in accordance with the ACNM Philosophy, Standards, and Code of Ethics
- J. Ability to evaluate, apply, interpret, and collaborate in research

- K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
- L. Development of leadership skills
- M. Knowledge of licensure, clinical privileges, and credentialing
  
- N. Knowledge of practice management and finances
- O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
- P. Support of the profession's growth through participation in midwifery education
- Q. Knowledge of the structure and function of ACNM

### **III. Components of Midwifery Care: Midwifery Management Process**

The midwifery management process is used for all areas of clinical care and consists of the following steps:

- A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
- B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
- C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
- D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
- E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
- F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
- G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

### **IV. Components of Midwifery Care: Fundamentals**

- A. Anatomy and physiology, including pathophysiology
- B. Normal growth and development
- C. Psychosocial, sexual, and behavioral development
- D. Basic epidemiology
- E. Nutrition
- F. Pharmacokinetics and pharmacotherapeutics
- G. Principles of individual and group health education
- H. Bioethics related to the care of women, newborns, and families
- I. Clinical genetics and genomics

## **V. Components of Midwifery Care of Women**

Independently manages primary health screening, health promotion, and care of women from the peri-menarcheal period through the lifespan using the midwifery management process. While the woman's life is a continuum, midwifery care of women can be divided into primary, preconception, gynecologic, antepartum, intrapartum, and post-pregnancy care.

A. Applies knowledge, skills, and abilities in primary care that include but are not limited to the following:

1. Nationally defined goals and objectives for health promotion and disease prevention
2. Parameters for assessment of physical, mental, and social health
3. Nationally defined screening and immunization recommendations to promote health and to detect and prevent disease
4. Management strategies and therapeutics to facilitate health and promote healthy behaviors
5. Identification of normal and deviations from normal in the following areas:
  - a. Cardiovascular and hematologic
  - b. Dermatologic
  - c. Endocrine
  - d. Eye, ear, nose, and throat
  - e. Gastrointestinal
  - f. Mental health
  - g. Musculoskeletal
  - h. Neurologic
  - i. Respiratory
  - j. Renal
6. Management strategies and therapeutics for the treatment of common health problems and deviations from normal of women, including infections, self-limited conditions, and mild and/or stable presentations of chronic conditions, utilizing consultation, collaboration, and/or referral to appropriate health care services as indicated.

B. Applies knowledge, skills, and abilities in the preconception period that include but are not limited to the following:

1. Individual and family readiness for pregnancy, including physical, emotional, psychosocial, and sexual factors including
  - a. Non-modifiable factors such as family and genetic/genomic risk
  - b. Modifiable factors such as environmental and occupational factors, nutrition, medications, and maternal lifestyle
2. Health and laboratory screening
3. Fertility awareness, cycle charting, signs and symptoms of pregnancy, and pregnancy spacing

C. Applies knowledge, skills, and abilities in gynecologic care that include but are not limited to the following:

1. Human sexuality, including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction
2. Common screening tools and diagnostic tests
3. Common gynecologic and urogynecologic problems
4. All available contraceptive methods
5. Sexually transmitted infections including indicated partner evaluation, treatment, or referral
6. Counseling for sexual behaviors that promote health and prevent disease
7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and gender concerns, and infertility
8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include but are not limited to the following:

1. Effects of menopause on physical, mental, and sexual health
2. Identification of deviations from normal
3. Counseling and education for health maintenance and promotion
4. Initiation or referral for age/risk appropriate periodic health screening
5. Management and therapeutics for alleviation of common discomforts

E. Applies knowledge, skills and abilities in the antepartum period that include but are not limited to the following:

1. Epidemiology of maternal and perinatal morbidity and mortality
2. Confirmation and dating of pregnancy
3. Promotion of normal pregnancy using management strategies and therapeutics as indicated
4. Common discomforts of pregnancy
5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
7. Emotional, psychosocial, and sexual changes during pregnancy
8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
9. Deviations from normal and appropriate interventions, including management of complications and emergencies
10. Placental physiology, embryology, fetal development, and indicators of fetal well-being

F. Applies knowledge, skills, and abilities in the intrapartum period that include but are not limited to the following:



1. Confirmation and assessment of labor and its progress
2. Maternal and fetal status
3. Deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies
4. Facilitation of physiologic labor progress
5. Measures to support psychosocial needs during labor and birth
6. Labor pain and coping
7. Pharmacologic and non-pharmacologic strategies to facilitate maternal coping
8. Techniques for
  - a. administration of local anesthesia
  - b. spontaneous vaginal birth
  - c. third stage management
  - d. performance of episiotomy repair of episiotomy and 1st and 2nd degree lacerations

G. Applies knowledge, skills, and abilities in the period following pregnancy that include but are not limited to the following:

1. Physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth
2. Management strategies and therapeutics to facilitate a healthy puerperium
3. Discomforts of the puerperium
4. Self-care
5. Psychosocial coping and healing following pregnancy
6. Readjustment of significant relationships and roles
7. Facilitation of the initiation, establishment, and continuation of lactation where indicated
8. Resumption of sexual activity, contraception, and pregnancy spacing
9. Deviations from normal and appropriate interventions including management of complications and emergencies

## **VI. Components of Midwifery Care of the Newborn**

Independently manages the care of the newborn immediately after birth and continues to provide care to well newborns up to 28 days of life utilizing the midwifery management process and consultation, collaboration, and/or referral to appropriate health care services as indicated.

A. Applies knowledge, skills, and abilities to the newborn that include but are not limited to the following:

1. Effect of maternal and fetal history and risk factors on the newborn
2. Preparation and planning for birth based on ongoing assessment of maternal and fetal status
3. Methods to facilitate physiologic transition to extrauterine life that includes but is not limited to the following:

- a. Establishment of respiration
  - b. Cardiac and hematologic stabilization including cord clamping and cutting
  - c. Thermoregulation
  - d. Establishment of feeding and maintenance of normoglycemia
  - e. Bonding and attachment through prolonged contact with neonate.
  - f. Identification of deviations from normal and their management.
  - g. Emergency management including resuscitation, stabilization, and consultation and referral as needed
4. Evaluation of the newborn:
- a. Initial physical and behavioral assessment for term and preterm infants
  - b. Gestational age assessment
  - c. Ongoing assessment and management for term, well newborns during first 28 days
  - d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated
5. Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:
- a. Teaching regarding normal behaviors and development to promote attachment
  - b. Feeding and weight gain including management of common breastfeeding problems
  - c. Normal daily care, interaction, and activity including sleep practice and creating a safe environment
  - d. Provision of preventative care that includes but is not limited to
    - (1) Therapeutics including eye ointment, vitamin K, and others as appropriate by local or national guidelines
    - (2) Testing and screening according to local and national guidelines
    - (3) Need for ongoing preventative health care with pediatric care providers
  - e. Safe integration of the newborn into the family and cultural unit
  - f. Appropriate interventions and referrals for abnormal conditions:
    - (1) Minor and severe congenital malformations
    - (2) Poor transition to extrauterine life
    - (3) Symptoms of infection
    - (4) Infants born to mothers with infections
    - (5) Postpartum depression and its effect on the newborn
    - (6) End-of-life care for stillbirth and conditions incompatible with life
  - g. Health education specific to the infant and woman's needs:
    - (1) Care of multiple children including siblings and multiple births
    - (2) Available community resources

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1. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health Care in a New Era*. Washington, DC: National Academy Press; 1996.
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3. American College of Nurse-Midwives. Midwives are primary care providers and leaders of maternity care homes. Position statement. <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000273/Primary%20Care%20Position%20Statement%20June%202012.pdf>. Published June 2012. Accessed December 17, 2012.

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Source: Basic Competency Section, Division of Education

Approved by the ACNM Board of Directors: December 2012

(Supersedes all previous *ACNM Core Competencies for Basic Midwifery Practice*)

# The Midwives Alliance Core Competencies

Revised 2014

## Introduction

The Midwives Alliance of North America Core Competencies establish the essential knowledge, clinical skills and critical thinking necessary for entry-level midwifery practice. An entry-level midwife is qualified to practice midwifery autonomously.

The Core Competencies inform practicing midwives, student midwives, midwifery education programs, consumers, accreditation and certification agencies, state and federal legislators, licensing authorities, health policy makers and other health care professionals concerning the practice of midwifery. Individual midwives are responsible to the licensing authority and regulations of the jurisdiction within which they practice.

The MANA Core Competencies are a living document. The competencies undergo continual evaluation and may be updated to incorporate new evidence and evolving midwifery practice, and as the needs of childbearing individuals and families change.

Midwives provide care in a variety of settings in accordance with the Midwives Model of Care™, which is based on the principle that pregnancy and birth are normal life processes.

The Midwives Model of Care™ includes:

- monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technological interventions;
- identifying and referring women who require obstetrical attention.

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

<http://cfmidwifery.org/mmoc/define.aspx>

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The scope of midwifery practice may be expanded beyond the Core Competencies outlined in this document to incorporate additional skills and procedures that improve care for clients and their families.

## The midwife provides care according to the following guiding principles of practice:

- Pregnancy and childbearing are natural physiologic life processes.
- The biological wisdom to give birth is innate, it has been held throughout time, and is experienced across cultures by all pregnant people.
- Physical, emotional, psychosocial and spiritual factors synergistically shape the health of individuals and affect the childbearing process.
- The childbearing experience and birth of a baby are personal, family and community events.
- Pregnant individuals are the only direct care providers for themselves and their unborn babies, thus the most important determinant of a healthy pregnancy is the pregnant person.

- The parameters of "normal" vary widely and each pregnancy, birth and baby is unique.

**In consideration thereof:**

- Midwives work in partnership with clients and their chosen support community throughout the caregiving relationship.
- Midwives respect and support the dignity, rights and responsibilities of the clients they serve.
- Midwives are committed to addressing inequities in health care status and outcomes.
- Midwives work as autonomous practitioners, and they collaborate with other health care and social service providers whenever appropriate.
- Midwives work to optimize the well-being of the mother-baby unit as the foundation of caregiving.
- Midwives recognize the empowerment inherent in the childbearing experience and strive to support clients to make informed decisions and take responsibility for their own and their baby's well-being.
- Midwives integrate clinical or hands-on evaluation, theoretical knowledge, intuitive assessment, spiritual awareness and informed consent and refusal as essential components of effective decision making.
- Midwives strive to ensure optimal birth for the whole family and provide guidance, education and support to facilitate the spontaneous processes of pregnancy, labor and birth, lactation and mother-baby attachment, using appropriate intervention as needed.
- Midwives value continuity of care throughout the childbearing cycle and strive to maintain such continuity.
- Midwives are committed to sharing their knowledge and experience through such avenues as peer review, preceptorship, mentoring and participation in MANA's statistics collection program.

**MANA Core Competencies**

Midwives have the ability to provide high quality, culturally relevant, and holistic midwifery care in a variety of settings. Midwives acquire and maintain the necessary knowledge and skills pertinent to midwifery practice and derived from a variety of fields including, but not limited to: human anatomy and physiology, midwifery, history of midwifery, obstetrics and gynecology, neonatology, genetics, embryology and fetal development, pharmacotherapeutics, nutritional sciences, naturopathy, social sciences, ethics, critical thinking, research and epidemiology, emergency care, communication, counseling and education.

Midwives obtain proficiency through various types of education, training, mentoring, clinical preceptorship, hands-on practice, and life experience.

The midwife involves the client and childbearing family in all aspects of decision making and maintains an integrated understanding of the needs, challenges, and goals of the client and family by utilizing midwifery knowledge and skills, critical thinking, intuition, and the process of informed consent, refusal, and shared-decision making.

**I. General Knowledge and Skills**

The midwife's knowledge and skills include but are not limited to:

- A. communication, counseling, and education;

- B. human anatomy and physiology;
- C. human sexuality;
- D. various therapeutic health care modalities for treating body, mind and spirit;
- E. community health care, wellness and social service resources;
- F. nutritional needs, health and lifestyle habits;
- G. cultural awareness, sensitivity and competency.

The midwife's knowledge and skills relate community health to client needs, including but not limited to:

- A. the community and social determinants of health, including race, income, literacy and education, water supply and sanitation, housing, environmental hazards, food security, disease patterns, and common threats to health;
- B. principles of community-based primary care using health promotion and disease prevention and control strategies;
- C. direct and indirect causes of maternal and neonatal mortality and morbidity in the local community, and strategies for reducing them;
- D. principles of epidemiology;
- E. principles of health education;
- F. emergency preparedness for disaster response including communication and transport mechanisms;
- G. human rights and their effects on health of individuals, including issues such as domestic violence, genital circumcision, gender equity, gender identity and expression, and how their expression affects health outcomes;
- H. advocacy and empowerment strategies;
- I. culture and beliefs, including religion, social norms, family structure and health practices;
- J. birth planning, benefits and risks of available birth settings.

The midwife maintains professional standards of practice including but not limited to:

- A. principles of informed consent and refusal and shared decision-making;
- B. critical evaluation of evidence-based research findings and application to best practices;
- C. documentation of care throughout the childbearing cycle;
- D. consistent actions in accordance with professional ethics, values and human rights;
- E. courteous, non-judgmental, non-discriminatory, and culturally appropriate behaviors with all clients;
- F. respect for individuals and their culture, customs and beliefs, ethnic origin, gender identity, sexual orientation, family structure, and religious beliefs;
- G. knowledge of commonly used medical terminology;
- H. implementation of individualized plans for client-centered midwifery care;
- I. support for the relationship among the mother-baby unit, the family and their larger community;
- J. judicious use of technology;
- K. self-assessment and acknowledgement of personal and professional limitations.

## **II. Care during Pregnancy**

The midwife provides care, support, and information throughout pregnancy, and determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:



- A. identification, evaluation, and support for the client's and baby's well-being throughout the process of pregnancy;
- B. initial and ongoing history at each antenatal visit;
- C. physical examination and explanation of findings to the client;
- D. education and counseling during the childbearing cycle;
- E. identification of pre-existing conditions and preventive or supportive measures to enhance client well-being during pregnancy;
- F. nutritional requirements of pregnancy and methods of nutritional assessment and counseling;
- G. emotional, psychosocial and sexual variations that may occur during pregnancy;
- H. environmental and occupational hazards during pregnancy;
- I. effects of smoking, alcohol and drug use on pregnancies and unborn babies;
- J. methods of diagnosing pregnancy;
- K. the growth and development of the unborn baby;
- L. genetic factors that may indicate the need for counseling, testing, or referral;
- M. screening methods and diagnostic tests used during pregnancy, including indications, risks and benefits;
- N. health and psychosocial needs associated with spontaneous or therapeutic abortion, including referral to community resources;
- O. anatomy, physiology, and evaluation of the soft and bony structures of the pelvis;
- P. palpation skills for evaluation of the baby and the uterus;
- Q. the causes, assessment and treatment of the common discomforts of pregnancy;
- R. Identification, implications and appropriate treatment of various infections, disease conditions and other problems that may affect pregnancy;
- S. basic principles of pharmacokinetics of drugs prescribed, dispensed or administered during pregnancy;
- T. effects of prescribed medications, herbal medicines, and over-the-counter drugs on pregnancy and the baby;
- U. administration of medications as indicated;
- V. management and care of the Rh-negative client;
- W. signs, symptoms and indications for referral of selected complications and conditions of pregnancy;
- X. the physiology of lactation and methods to prepare for breastfeeding;
- Y. counseling to the client and family to plan for a safe, appropriate place of birth.

### **III. Care during Labor, Birth, and the Immediate Postpartum**

The midwife provides care, support and information throughout labor, birth, and the hours immediately thereafter. The midwife determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:

- A. the processes of labor and birth;
- B. parameters and methods, including relevant health history, for evaluating the client's and baby's well-being during labor, birth and immediately thereafter;
- C. assessment of the birthing environment to assure that it is clean, safe and supportive and that appropriate equipment and supplies are on hand;
- D. attention to emotional responses and their impact during labor, birth, and immediately thereafter;
- E. comfort and support measures during labor, birth, and immediately thereafter;

- F. fetal and maternal anatomy and their interrelationship as relevant to assessing the baby's position and the progress of labor;
- G. hydration and nutritional requirements during labor, birth, and immediately thereafter;
- H. techniques to assist and support the spontaneous vaginal birth of the baby and placenta;
- I. recommendations for rest and sleep as appropriate during the process of labor, birth, and immediately thereafter;
- J. techniques to assist and support labor, birth and the immediate postpartum in water;
- K. treatment for variations that can occur during the course of labor, birth, and immediately thereafter, including prevention and treatment of maternal hemorrhage;
- L. emergency measures and transport for critical problems arising during labor, birth, or immediately thereafter;
- M. appropriate support for the newborn's natural physiologic transition during the first minutes and hours following birth, including skin-to-skin contact and practices to enhance mother-baby attachment and family bonding;
- N. pharmacological measures for management and control of indications in the intrapartum and immediate postpartum for client and baby;
- O. current interventions and technologies that may be commonly used in a medical setting;
- P. care and repair of the perineum and surrounding tissues;
- Q. third-stage management, including assessment of the placenta, membranes and umbilical cord, and collection of the cord blood;
- R. breastfeeding and lactation;
- S. identification of pre-existing conditions and implementation of preventive or supportive measures to enhance client well-being during labor, birth, the immediate postpartum and breastfeeding.

#### **IV. Postpartum Care**

The midwife provides care, support, and information throughout the postpartum period and determines the need for consultation, referral or transfer of care as appropriate. The midwife has knowledge and skills to provide care that include but are not limited to:

- A. anatomy and physiology of the birthing parent;
- B. lactation support and appropriate breast care and treatments for breastfeeding problems or complications, including mastitis;
- C. management and care of the Rh-negative client with the Rh-positive baby;
- D. support for the client's well-being and mother-baby attachment;
- E. treatment for client discomforts;
- F. nutrition, rest, activity and physiological needs during the postpartum period and lactation;
- G. emotional, psychosocial, mental, and sexual variations;
- H. signs and symptoms of postpartum conditions requiring management, including those needing immediate medical intervention;
- I. current identification and treatments for psychosocial adjustment problems including postpartum depression and mental illness;
- J. principles of interpersonal communication with, and support for, grief counseling when necessary;
- K. family planning methods, as desired.

#### **V. Newborn Care**

The midwife provides care to the newborn during the postpartum period as well as support and information to parents regarding newborn care and informed decision making, and determines the need for consultation, referral or transfer of care as appropriate. The midwife's assessment, care and shared information include but are not limited to:

- A. anatomy, physiology, and support of the newborn's adjustment during the first days and weeks of life;
- B. newborn wellness including relevant historical data and gestational age;
- C. nutritional needs of the newborn;
- D. benefits of breastfeeding and lactation support;
- E. prophylactic treatments and screening tests commonly used during the neonatal period including applicable laws and regulations;
- F. newborn growth, development, behavior, nutrition, feeding, and care;
- G. traditional or cultural practices related to the newborn;
- H. neonatal problems and abnormalities, and referral as appropriate;
- I. discussion of circumcision and immunizations;
- J. safety needs of the newborn.

#### **VI. Health Care and Family Planning**

The midwife provides care, support and information regarding reproductive health and determines the need for consultation or referral by using a foundation of knowledge and skills that includes but is not limited to:

- A. reproductive health care across the lifespan;
- B. evaluation of the client's well-being, and relevant health history;
- C. common laboratory tests and screenings;
- D. physical examination, including clinical breast and pelvic examination, focused on the presenting condition of the client;
- E. anatomy and physiology related to conception and reproduction;
- F. contemporary family planning methods, including natural, chemical and surgical methods of contraception, mode of action, indications, benefits and risks;
- G. decision making regarding timing of pregnancies and resources for counseling and referral;
- H. preconception and interconceptual care;
- I. wellness care and gynecology.

#### **VII. Professional, Legal and Other Aspects of Midwifery Care**

The midwife assumes responsibility for practicing in accordance with the principles and competencies outlined in this document. The midwife uses a foundation of theoretical knowledge, clinical assessment, critical-thinking skills and shared decision making that are based on:

- A. MANA's Essential Documents concerning the art and practice of midwifery;
- B. the purpose and goals of MANA and local (state or provincial) and national midwifery associations;
- C. principles and practice of data collection as relevant to midwifery practice;
- D. ongoing education;
- E. peer review, quality assessment and other professional and legal accountability processes;
- F. principles of research, evidenced-based practice, critical interpretation of professional literature, and research findings;
- G. professional guidelines, jurisdictional laws and regulations governing the practice of midwifery, health and reproduction;

- H. knowledge of community health care delivery systems, and needed resources for midwifery care;
- I. strategies for increasing access to midwifery care, especially in underserved communities;
- J. skills in entrepreneurship and midwifery business management.

*Revised 12/14*

## What's new for Healthiest Weight Florida?

### Healthy Weight Community Champions Program NOW OPEN

Applications for 2016's State Surgeon General [Community Champion Recognition Program](#) are now being accepted! This program recognizes municipalities and counties who have implemented "best practice" policies to create healthier communities.

### Maintain, Don't Gain Holiday Challenge Begins Nov. 16

Sign up for this FREE seven-week challenge to help you [maintain your weight](#) through the holiday season.

### Small Steps to Living Healthy

Finding success in healthy weight isn't always easy, but it helps to take small steps. Small Steps to Living Healthy is an email-based program that allows Floridians to [sign up](#) for weekly tips and tricks delivered directly to their inbox.

## What is Healthiest Weight Florida?

The number one public health threat to Florida's future is unhealthy weight.

Currently, only 36 percent of Floridians are at healthy weight. On our current trend, by 2030, almost 60 percent will be obese. Additionally, six out of ten children born today will be obese by the time they graduate high school.

Over the next 20 years in Florida, obesity is expected to contribute to millions of cases of preventable chronic diseases such as type 2 diabetes, heart disease and cancer, costing an estimated \$34 billion. To address this important public health issue, the Department of Health launched the Healthiest Weight Florida initiative in January 2013.

*Healthiest Weight Florida* is a public-private collaboration bringing together state agencies, not for profit organizations, businesses, and entire communities to help Florida's children and adults make consistent, informed choices about healthy eating and active living.



The initiative works closely with partners to leverage existing resources to maximize reach and impact. These partners include the business community, hospitals, non-governmental organizations, non-profit agencies, other federal, state, or local government agencies, and volunteer coalitions. The overall goal is to bend the weight curve by 5% by 2017.



# I Promise... As Floridians

we promise to help become the  
healthiest state in the nation.

Click "Submit Your Promise" to display  
your promise on the online wallboard  
for others to be inspired.

[View Submitted Promises](#)

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**HealthiestWeight**