FLORIDA | Council *of* Licensed Midwifery

Agenda Outline

July 13, 2015 at 9:00 am

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

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

Call to Order: **Melissa Conord-Morrow, LM, Chair**
Roll Call: **Christy Robinson, Executive Director**

Review of Minutes from Previous Meetings:

1. April 11, 2015, General Business Meeting Minutes
2. April 27, 2015, Rules Workshop Meeting Minutes

General Business:

3. 2016 Proposed Meeting Dates

Rule Discussion (draft language will be provided separately):

4. 64B24-1 Organization
5. 64B24-2 Requirements for Licensure
6. 64B24-3 Fees
7. 64B24-4 Training Programs
8. 64B24-5 Renewal, Inactive Status, Reactivation
9. 64B24-6 Continuing Education
10. 64B24-7 Midwifery Practice
11. 64B24-8 Discipline

Reference Material and Correspondence:

12. Annual Report Draft and Comments Provided by Robyn Mattox
13. Research Obtained by Council Members and Staff as of 4/23/2015
14. Comments Received from the Midwives Association of Florida

Old Business

New Business

Adjourn

FLORIDA | Council *of* Licensed Midwifery

Draft Meeting Minutes

April 11, 2015 at 9:00 am

Orlando Marriott Lake Mary
1501 International Parkway
Lake Mary, FL 32746

Call to Order:

The meeting was called to order by Ms. Conord-Morrow, Chair, at 9:00 am. Those present for all or part of the meeting included the following:

MEMBERS PRESENT:
Melissa Conord-Morrow, RN, LM, Chair
Dana Barnes, MD
Kathy Bradley, Consumer Member
Robyn Mattox, LM
Tania Mondesir, RN, LM
Robert Pearson-Martinez, MD
David Stewart, MD
Stephanie Wombles, CNM
Charlie Young, LM

MEMBERS ABSENT:
None

STAFF PRESENT:
Christy Robinson, Executive Director
Don Olmstead, Program Operations Administrator
Linda McMullan, Assistant General Counsel
Lucy C. Gee, MS, Director, Division of Medical Quality Assurance
Adrienne Rodgers, Chief, Bureau of Health Care Practitioner Regulation

COURT REPORTER:
American Court Reporting
407-896-1813

Please note that the meeting minutes reflect the actual order that agenda items were discussed during the meeting and may differ from the agenda outline.

Welcome from Lucy C. Gee, MS, Director, Division of Medical Quality Assurance

Ms. Gee welcomed the Council and provided opening comments. She outlined the Council's roles and responsibilities and thanked them for their service. She asked that they focus on three specific areas during their discussions: review of all rules to reduce unnecessary regulation,

review and revision of emergency care procedures, and mandatory annual reporting requirements.

Recognition of Former Council Members

Ms. Conord-Morrow recognized Jennifer Joseph, LM, former Council member. Ms. Joseph was presented with a plaque for her service on the Council, as well as a certificate of appreciation from the State Surgeon General.

Char Lynn Daughtry was also recognized with a plaque and certificate of appreciation, but was not present to accept them.

Council member Roles and Responsibilities

Tab 1 - Overview of Roles and Responsibilities of the Council of Licensed Midwifery
Ms. Gee provided this overview during opening remarks.

Rules Review and Discussion

Tab 5 - 64B24-4 Training Programs

Ms. Robinson explained many of the proposed changes were technical in nature and asked for feedback and guidance on curriculum guidelines for the reduced 2-year training programs. She also summarized the remaining changes.

64B24-4.001 – Definitions
64B24-.4.007 – Clinical Training
These sections were discussed simultaneously.

Ms. Robinson summarized the proposed changes. There was discussion regarding direct supervision versus indirect supervision. The Council indicated clarification may be needed as to which procedures would require direct supervision and indirect supervision. There was consensus that direct supervision should be required for second and third stage.

There was also a consensus of the Council that the definition of direct supervision should include physical presence. It was suggested that staff obtain information from NARM and MANA on which clinical experiences should be done under direct supervision.

64B24-4.002 – Approval of Training Programs

Jennifer Joesph, LM addressed the Council on the issue of obtaining accreditation. She recommended that provisional approval should be granted for at least 5 years. She explained students can't actually complete the program within the 3 years because of the large number of clinical experiences they must complete. It was also indicated students cannot sit for the licensure examination without having the clinical experiences.

It was the consensus of the Council that the provisional approval term should be 5 years, due to the length of time it takes for students to complete their clinical experiences, which are often done after completion of the didactic portion of the program.

2-Year Reduced Training Program:

Jennifer Joseph, LM suggested obtaining the curriculum guidelines from the Florida Commission on Independent Education. Staff was also asked to obtain information, if possible, from NARM, MANA and ACNM.

64B24-4.003 –Acceptance into Training Program

The Council discussed this section and agreed to leave (2) in the rule.

64B24-4.005 – Faculty

There was discussion about requiring an instructor to have been actively engaging in their practice for the past 4 years. There was also concern that the rule only required one instructor to meet the licensing and practice criteria, while allowing other instructors to have no criteria.

There was also discussion about the possibility of defining active practice for this section.

Staff was asked to obtain information from the Florida Commission on Independent Education and MEAC regarding faculty qualifications.

64B24-4.010 – Four-month Pre-licensure Course

Jennifer Joseph, LM briefly discussed the education equivalence process and the use of the evaluation tool forms. She suggested that individuals who have delivered no babies may need to participate in additional clinical experiences.

There was discussion regarding changing the rule and process to require the educational equivalency prior to acceptance into the 4-month pre-licensure course. It was noted that NARM has specific requirements, including number of clinical experiences, which must be completed prior to admittance to the exam.

Ms. Gee explained the endorsement process for many other professions within her purview. She suggested a potential statutory change to require active practice and completion of a laws and rules exam, in lieu of the 4-month pre-licensure course, for licensure by endorsement.

Staff was asked to see if NARM required active practice to maintain certification.

Break

Tab 8 - 64B24-7 Midwifery Practice

Ms. Conord-Morrow suggested the Council should look at requirement of both annual statistical reports and sentinel reporting.

64B24-7.014 – Records and Reports

Annual Report Discussion:
There was discussion about clarifying the language in (6) so that it included midwives and midwives serving as a preceptor for a student as separate categories in the annual report. There was also much discussion regarding who should be responsible for reporting statistical data in group practices where the patients see multiple midwives. It was suggested that the rule contain language clarifying reporting procedures for group practices.

Ms. McMullen clarified the intent of requiring annual reporting. This included justification of the Council and midwifery licensure, protection of the public, and to provide a picture of the practice for stakeholders and interested parties.

There was discussion regarding whether or not data by county should be required.
The Council suggested that there be some outreach and education to licensed midwives explaining the purpose and benefit of annual reports to ease fear and address potential concerns associated with reporting.

Ms. Robinson indicated she would look into the viability of the Department creating an on-line solution for annual reporting. There was also a suggestion that the Department work with MANA to see if they could collect the data for the Council.

Action Taken: Ms. Conord-Morrow moved to require mandatory reporting. The motion was seconded and carried unanimously.

It was suggested that it may be difficult to quantify the number of patients "served" as listed in (c) of the draft language. Clarification or additional definition of this term will be needed to ensure duplicate reporting does not occur.

Council members were asked to review the potential data points provided in the agenda materials and email staff with their preferred data collection points.

The Council discussed immediate reporting for sentinel events. Ms. McMullen indicated she would look into whether or not the Council has statutory authority to require these types of reports.

Break

Emergency Care Plan Discussion:
Ms. McMullen summarized the statutory provision and draft rule language regarding the emergency care plan.

There was discussion regarding the deadline for completion of the form. There was consensus to change the name of the form to Emergency Care Plan for Delivery. Other changes that need to be made to the form include patient name, information and signature and name and information of pediatrician.

The Council discussed what type of plan should be submitted at initial licensure and renewal, as well as what should be discussed with each patient. There was consensus that the current form should be amended to include the information discussed previously.

There was additional discussion regarding the deadline for completion of the form. It was suggested the deadline be by 36 weeks or at initial consultation, in the event of a late entry to care.

64B24-7.001 – Definitions

There were no major revisions to this section. There is a typographical error in (2) that should be corrected.

64B24-7.004 – Risk Assessment

Staff was asked to research how other states handle risked-out patients that are unable to find care in a timely manner. Staff was also asked to research the source of the risk assessment point system, if possible, and obtain more recent guidelines. It was suggested that length of time to get the patient consult may be a good number to collect as part of the annual report.

Miriam Pearson-Martinez, LM, President of the Midwives Association of Florida, provided comments on the risk assessment scoring system. She indicated that the association was interested in providing suggestions for changes to this rule.

64B24-7.005 – Informed Consent

Ms. Robinson indicated these changes were technical in nature. There was discussion regarding the current form and changes that should be made to it. Council members were asked to send their versions of the form to staff so they can revise the form.

64B24-7.006 – Preparation for Home Delivery

It was suggested that the word “facilities” in (2) be changed to “birth environment”.

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

There was discussion regarding the requirement of a pelvic exam or pap smear. There were also recommendations that Hepatitis C screening, HSV screening and education on vaccinations be added under (1)(c). It was the consensus of the Council to add “cervical cancer screening, if appropriate”, under section (1)(c).

There was much discussion regarding the tests and procedures that should be offered and required. The Council also discussed offering a waiver to patients who refuse certain procedures or tests. Staff was asked to research the current standards of practice nationally and in other states to assist them in revising the rule. It was suggested that staff also reach out to MANA, NARM and ACNM for information.

Ms. Robinson indicated time would not allow discussion of all the rules and asked if there were any specific rules the Council wanted to discuss.

64B24-7.013 – Requirement for Malpractice Insurance

Ms. McMullen advised the Council that there was no statutory authority for malpractice insurance so the rule was being repealed to comply with the law. There was discussion about whether or not this should be mandated legislatively. Staff was asked to research the cost, market and availability of malpractice insurance.

Ms. Robinson indicated she would provide updates on the progress of the rules and research as frequently as possible. She also indicated that the Council would have to meet more frequently until adoption of these rule changes. Ms. McMullen suggested the Council form subcommittees for specific topics for timeliness and efficiency. Ms. Robinson indicated she would work with the Council on necessary committees and their roles, for discussion at a future meeting.

Tab 2 - 64B24-1 Organization
Item not discussed due to time constraints.

Tab 3 - 64B24-2 Requirements for Licensure
Item not discussed due to time constraints.

Tab 4 - 64B24-3 Fees
Item not discussed due to time constraints.

Tab 6 - 64B24-5 Renewal, Inactive Status, Reactivation
Item not discussed due to time constraints.

Tab 7 - 64B24-6 Continuing Education
Item not discussed due to time constraints.

Tab 9 - 64B24-8 Discipline
Item not discussed due to time constraints.

Tab 10 – Council Forms
Informational item.

Tab 11 – Reference Materials
Informational item.

Discussion Regarding Potential Statutory Changes

Tab 12 – Chapter 467, Florida Statutes
Item not discussed due to time constraints. However, Ms. Robinson she would be putting forth technical changes to the statute.

Election of Vice Chair

Election of Chair – Ms. Robinson explained the necessity of conducting an election for Chair.

Ms. Bradley nominated Ms. Conord-Morrow for chair. Dr. Stewart seconded the motion, which passed unanimously.

Election of Vice Chair - Ms. Bradley nominated Ms. Mattox for vice chair. The motion was seconded the motion, and passed unanimously.

Old Business

New Business

The meeting was adjourned at approximately 5:00pm.

FLORIDA | Council *of* Licensed Midwifery

Draft Rule Workshop Minutes

April 27, 2015 at 9:00 am

Department of Health Building
4042 Bald Cypress Way, Room 301
Tallahassee, FL 32399

Call to Order:

The workshop was called to order by Ms. Robinson, Executive Director, at approximately 9:00 am. Those present for all or part of the workshop included the following:

MEMBERS PRESENT:
Melissa Conord-Morrow, RN, LM, Chair
Dana Barnes, MD
Kathy Bradley, Consumer Member
Robyn Mattox, LM
Tania Mondesir, RN, LM
Charlie Young, LM

MEMBERS ABSENT:
Robert Pearson-Martinez, MD
David Stewart, MD
Stephanie Wombles, CNM

STAFF PRESENT:
Christy Robinson, Executive Director
Linda McMullan, Assistant General Counsel
Lucy C. Gee, MS, Director, Division of Medical Quality Assurance
Adrienne Rodgers, Chief, Bureau of Health Care Practitioner Regulation
Jacqueline Clahar-Anderson, Regulatory Specialist II

COURT REPORTER:
For the Record Reporting
850-222-5491

The Department of Health (Department) took testimony from interested parties and Council members regarding the entire rule chapter. The exact comments and testimony can be found on the attached transcript.

The workshop adjourned at 10:04 am.

STATE OF FLORIDA
DEPARTMENT OF HEALTH
COUNCIL OF LICENSED MIDWIFERY

Re: Rule Development Discussion
For Rule 64B24
_____/

RULE WORKSHOP

April 27th, 2015

9:00 a.m. - 10:04 a.m.

Department of Health
4042 Bald Cypress Way, Room 301
Tallahassee, Florida 32399

Reported by:

SCHEDALE WOODS, Court Reporter
For the Record Reporting, Inc.
1500 Mahan Drive - Suite 140
Tallahassee, Florida, 32308

PRESENT

CHRISTY ROBINSON

LINDA MCMULLEN

MELISSA CONORD-MORROW

SUSAN "ROBYN" MATTOX

JACQUELINE ANDERSON

DANA BARNES

ADRIENNE RODGERS

CHARLIE YOUNG

TANIA MONDESIR

KATHY BRADLEY

* * *

P R O C E E D I N G S

MS. ROBINSON: All right. We're going to go ahead and get started. Good morning, everyone. Good morning. My name is Christy Robinson. I'm the Executive Director for the Council of Licensed Midwifery. Welcome to the April 27th, 2015, Department of Health Rule Workshop on the Council of Licensed Midwifery rules. Your panel today is myself, Christy Robinson, the following council members: Melissa Conord-Morrow, Robyn Mattox, Kathy Bradley, Tania Mondesir, which hopefully, will be joining us soon, Dana Barnes, and Charlie Young.

So again, I already kind of said earlier, we have sign-in sheets in the back, because we want to keep an official record of the meeting. And also, anyone interested in speaking, fill out a speaker card request form and you can bring them up to us and we'll keep track and call your name whenever it's time. And I think everybody pretty much has done that already.

When your name is called to come speak on your particular item of interest, you'll be sworn in by the court reporter who is taking official -- no? They're not swearing in? Okay. All right.

You won't be sworn in by the court reporter. So she is here just to keep an official record of the comments made here today. And then, Ms. McMullen, Lin McMullen, who represents the Department of Health, will explain the ruling making process very briefly.

MS. MCMULLEN: Is that where we are now?

MS. ROBINSON: That's where we are.

MS. MCMULLEN: Okay. Today is really the first step in the rule making process. I'm going to give you just a general overview of how it works. We're doing a workshop today and we'll take public testimony and we will continue to take public testimony for a period of probably 10 days, 10 to 14 days. And so you should continue to talk to your colleagues and friends about things that you think should be changed in the rules and submit them to us in writing. Everything is taken into account.

The next step in this process will be the notice of rule making. And we put that -- this is not -- it's not a quick process the way this works. It's governed by Chapter 120 of the Florida Administrative Procedures Act. We'll notice the rule of rule development, and then

there may be changes and we'll do a Notice of Change. There may be other things that come to our attention as we go along. We'll probably -- we will definitely have another council meeting where the council will review all of the comments and testimony that has been given.

And then we will have, at that point, after we notice the rule, we'll have a final draft of the rule. We will submit that to the Joint Administrative Procedures Committee. And then that is the -- the legislative committee that's made up of house members and senate members, and they review the rule and they make comments and send it back to us, and if they like it and it's fine. But usually, you get a letter saying we think you should change this number and this comma and, you know, this paragraph, and that sort of thing. So we have to accommodate that.

Then, we finally get to a point where we'll get a certification from the Joint Administrative Procedures Committee. We call is JAPC for short. Once we get that then we can file the rule for final adoption and it gets filed with the Secretary of State if there's no challenges to it, no requests for a hearing. It becomes final 20

days after that.

So you can kind of get an idea of the rough timeline. We're probably looking at 60 days before anything, at the earliest, that anything's going to be finalized. That assumes there's no challenges to the rule and no rule hearings that would have to be scheduled, which means that everybody's happy with it. It also means that we are able to address all of the concerns that the Joint Administrative Procedures Committee might have.

Once it's filed with the Secretary of State, it becomes final 20 days after that, assuming nothing else happens. And then, from that point forward, then you start operating under the rule as it's been drafted. So that's just a general view of it. We're at step one today, so is there any questions about the procedure?

Okay. Thank you.

MS. ROBINSON: Okay. So today, what we're going to do is we are going to follow the order of the agenda with respect to when we discuss certain rules. So I did notice that on the speaker card -- I have three speaker cards, and each individual has indicated they want to discuss, potentially,

every rule, which is fine. So if you could please keep your comments concise. You know, we have, obviously, a lot of discussion to go over here today. So, you know, we'll try to keep it moving along.

So the first item on the agenda is Rule 64B24-1, Organization. And what we are doing -- or proposing that we do with those particular rules are clarifying terms, procedure, and unexcused absences, and creating a requirement for a department annual report that includes some statistical information, as well as, hopefully, statistics that we receive from licensed midwives in the future. So I'll go ahead and call up the first interested party, which is Michelle Ruffalo.

MS. RUFFALO: I have nothing.

MS. ROBINSON: No comments?

MS. RUFFALO: No.

MS. ROBINSON: Okay.

Christy Phillips?

MS. PHILLIPS: I'm fine right now.

MS. ROBINSON: All right.

Kim Stewart or Laura McLafferty?

MS. STEWART: No.

MS. ROBINSON: Good?

MS. MCLAFFERTY: Good.

MS. ROBINSON: All right. Do the council members want to provide any comments on this rule at this time? Organization? No.

Okay. All right. We will move on to 64B24-2, Licensure Requirements. A lot of the proposed changes that we were making in this rule are just clarification and there's edits. We're also clarifying the examination fee, clarifying the emergency care plan requirements, and clarifying temporary certificates.

So do the interested parties -- Michelle Ruffalo?

MS. RUFFALO: On licensure --

MS. ROBINSON: Come on -- if you're going to provide comments, come on up.

MS. RUFFALO: Hi. I'm Michelle Ruffalo. I'm representing the Midwives Association of Florida.

(Whereupon, the court reporter asked for clarification.)

MS. RUFFALO: So we -- for 64B24-4.010, the pre-life -- pre -- four month pre-licensing course. Did I jump ahead of the thing? I'm sorry.

MS. ROBINSON: What was that rule number, again?

MS. RUFFALO: 64B24 -- I went ahead. We're on .2. Yeah. It's 2.004, Licensing By Endorsement.

MS. ROBINSON: Okay. That's on Page 3 of the draft.

MS. RUFFALO: Uh-huh.

MS. ROBINSON: Okay.

MS. RUFFALO: For the Midwives Association, one of the things, and I believe it is already in here, was to make sure that the certificate or diploma awarded by the Midwifery Program was accredited by a MEAC or accredited by an entity recognized by the U.S. Department of Education, and is approved by the certifying body of the state in which it was located. And that's -- that's just one of the things that we were hoping to --

MS. ROBINSON: And that's for individuals that graduated from school in an another state?

MS. RUFFALO: Foreign trained.

MS. ROBINSON: Also?

MS. RUFFALO: Uh-huh.

(Whereupon, the court reporter asked for

clarification.)

MS. RUFFALO: For them to be licensed by endorsement.

MS. ROBINSON: Just for all the audience, there is a copy of the draft proposed changes in the back, if you didn't already see it.

MS. MATTOX: Michelle, can you repeat that, please?

MS. RUFFALO: Okay. So where it's coming from is that when they go to take their licensure by endorsement course, that the course is -- that they're going to an accredited MEAC or accredited by a school that is accredited by an entity that is recognized by the U.S. Department of Education.

MS. ROBINSON: So you're suggesting that the school that they graduate from, whether it be in another state or in a foreign country, that it be accredited by MEAC?

MS. RUFFALO: MEAC and the Department of -- yes, and the U.S. Department of Education.

MS. ROBINSON: I don't necessarily know that that would be possible for individuals coming from a foreign institution.

MS. RUFFALO: Well, but the licensing -- right now, the licensing by endorsement class,

that's -- we want it to be offered by a school that is MEAC accredited or --

MS. ROBINSON: Okay. So you mean the four-month licensure course.

MS. RUFFALO: Correct. Correct.

MS. ROBINSON: You want that to be accredited?

MS. RUFFALO: Yes.

MS. ROBINSON: Okay.

MS. RUFFALO: Yes. I'm sorry.

MS. ROBINSON: That's okay. That's what we're here for.

Did you have any other comments about the rules in that section?

MS. RUFFALO: Not for that section.

MS. ROBINSON: Okay.

How about Kristen Phillips?

MS. PHILLIPS: Nope.

MS. ROBINSON: Kim Stuart or Laura?

MS. STUART: No.

MS. ROBINSON: Okay.

Do any council members have any comments about that? No? Okay.

MS. BRADLEY: Well, where is it in our overall -- like, what midwifery school, not just

the four-month licensure, where is it stated --

MS. CONORD-MORROW: Under Training Programs, D -- yeah. It would be in a different rule.

MS. BRADLEY: Right. But I wanted to look at that, how it reads there. So --

MS. CONORD-MORROW: Do they match?

MS. BRADLEY: Yeah. That's what I'm looking at.

MS. CONORD-MORROW: That would be -- Page 10.

MS. BRADLEY: Under Training Programs --

MS. CONORD-MORROW: No. Remember it used to say --

MS. MCMULLEN: 64B24-4.002. And that's one of the things that is being considered once we get to that rule. That's one of the things that's being considered as something that needs to be looked at.

MS. BRADLEY: When we do -- we -- when we get there, can we then come back to this?

MS. MCMULLEN: Yes. We need to do it in order. We'll take that up when we get to that rule.

MS. ROBINSON: And just as a matter of clarification, procedurally, we do require that

anyone offering the four-month pre-licensure course go through the same approval process as we would someone offering the full training program. And the law does say they're supposed to be accredited.

Were there any other comments about any of the rules in 64B24-2?

MS. CONORD-MORROW: And I think that I had a note on this .004. Number 6 and number 9 seem to be repetitive, under (1)(a).

MS. MCMULLEN: Can you speak up?

MS. CONORD-MORROW: 2.004 (1)(a), 6 and 9 seem to be a repetitive statement.

MS. BARNES: I don't even see 9.

MS. MATTOX: Are we looking at different drafts, Christy, between this one and this -- this third draft, and this one?

MS. ROBINSON: The draft that we have, that we gave you on the table should be pretty much identical to the third draft, third version draft we reviewed at the last meeting.

MS. MATTOX: Okay.

MS. ROBINSON: I think we might have changed a word.

MS. CONORD-MORROW: And you took out 5, as

well.

MS. ROBINSON: Okay.

MS. CONORD-MORROW: Disregard.

MS. ROBINSON: So are we good? Okay.

So specifically, one of the things that we are attempting to do in this particular section is clarifying what the emergency care plan needs to include as part of the initial licensure process. So does anyone just want to get on the record, if anyone has any questions or comments or concerns about that particular portion? None? Okay.

And then, did anyone have any comments to provide regarding the temporary certificate to practice in the area of critical need? Okay.

All right. The next rule is 24-3, and that's our fee rule. Basically, what we are doing -- we haven't recommended that any of fees be changed. We just changed the format of the rule to make it less wordy and more concise. So does anyone have any -- I know all the speakers said they wanted to speak about that rule, but -- does anyone? No? Okay. All right. Council members?

The next rule is 24-4, Training Programs. Again, we are clarifying terms and streamlining the language. We are also trying to further

define how to handle new schools applying with respect to the accreditation process since that is a very lengthy ordeal as we understand it. We are also trying to work out our process for evaluating the training programs, as well as come up with requirements specifically for the two-year reduced training program. So we will start with Michelle Ruffalo. Am I saying that right?

MS. RUFFALO: Yes, ma'am.

I think that you guys have already talked about what we wanted to have added in regards to this part previously with the accreditation and the length of training. So I think that you guys covered this before. Yes, you have.

MS. ROBINSON: How about Kristen Phillips?

MS. PHILLIPS: Not at this time.

MS. ROBINSON: Okay. And Kim Stuart, Laura McLafferty? No? Council members, do you have any comments about that section? Okay.

And just one of the -- just to kind of go over very, very quickly, one of the changes that -- we are in the process of gathering research to come up with any curriculum framework or guidelines for offering a reduced two-year program for individuals that have prior nursing training

or prior midwifery training, things of that nature. So we're still in the information gathering stages for that. We've contacted the Florida Department of Education and gotten a little bit of information from the public school side of the Department of Education.

The Commission on Independent Education didn't -- they don't do -- apparently, they don't do curriculum frameworks. So they didn't have any information but were able to put me in touch with the individuals from the public school section. So she sent me information so the council will be having to discuss that in a little more detail at our next meeting. But I just want to make sure that -- to see if anybody has any feedback regarding that at this point. No.

And then again, we are clarifying the -- initially, the rule with respect to the accreditation section of approving the training programs we initially, did not have a timeframe specified in rule for how long a school or program could remain provisionally approved. And that was not the intent of the provisional approval status. So what we are actually recommending based on consensus from the last council meeting is that we

allow a school to remain provisionally approved for five years.

I realize the draft that you have says three years. But we are recommending five years, because we received testimony at the last meeting indicating that even though the training portion, or the training program itself, is typically three years in length, you know, getting all of the clinical experience in verse may take additional time outside of that three years just because there's limited availability and preceptors and things of that nature. We are going to recommend changing that to five years. And I think that was pretty much the major change in that section.

MS. CONORD-MORROW: Direct supervision was not defined completely at our last meeting.

(Wherupon, the court reporter asked for clarification.)

MS. ROBINSON: You are correct. We are still tweaking out also the definition of "direct supervision." Is that -- we have others in that section -- because one of the things that the council discussed at their last meeting was whether or not -- if we have a delineation between indirect supervision of clinical experiences

versus indirect -- or direct versus indirect, sorry. We are probably going to have to specify which procedures need to be done under direct versus indirect,

So we are still gathering information on those topics as well. And again, we'll, you know, we'll bring all that back to the next council meeting. But if anybody in the audience has any feedback regarding that, we'd love to hear it.

Okay. Next, is 24-5, License Status. The changes in these particular set of rules really is just cleaned up language, just removing language that's repetitive, because it's already in the statute. It just -- there's really nothing substantive that we changed in that section. But just to be official, Michelle Ruffalo, do you have any comments on that section?

MS. RUFFALO: No. But I do have a comment on the previous section. I'm sorry.

MS. ROBINSON: It's okay. We can go back.

MS. RUFFALO: It skipped ahead. I'm sorry. I'm looking at the numbers just trying to make it all match. I apologize.

MS. ROBINSON: Do you want to come up --

MS. RUFFALO: I apologize. It's my first

time.

MS. ROBINSON: It's ours, too.

MS. RUFFALO: Okay. So I'm going back to 64B24-4010, the Four-Month Pre-Licensing Course.

MS. ROBINSON: Okay.

MS. RUFFALO: I know that Kathy or Melissa had talked about defining the term "supervised." One of the provisions that we wanted to have added into that was that provisions for supervised labor, post-partem, newborn exams, intro-partem, post-partem to be equivalent or exceeding the non-requirements by each participant.

MS. MATTOX: So you're talking about the -- the 4.010 --

MS. RUFFALO: Uh-huh.

MS. MATTOX: -- about the --

MS. CONORD-MORROW: The C?

MS. MATTOX: C. Yes. You're talking about changing that one --

MS. RUFFALO: Uh-huh.

MS. MATTOX: -- to read what? Repeat again.

MS. RUFFALO: The provisions for supervised labor, supervised post-partem, supervised newborn exams and deliveries, and supervised prenatal visits equivalent or exceeding the NARM

requirements by each course participant with a Florida preceptor and completed within the state of Florida. A lot of this is some of the stuff that was talked about in the council meeting before.

MS. ROBINSON: And I'll go over this again at the end. But for those of you that have very specific comments with, you know, how you want a particular section of a rule to read, it would be really helpful if you could forward that to me via e-mail just so that we have it. But I'll go over that again.

MS. RUFFALO: Absolutely.

Robin, what was your question?

MS. MATTOX: So is that just making sure that they already have equivalent of that experience, or going back to repeat or having them do the number of requirements? It sounds like --

MS. RUFFALO: No. It's to make -- it's to have them do --

MS. MATTOX: Again, in Florida -- in Florida --

MS. RUFFALO: Not necessarily the 50. You know, we're not talking 50, what someone is coming -- or, you know, in a MEAC accredited program.

But if someone who is coming from another country, you know, who -- an OB in particular, you know, who's to say that they have any out-of-hospital experience. So it would be, you know, for that pre -- that licensing circumstances that, you know, we would -- that they would be with a Florida preceptor and that they would actually have to have some supervised prenatals, labors, post-partems, everything.

MS. CONORD-MORROW: Including what -- NARM standards, so that's all of --

MS. RUFFALCO: Or Florida standards. Correct.

MS. CONORD-MORROW: So that would be all of our clinicals.

MS. RUFFALO: Right. But not -- I'm not saying 50. We're not saying like 50, but we're saying like, you know, 10, you know -- or, you know, that they have to -- they, you know, they can't just come in and take the licensing course and then go take the NARM? And, you know, go open a birth center in Miami. Sorry.

So -- so it's just to kind of, you know, make sure that you know who their preceptor is, just kind of say, okay. You know, I can sign off with

a good conscience that this person does know how to, you know, treat women with -- you know, prenatally and they do have a -- you know, they are competent for labor and delivery and post-partem. So that's what, you know --

MS. MATTOX: In and out of hospitals though?

MS. RUFFALCO: In and out of hospitals, that's correct.

MS. MATTOX: So possibly requiring the NARMs requirements, but not the full Florida --

MS. RUFFALO: Correct.

MS. MATTOX: -- clinicals, which are less -- it's 40.

MS. CONORD-MORROW: It's 40 --

MS. YOUNG: Does that have a different requirement for, like, midwives who are physicians? Or maybe that's something --

MS. ROBINSON: So but -- just -- NARM does have specific requirements on this -- for this area?

MS. YOUNG: For the CPM.

MS. ROBINSON: All right.

MS. MATTOX: And we addressed this quite a bit at the council meeting. And -- okay.

MS. CONORD-MORROW: We agree these are

little requests, but that seems like repeating the same thing that we do for another practitioner from another country. Say from England, a licensed midwife who's come from there and she's already done this work, and then we're asking her to repeat the entire NARMs again in Florida.

MS. YOUNG: I think the concern is that they -- that yes, somebody who equivocally trained, or just, like someone from England, not a problem.

MS. CONORD-MORROW: But if we put in there, done in Florida with a Florida preceptor, they wouldn't have to repeat everything all over again. That's restrictive for someone who is trained.

MS. RUFFALO: Well, equivalent, I think, is the key word in out-of-hospital, because, you know, if they're in England and they're, you know, with the Royal College of Midwifery and they're practicing, they are -- you know, a lot of them are practicing out-of-hospital and in-hospital. But if we have other physicians who are coming from somewhere else who have never stepped outside of a hospital or never stepped into a birth center, and then all of the sudden they're, you know -- and we know that this is something that has happened in our state, that they've come and

gotten their four-month licensing program, you know, and, you know, that's their goal, is to come in and practice, you know.

MS. MONDESIR: Are you we talking about the pre -- the four month -- okay. We went over this when we were discussing what the numbers were that we were going to accept, and we decided that it has to be, right, than what's already written down. We just haven't locked in what the numbers are.

MS. RUFFALO: Right. Right. And I'm just -- as -- we're just requesting that -- that language.

MS. MATTOX: That's the language that you're requesting.

MS. RUFFALO: It's the same language that you guys have already -- yes.

MS. MATTOX: That's very different language than what we proposed.

MS. RUFFALO: Is it? Okay.

MS. MATTOX: Yeah. It's very different language but, you know, I understand.

MS. RUFFALO: Okay.

MS. ROBINSON: But what we will do is as -- as we get testimony and comments from the

interested parties here, like I said, we will consider all of these comments. We'll bring it back to the council at our next meeting at a date to be determined. We're still working on that. And then, we'll, you know, we'll hash out what the language needs to be.

MS. RUFFALO: Okay. Absolutely. Thank you.

MS. ROBINSON: So are we ready to move on to 24-5, License Status?

Okay. So Michelle, you didn't have any comments on that section --

MS. RUFFALO: No, ma'am.

MS. ROBINSON: What about Kristen Phillips?

MS. PHILLIPS: No.

MS. ROBINSON: Okay. Kim Stuart or Laura?

MS. STUART: We'll let you know if we have a comment. How about that?

MS. ROBINSON: Okay.

MS. MCLAFFERTY: So you don't have to keep calling our names.

MS. ROBINSON: Okay.

MS. MCLAFFERTY: We just signed it just in case we had a comment.

MS. ROBINSON: Got you. All right.

(Whereupon, the court reporter asked for

speaker's name.)

MS. ROBINSON: Okay. And council members, do you have any questions, comments? Again, that was just mostly clarification and streamlining that section.

All right. All right. The next section is 24-6, Continuing Education. Again, this is mostly streamlining and clarification of language. Also -- oh, yeah. We did some clean-up with respect to the performance of pro bono continuing education services, and then, also, some clean-up regarding the program requirements. So does anyone have any comments about that section?

MS. BARNES: We're on six?

MS. ROBINSON: Yes.

MS. BARNES: Madam Chair, can I pose a question to the midwives that are here? Twenty hours of continuing medical education for two years, it seems to me to be a small number. I wonder if that seems an adequate number?

MS. MCMULLEN: It's actually set in statute. The legislature made that decision for us.

MS. BARNES: All right.

MS. ROBINSON: Any of the interested parties have comments about that section?

Okay. Council members?

MS. MATTOX: I just wanted -- on the criteria for education programs, 6.005 I think it is, it was just talking about the -- taking out the video cassette for approved courses on electronic media. Does that include computer-based training?

MS. MCMULLEN: Does it include what?

MS. MATTOX: Computer-based -- it's continuing education --

MS. MCMULLEN: That was the purpose of the change, so that you could get it online and in other ways. Video cassette is sort of an outdated term.

MS. MATTOX: Right. And it was just a maximum of five hours per subject. So I just wanted to make sure --

MS. MCMULLEN: That's set in statute. They limit the amount of time that you can get the out-of-classroom, you know, continuing education. So we're kind of stuck with that.

MS. MATTOX: Thank you for that.

MS. BARNES: I have a question about number 6.005, also. Is -- why do we have to have a minimum one-clock hour in duration? Are there not

programs that would be 30 minutes that would be valuable programs?

MS. MCMULLEN: There probably are, but that's true across all professional health care. A one-clock hour is at least 50 minutes and that's typically the way they're measured. So -- and I think that that also is in statute.

MS. ROBINSON: I was going to say I thought it was too.

MS. RODGERS: I have a question then. You're saying that they have to be at least one-clock hour in duration. Can they be 1.5?

MS. MCMULLEN: Sure.

MS. RODGERS: Okay.

MS. MCMULLEN: But you can't have but 30 minutes. That's -- that's the issue you can't have less than -- less than one.

MS. ROBINSON: Any other questions or comments?

All right. The next rule section is 24-7, Midwifery Practice. When we were going through and coming up with the proposed changes to these rules as part of our process, you'll notice that we did not spend -- we did not recommend a whole lot of changes to this particular section, because

as department staff, we're not the experts in the standard care for midwifery practice.

We talked about these rules at length at our meeting last time, and we still have a lot of research to do in these areas. Specifically, some of the focused areas were the risk assessment criteria, responsibilities of the midwife. We had some discussion about the malpractice insurance requirement, which we're actually going to revisit because we found some additional information. And then, also, lots of discussion regarding the requiring an annual report to be submitted by all licensed midwives. So I'm going to ask interested parties, if anyone is interested in commenting on any of these rules.

MS. RUFFALO: Should we have a lot, then we'll put it in writing and, you know, we'll make sure that you have it in writing since there is still research going on.

MS. ROBINSON: Yes.

MS. RUFFALO: So we'll do that. We'll submit it in writing.

(Whereupon, the court reporter asked for speaker's name.)

MS. ROBINSON: Okay. Kristen, does that go

for you, also?

MS. PHILLIPS: Yeah.

MS. ROBINSON: Anybody else? Do the council members have any discussion points at this point?

MS. CONORD-MORROW: There was the historical aspect with risk assessment, and I was able to find out that it was from the maternity center from Manhattan in the early 1900s, but also used later in the '70s, I believe. Like, that was drawn from their research, that was a program that was -- or an organization that was alive and well during that time, and it was moved forward. And then, they drew that information from the '70s, I guess, from that -- what they were considering risk in maternity care at that time.

MS. ROBINSON: So do we know if that is a document that has been changed over the years or --

MS. CONORD-MORROW: I believe they just abstracted the information and made this.

MS. ROBINSON: Okay. Any other comments?

All right. Moving along, the next rule is 64B24-8. These are your disciplinary guidelines. We are actually going to try to change the format of the guidelines by -- rather than having them

listed in the rule language itself, we are going to try to incorporate them by reference, similar to what we do with applications and other forms requiring a rule. We also are going to be looking at the validity and appropriateness of the existing penalty guidelines and adding mediation requirements. And note, there is a representative from the department's Prosecution Services Unit.

Do you have any comments or concerns on that? Okay.

MS. SYKES: I do not.

MS. ROBINSON: Okay.

MS. MCMULLEN: Let me say this, that the guidelines chart that was -- that you received with the draft rule, that doesn't reflect the existing -- the existing penalties. There is another table that's on the -- that's on the table in the back that has the existing penalties so you can run through that and look at that.

One of questions we have is, are the existing penalties appropriate for the circumstances in today's world? So at some point, if you all would grab one of those, you can look at that. But the chart that you have doesn't reflect the -- as it exists now -- or the rule as it exists now.

MS. ROBINSON: Do any interested parties have any comments or feedback regarding the disciplinary guidelines or the proposed mediation rule?

Do council members have any comments?

MS. CONORD-MORROW: Christy, where is the -- the proposed mediation?

MS. ROBINSON: On the back, the very back.

MS. MCMULLEN: That's a statutory requirement. There's another section of 456 that requires that all boards and councils provide for mediation, and that had been left out previously in the midwifery rules; so now it's being inserted to comply with the statutory requirement.

MS. ROBINSON: No comments on the disciplinary rule?

All right. So --

MS. CONORD-MORROW: Could you possibly explain how the mediation would be applied in a circumstance -- how is this used? Is -- I mean, I understand what mediation is, but is that a legal representative? Is that someone who the community -- is that some -- how does that work?

MS. MCMULLEN: You would have a mediator assigned. Probably would be someone from the

department. And you can have representation. You bring your lawyer, or not. But basically, it's a negotiation process where you arrive at a mutually acceptable penalty for whatever the violation was.

MS. CONORD-MORROW: How is that different than what we already do?

MS. MCMULLEN: Essentially, probably at the end of the day, it's not much different, because if you go through the disciplinary process, there -- there very well may be a settlement negotiation that goes on for a recommended settlement of the administrative complaint that's filed against the -- the department would file a complaint against the licensed midwife.

And there may be a settlement negotiation that goes back and forth where the licensed midwife would offer mitigating circumstances. You know, yes, I did this, but I also have this, this, and this. And the department would come back and say, okay. We'll take that into consideration, so we'll reduce the fine from this to this, and we'll reduce the probation from this to this.

And then, if that's acceptable to the licensed midwife and they agree, and then that settlement is then presented to the department.

And the department can accept it or reject it. So that's the way it would normally work. So in any of the disciplinary processes, typically, there is some give and take in the punishment level. It's just that mediation -- you just go straight to mediation. You basically say, yes, and -- you know, I did this. There's no question of facts. Let's just mediate and be it whatever the disciplinary punishment is going to be.

MS. BRADLEY: At what point is it ever, and where and what is public knowledge since we're charged with, you know, safety of mom, baby, on behalf of the state?

MS. MCMULLEN: It becomes public when a complaint is filed that's confidential -- and it stays confidential through the investigatory stages. It becomes public 10 days after probable cause is found. And it goes to a probable cause panel, who evaluates the complaint, the evidence that's been collected, and all of the evidence that's available. And then the probable cause panel makes a determination that, yes, there's probable cause here, we can go forward, or there is no probable cause and it ends.

If there is probable cause, then they'll make

a finding of probable cause. Ten days after that finding, it becomes public. It goes up on the department's website. If there is no finding of probable cause, that's the end of it, and that complaint and everything that happened with regard to that complaint stays confidential.

It's kind of like the criminal process where, you know, you have an arraignment and -- you know, where they say yes, there's enough evidence to proceed to the next step, which is with trial. So that's essentially the way it works. It's 10 days after probable cause when it becomes public.

MS. CONORD-MORROW: And how long is that from the time of the complaint?

MS. MCMULLEN: Could depend. Each case is -- turns out its own facts. Sometimes it takes longer than others to investigate. The investigators -- department of investigators actually go out and gather evidence, interview witnesses, and sometimes it happens very quickly. Sometimes it will take months, so it just depends.

The person complained against is notified that the complaint has been filed so they're aware from the very beginning. They're not allowed to share that with anybody because it's still

confidential. But that's the way the disciplinary process works. Some of the more complicated cases that require -- that have voluminous records, for instance, medical records that require a lot of review, can take longer than others.

MS. ROBINSON: I would actually like to go back to 64B24-7, the Midwifery Practice Section. I know you said you had -- Laura and Michelle, you had written comments.

MS. RUFFALO: We did.

MS. ROBINSON: But if you are prepared, we would -- I think we would like to hear if you're able to give us some comments, because that might help jar our thought process with respect to where we need to be conducting research, and that type of thing might be very, very helpful.

MS. RUFFALO: Okay.

MS. ROBINSON: We have plenty of time.

MS. RUFFALO: All right. I'm Michelle Ruffalo, representing the Midwives Association of Florida. Okay. The definitions in 7.001. So in our -- for consultation, "Communication" -- what it states now is "Communication between a licensed midwife and a health care provider for the purpose of assessing a potential or actual problem

relevant to the patient."

We would like to have on record that a discussion could be between -- a situation between the midwife seeks advice or information from another midwife, an ARNP, or a physician about a clinical situation presenting her management plan for feedback.

MR. MCMULLEN: Presenting her management plan for --

MS. RUFFALO: Feedback. So basically presenting the plan and then getting the feedback from them. And granted, this is clean up.

Just -- for consultation, "A consultation refers to a situation in which the midwife, using her professional knowledge of the client, in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that lead to the consultation. In providing care, licensed midwives and physicians will take into account their patient's informed choices."

Number 3, Transfer. "When care is

transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making together with the client."

So according to this -- according to what our law says now in Transfer, we transfer means it's a formal dissolution of care. For ours, we're saying that it could be permanent, but it could also be temporarily, and the physician allows the client to come back in the care.

The Risk Assessment --

MS. MATTOX: So you're bringing in four definitions instead of three, right? Discussion, Consultation, and Referral and Transfer?

MS. RUFFALO: Uh-huh.

MS. MATTOX: Where your collaborative management would be under Referral?

MS. RUFFALO: Uh-huh.

And then -- I'm sorry. And then it's broken down into pre-existing conditions and, you know, conditions that would require a discussion, conditions that would require a consultation, and conditions that would require a transfer. And we have it broken down into pre-existing,

ante-partem, inter-partem, and post-partem, also. So specific conditions which would require discussion, consultation, referral, transfer.

MS. BARNES: And that would be to replace the, like, long list --

MS. MATTOX: The risk assessment -- the point system.

MS. RUFFALO: Correct.

MS. MATTOX: It would be replacing the point system.

MS. RUFFALO: Correct.

MS. MATTOX: And this -- can you give us, Michelle, the history of where that came from?

MS. RUFFALO: It came from multiple conference calls with members of the Midwives Association of Florida, pulling from different, you know, all the midwives' experiences, and that's where it came up from.

MS. YOUNG: Did you guys use any guidelines?

MS. RUFFALO: Well, we had -- I mean, we had our guidelines for this, you know, the MANA Core Competencies and the ACNM.

MS. YOUNG: Okay.

MS. MATTOX: Is there any other systems that function under that set of rules? Probably not.

Not that you know?

MS. RUFFALO: Not that I know of. And then, instead of -- that's why I said instead of listing every single one individually, that's why I was -- said we could submit it in writing.

MS. BARNES: Do you have it in electronic format now?

MS. RUFFALO: I do. Yes.

MS. BARNES: Is there any way we can disseminate it and look at it now?

MS. ROBINSON: Well, I don't have internet on.

Do you know what the password is.

MS. RUFFALO: Well, Robyn, you were able -- I got yours on. I can --

MS. MATTOX: I don't have my air card.

MS. ROBINSON: Okay.

MS. MCMULLEN: First of all, let me explain. This is not -- we're not here to debate this. We're not here to debate whether this is good or bad. This is testimony that she's offering. So it's not appropriate in a workshop to discuss it.

MS. RUFFALO: Okay.

MS. ROBINSON: When she -- when she sends us her written comments, we'll disseminate it to

everyone so you can see it so that we can discuss it at the next meeting.

MS. MCMULLEN: The time for discussion will be at the next council meeting.

MS. RUFFALO: Okay.

MS. MCMULLEN: It's appropriate to ask questions, you know -- and, you know, to -- so that you understand what her testimony is. But now is not the time we're going to say, well, why don't we do it this way, this way, or this way.

MS. RUFFALO: And again, as you guys are researching, we are researching, too, to try and find what is going to, you know, move us forward into the future.

MS. MATTOX: Can you give us an example of each one of your sections? Could you just give --

MS. RUFFALO: Give a quick example --

MS. MATTOX: Like, a couple of examples on what would be considered a consultation, or reason for referral, reason for transfer?

MS. RUFFALO: Absolutely. So I'll just start with ante-partem real quick. So discussions -- so under "Discussion" would be, you know, something like urinary tract infections that are unresponsive to treatment, or well-controlled

gestational diabetes, persistent -- discrepancies for discussion.

And consultation would be significant abnormal pap in the current pregnancy, pyelonephritis, thrombosis, you know, unresolved polyhydramnios or oligohydramnios.

And then, transfer would be premature, pre-labor rupture of membranes, someone who has developed health or preeclampsia, placenta previa at 32 weeks gestation or an ectopic pregnancy. I mean, that's just an example. And again, it's a work in progress. So basically, they took from the risk assessment, and instead of doing points, added it into different categories.

MS. YOUNG: Same as the MANA guidelines.

MS. RUFFALO: Uh-huh.

MS. RODGERS: I have a question. Is anyone still using the point system?

MS. RUFFALO: Everyone uses the point system.

MS. RODGERS: But you're suggesting not to use it?

MS. RUFFALO: Uh-huh. That's correct.

MS. MATTOX: As far as I know, there -- as far as I know, there's no other system like that.

I think Florida's the only one that uses this type of point system. This is kind of an outdated system.

MS. RUFFALO: From the 1900s.

MS. BRADLEY: So the other systems that are used is it -- if you -- within those categories, if somebody -- it has that one category and it's transfer out or --

MS. YOUNG: It's broken down. Just like Michelle was explaining their suggestions, it's broken down. Like, if these things come up, then you need a consultation. If these things come up, then you need to have collaborative management. If these come up, they shouldn't be in your care, period. So it's very clear, direct. Yes.

MS. RUFFALO: And if someone has gestational diabetes or they -- or they're borderline and they're seeing a dietitian, and they're being -- have well-controlled and they're doing their finger sticks, and a physician is consulting and collaborating, then, you know, that would be -- whereas now, it's a transfer. So --

MS. YOUNG: Well, and then on the other side of that, there's things that are -- are risk assessment that, you know, they really should not

be not be in our care. But according to the law, we could get a consultation and they would send them right back. So I mean, it's both directions, which is sometimes a problem.

MS. ROBINSON: Thank you.

MS. YOUNG: Christy, would you like me to send this to your address?

MS. ROBINSON: Yes. Absolutely. Yeah.

Is there any other rule or language that anybody would like to revisit before we finish?

All right. So again, any interested parties that have interested comments, you can e-mail those to me. My e-mail address is up on the board. If you could please submit them to us within the next 10 or so days, because what we'll do is we'll compile all the comments, in addition to the testimony we've heard here today, to get that ready to present to the council at their next meeting. We don't have a date yet, but whenever that is.

And then we will obviously consider all comments that we have received here today and that we will receive via e-mail, or you can mail them, also. And once -- yeah. Once we have all of that, we can start looking at coming up with

proposed draft language to incorporate comments and, you know, bring all that back to the council with further discussion, tweaks, if necessary. And I appreciate everyone coming today and thank you for your time and look forward to getting feedback from you via e-mail.

(Whereupon, the proceedings were concluded 10:04 a.m.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, SCHEDALE L. WOODS, Court Reporter and Notary Public, do hereby certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages numbered 3 through 45, are a true and correct record of the aforesaid proceedings.

I FURTHER CERTIFY that I am not a relative, employee, attorney or council of any of the parties, nor relative or employee of such attorney or counsel, or financially interested in the foregoing action.

Dated this 27th day of April, 2015.

_____
SCHEDALE L. WOODS
FOR THE RECORD REPORTING
1500 Mahan Drive
Tallahassee, FL 32308
(850)222-5491

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MEMORANDUM

To: Council of Licensed Midwifery

From: Daisy King, Program Operations Administrator, Council of Licensed Midwifery

Date: June 30, 2015

Re: **2016 Proposed Midwifery Meeting Dates and Deadlines**

Below please find the proposed meeting dates and agenda deadlines for the **2016 Council of Licensed Midwifery** meetings. Please note meeting dates are subject to change.

All meetings will be held by conference call **with the exception of the August 16, 2016** meeting which will be a face to face meeting.

Conference Call Number: (888) 670-3525 | Participant Passcode: 1802593023

Meeting Date	Material Deadline	Board Office Administrator
February 8, 2016	01/06/16	**Andrew Hood** Discs mailed 01/09/16
June 6, 2016	05/06/16	**Andrew Hood** Discs mailed 05/09/16
August 16, 2016	07/16/16	**Andrew Hood** Discs mailed 07/19/16
October 3, 2016	09/03/16	**Andrew Hood** Discs mailed 09/06/16

Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin C-06 • Tallahassee, FL 32399-3251
PHONE: 850-245-4444 • FAX: 850-412-2681

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FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh

The following rule material will be forthcoming under separate cover as soon as possible.

Rule Discussion:

4. 64B24-1 Organization
5. 64B24-2 Requirements for Licensure
6. 64B24-3 Fees
7. 64B24-4 Training Programs
8. 64B24-5 Renewal, Inactive Status, Reactivation
9. 64B24-6 Continuing Education
10. 64B24-7 Midwifery Practice
11. 64B24-8 Discipline

Robinson, Christy

From: Robyn Mattox <robyn@midwife.cc>
Sent: Friday, May 29, 2015 3:13 PM
To: Robinson, Christy
Subject: RE: Midwifery Council Request

Hi Christy, Did you receive my email a few weeks ago about the letter I received in the mail RE: Oath ? I have it attached again.

Also on Data points – so far the only thing I can see to add to the list is water birth.

I would like to track how many water births are done each year. And have it be an option net to newborn transfer whether it was a water birth.

There has been much debate in the midwifery community about what data points to collect – so what a lot of detail – like whether an IV was required in labor or PP etc... and others want no detail at all – they don't even like the idea of data collection – so the debate continues in the community. I think the midwives feel the state is "after them" and wanting us to collect data for the purpose of getting rid of midwives. Anyway – luckily that is in the minority.

So you have all my data points I suggested on the form I submitted – so I would just add # of water births to the list and then have place to put next to newborn transfer whether it was a Water Birth. Oh and # of mothers requiring suturing.

I ideally I would love for the statistics to reflect our good work and that we are safe practitioners, so picking data points is actually kind of hard – I would have it be 10 pages long! LOL If I think of any more I will let you know!

Any news one the next meeting?

Robyn Mattox

From: Robinson, Christy [mailto:Christy.Robinson@flhealth.gov]
Sent: Thursday, May 28, 2015 5:20 PM
To: 'celebratebirthmidwifery@gmail.com'; 'Charlie Rae Young LM, CPM, CLC '; 'Robyn Mattox, Midwife'; 'tania_mondesir@yahoo.com'; 'kathybradley5@yahoo.com'; 'Stephanie Wombles CNM'; 'davestewartmd@gmail.com'; 'Dana Barnes'; 'R Zachary Pearson-Martinez'
Subject: Midwifery Council Request

Good afternoon all! I hope this email finds you all doing well and enjoying your spring/summer! In preparation for the next Council meeting (date to be determined), I am soliciting your research, feedback and suggestions regarding the several rules that need to be created or amended. In particular, I would really like to get everyone's feedback and ideas regarding the data points that should be collected for the new **annual report**.

Please provide your comments by Friday, June 12 if possible. As always, if you have any questions please let me know!!! Thanks!

Christy Robinson
Executive Director
Boards of Osteopathic Medicine, Speech-Language Pathology and Audiology, Massage Therapy, Acupuncture and the Council of Licensed Midwifery
(850) 245-4162 - phone
NEW EMAIL ADDRESS: Christy.Robinson@flhealth.gov

Robyn's Draft

STATE OF FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

LICENSED MIDWIFE ANNUAL REPORT

Report data from January 1 through December 31st of each calendar year. Reports are due within 30 days.

SECTION 1: PRACTICE INFORMATION

1. PRACTICE NAME: _____

ADDRESS: _____

_____

3. List Each Licensed Midwife in the Practice	License Number	Number of Deliveries during the Reporting period

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

Section number			Total(s)
2	A	Total number of maternity clients accepted for care in the reporting period:	
	B	Total number of deliveries in the practice during reporting period:	
	C	Total number of licensed midwife student assigned to the practice during the reporting period	
	D	How many delivered at: Home: ____ Birthing Ctr: ____ Hospital: ____	
	E	Number of Planned: Breech: ____ Twins / Multiples ____	
	F	Number of Planned VBAC: # of Primary VBAC: ____ # of Subseq. VBAC: ____	
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.

Date : _____

Signature of Practice Representative: _____

Print Name: _____

Title: _____

Telephone Number: _____

Email Address: _____

Information obtained as of 4/23/15

Reporting:

- Washington State Rule WAC 246-834-270- Mandatory Reporting
- Contacted MANA to see what information they collect

Practice Guidelines:

- Recommendation from Dr. Barnes
- Health Net 2015 Prenatal/Perinatal Health Guidelines (received from Ms. Young)
- Midwives Association of Washing State Indications for Discussion, Consultation and Transfer

Student Clinical Experiences

- Washington State Rule WAC 246-834-230- Preceptor for Midwife-in-Training Program
- NARM Policies on Preceptor/Apprentice Relationships
- NARM Guidelines for Documentation of Clinical Experience
- NARM Preceptor Registration Form

Training Programs:

- Florida Department of Education Public School Curriculum Framework for AS Degree
- Washington State Rule WAC 246-834-140- Curriculum
- Washington State Rule WAC 246-834-130- Staffing and Teacher Qualifications
- Washington State Rule WAC 246-834-150- Students
- Contacted MEAC for information

Emergency Care Plan:

- Sample form (received from Ms. Young)

WAC 246-834-270

Agency filings affecting this section

Mandatory reporting.

(1) All reports required by this chapter shall be submitted to the department as soon as possible, but no later than twenty days after a determination is made.

(2) A report should contain the following information if known:

(a) The name, address, and telephone number of the person making the report.

(b) The name and address and telephone numbers of the midwife being reported.

(c) The case number of any patient whose treatment is a subject of the report.

(d) A brief description or summary of the facts which gave rise to the issuance of the report, including dates of occurrences.

(e) If court action is involved, the name of the court in which the action is filed along with the date of filing and docket number.

(f) Any further information which would aid in the evaluation of the report.

(3) Mandatory reports shall be exempt from public inspection and copying to the extent permitted under RCW 42.17.310 or to the extent that public inspection or copying of the report or any portion of the report would invade or violate a person's right to privacy as set forth in RCW 42.17.255.

(4) A person is immune from civil liability, whether direct or derivative, for providing information to the department pursuant to RCW 18.130.070.

[Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.130.070. WSR 89-14-092 (Order PM 842), § 308-115-270, filed 6/30/89.]

From:	Barnes, Dana
To:	Robinson, Christy; "celebratebirthmidwifery@gmail.com"; "Robyn Mattox, Midwife"; "Charlie Rae Young LM, CPM, CLC "; "kathybradley5@yahoo.com"; "tania_mondesir@yahoo.com"; "Stephanie Wombles CNM"; "R Zachary Pearson-Martinez"; "davestewartmd@gmail.com"
Subject:	64B24-7.007
Date:	Friday, April 17, 2015 1:22:52 PM

Here are my suggestions for changes to this section, only suggestions of course(!), as a work in progress by all:

Responsibilities of Midwives During Antepartum:

The LM shall require every patient to have the following minimum antepartum care, however, if after thorough counseling and discussion the mother refuses one or more components of care, and the midwife determines that care may safely proceed, the midwife may continue providing prenatal care, appropriately documenting any refusal in the health record: (Dr. P-M will need to fix my grammar here☺)

1st trimester (or as early as possible upon entry into care for those entering care late):
Complete medical, surgical, social, and family history
Complete Physical exam
Ensure Healthy Start Prenatal Screen completed
Assessment for expected date of delivery, if this cannot be accurately determined, refer for ultrasound measurements
Blood pressure measurement at every visit, medical consultation if abnormal
Blood type and Rh(D) antibody screen, medical consultation if Rh sensitization
Hepatitis B screen
HIV test, medical referral if positive
Syphilis screen
Gonorrhea and Chlamydia screen
Urine culture
Tobacco use screen and cessation counseling if positive
Cervical cancer education and screening if indicated
Hemoglobin, medical consultation if <10
Platelet count, medical consultation if <140,000
Folic acid requirement counseling
Nutrition, dietary supplement, and exercise counseling
Herpes Simplex Virus education, medical consultation if active lesions or history of frequent recurrence

2nd/3rd Trimesters:
Blood pressure measurement at every visit, medical consultation if abnormal
Fundal height and Fetal Heart tone measurement at every visit
Antibody screen if Rh(D) negative, administer RhoGAM prophylaxis if negative or medical consultation if positive
Breastfeeding education and counseling

Gestational diabetes screening between 24-28 weeks, medical consultation if positive
Herpes Simplex Virus education, medical consultation to consider prophylaxis if any history
Group B strep screen, between 35-37 weeks, medical consultation if positive
Syphilis, Gonorrhea, Chlamydia, HIV, Hepatitis B screening if at increased risk, referral if appropriate
Visits at least weekly after 36 weeks with determination of fetal presentation, medical consultation if non-vertex presentation
Education regarding risks of post term pregnancy starting at 41 weeks, medical consultation by 42 weeks

The following additional care is recommended, but may be opted out of after thorough counseling and education regarding potential benefits and risks:
Pelvic exam
Visits at least every 4-8 weeks until 28 weeks, then every 2-3 weeks until 36 weeks
Maternal weight at every visit
3rd trimester Hemoglobin, medical consultation if < 10
Education regarding available antepartum screening tests for neural tube defects, sickle cell disease, and other genetic abnormalities
Education regarding screening fetal ultrasound
Education regarding maternal vaccinations: influenza, tetanus, pertussis, varicella, and rubella

Thanks all, Dana B

From: Robinson, Christy [mailto:Christy.Robinson@flhealth.gov]
Sent: Wednesday, April 15, 2015 4:50 PM
To: 'celebratebirthmidwifery@gmail.com'; 'Robyn Mattox, Midwife'; 'Charlie Rae Young LM, CPM, CLC '; 'kathybradley5@yahoo.com'; 'tania_mondesir@yahoo.com'; 'Stephanie Wombles CNM'; 'R Zachary Pearson-Martinez'; Barnes, Dana; 'davestewartmd@gmail.com'
Subject: Data Points for Annual Report

Good afternoon! Don't forget to email us your suggestions for the collection of the annual report data. I know many of you won't be able to attend the rules workshop, but I want to be sure to capture everyone's ideas for discussion!

Thanks!!!

Christy Robinson
Executive Director
Boards of Osteopathic Medicine, Speech-Language Pathology and Audiology, Massage Therapy, Acupuncture and the Council of Licensed Midwifery
(850) 245-4162 - phone
NEW EMAIL ADDRESS: Christy.Robinson@flhealth.gov
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
Attention Health Care Practitioners*: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.*

Mission: **To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.**

Vision: To be the **Healthiest State** in the Nation**.**

Values: I CARE

Innovation: We search for creative solutions and manage resources wisely.

Collaboration: We use teamwork to achieve common goals & solve problems.

Accountability: We perform with integrity & respect.

Responsiveness: We achieve our mission by serving our customers & engaging our partners.

Excellence: We promote quality outcomes through learning & continuous performance improvement.

Purpose: To protect the public through health care licensure, enforcement and information.

Focus: To be the nation's leader in quality health care regulation.

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to Department of Health Executive Staff Office the public and media upon request. Your email communication may therefore be subject to public disclosure.

Health Net

2015 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
The first prenatal visit should be within the first 12 weeks of pregnancy	Visits should be every four weeks *	Visits should be every two weeks*	Visits should be weekly *
Complete physical exam, including review of systems	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment • Fetal presentation
Complete medical history of expectant mother including menstrual history and previous pregnancies	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Genetic screening/counseling of expectant mother and father and any pertinent family history	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Lab tests: • Blood group and RH type • Antibody screen • Complete blood count • Varicella • Rubella	Lab tests (when indicated) • Repeat antibody tests in unsensitized, D-negative patient at 28-29 weeks and prophylactic anti-D immune globulin should be administered. • Screen for gestational diabetes	Lab tests: • Hct/Hgb • Screen at 35-37 wks for Group B strep Additional Lab tests (when indicated): • Ultrasound	

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
• VDRL/RDR (syphilis) • Urinalysis • Urine culture & sensitivity • Chlamydia Screen • Hepatitis B surface antigen • Cervical cytology (as needed) • Human immunodefiency virus (HIV) counseling/ testing (offered)	mellitus at 24-28 wks • Repeat hematocrit & hemoglobin • The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.	• VDRL • Gonorrhea • Chlamydia (Women younger than 25yrs or at high risk) • HIV (Women at high risk for HIV)	
Optional lab test offered or recommended based on history: (May not be all inclusive) • Hemoglobin Electophoresis • PPD • Gonorrhea • Screen for Cystic Fibrosis • Tay-Sachs Genetic screening tests • Ultrasound at 8-10 weeks (when indicated) • Prenatal genetic diagnosis • Mantoux tuberculin skin test or interferon –gamma release assay	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.
• 1st trimester aneuploidy risk assessment • MSAFP/multiple markers** • Patients at increased risk of aneuploidy can be offered	Integrated screening or sequential screening should be offered to women who seek prenatal care in the first trimester.		

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
testing with cell free fetal DNA after pretest counseling and informed patient choice (Cell free fetal DNA testing should not be part of routine prenatal laboratory assessment, nor should it be offered to low risk women or women with multiple gestation) **All women presenting for prenatal care before 20 weeks of gestation should be offered screening for aneuploidy. All women, regardless of age, should have the option of invasive prenatal diagnosis (ie, CVS or amniocentesis) for fetal aneuploidy. Cell free fetal DNA does not replace the accuracy and diagnostic precision of prenatal diagnosis with CVS or amniocentesis, which remain an option for women.	Integrated screening uses both the first-trimester and second-trimester markers. Results are reported only after both first- and second-trimester screening tests are completed. In sequential screening, the patient is informed of the first-trimester screening result. Those at highest risk might opt for an early diagnostic procedure and those at lower risk can still take advantage of the higher detection rate achieved with additional second-trimester screening. • First-trimester combined serum screening (pregnancy associated plasma protein-A and free B-hCG) with nuchal translucency measurement (10-13 weeks of gestation) • Second-trimester triple (alpha-fetoprotein (AFP), estriol, B-hCG) or Quadruple (AFP,estriol, B-hCG, inhibin-A) marker serum screening (15- 20 weeks of gestation) • The options for women who are first seen during the second trimester are limited to quadruple (or "quad") screening and ultrasound examination. • First trimester nuchal translucency testing alone for multiple gestations (Serum screening tests are not as sensitive in multiple gestations)		

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS

	• If nuchal translucency measurement is not available or cannot be obtained in an individual patient, a reasonable approach is to offer serum integrated screening to patients who present early and second-trimester screening to those who present later.
	
	• Women found to be at increased risk of aneuploidy with first-trimester screening should be offered genetic counseling and option of CVS or second trimester amniocentesis.
	
	• Indications for Considering the Use of Cell Free Fetal DNA:
	
	  • Maternal age 35 years or older at delivery;
	  • Fetal ultrasonographic findings indicating an increased risk of aneuploidy;
	  • History of a prior pregnancy with a trisomy;
	  • Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen;
	  • Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21.		

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
Counsel regarding: • Prenatal Vitamins and folic acid • HIV and other prenatal tests • Risk factors identified by history • Anticipated course of prenatal care • Nutrition and weight gain • Toxoplasmosis precautions • Sexual Activity • Exercise • Seasonal Influenza vaccine (All pregnant women, regardless of trimester, should receive the inactivated influenza vaccination during the flu season) • Other vaccines recommended in pregnancy, if indicated, include Tdap, hepatitis A, Hepatitis B, and pneumococcal (recommended for pregnant women with prior splenectomy or functional asplenia). According to CDC, pregnancy should not preclude vaccination with meningococcal polysaccharide vaccine, if indicated. • Smoking counseling • Environmental/work hazards • Travel	Counsel regarding: • Signs & symptoms of preterm labor • Abnormal lab values • Injectable Influenza vaccine (for all pregnant women who will be pregnant during the influenza season) • Selection of pediatrician • Smoking counseling • Postpartum family planning/tubal sterilization	Counsel regarding: • Anesthesia/analgesia plans • Fetal movement monitoring • Labor signs • VBAC counseling (if indicated) • Signs & symptoms of pregnancy induced hypertension • Post term counseling • Circumcision • Breast or bottle feeding • Postpartum depression • Influenza vaccine • Smoking counseling • Domestic Violence • Newborn education • Family medical leave	

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
• Tobacco use • Alcohol use • Illicit/recreational drugs • Use of any medications (supplements, OTC etc) • Indications for ultrasound • Domestic violence • Seat belt use • Childbirth classes and choosing newborn care provider • Air travel during pregnancy • Umbilical cord blood banking • Breastfeeding (promote & support) • Circumcision • Vaginal Birth after Cesarean delivery (VBAC) • Newborn screening • Dental care in pregnancy			

*The frequency of follow up visits is determined by the individual needs of the woman and assessment of her risk. Women with medical or obstetric problems, as well as women at the extremes of reproductive age, will likely require closer surveillance.

**Inclusion of routine dipstick assessment for all pregnant women can be modified. A baseline screen for urine protein content to assess renal status is recommended. However, in the absence of risk factors for urinary tract infections, renal disease and preeclampsia (such as diabetes, hypertension, and autoimmune disorders) and in the absence of symptoms of urinary tract infection, hypertension or unusual edema, there has not be shown to be a benefit in routine dipstick testing during prenatal care for women at low risk.

Postpartum Visit:

4-6 weeks after delivery but may be modified according to the needs of the patient. A visit within 7-14 days after delivery may be advised for cesarean delivery or complicated gestation.

Postpartum review should include:

- Interval history
- Physical exam
- Pap smear if indicated
- Review of family planning/birth control/preconceptional care
- Screen for depression
- Review of immunization status and recommendations as necessary

Preconception Care:

Consists of the identification of those conditions that could affect a future pregnancy or fetus and that maybe amenable to intervention. Counseling to optimize pregnancy outcomes should include:

- Family planning and pregnancy spacing
- Family HX
- Genetic history (both maternal and paternal)
- Medical, surgical, and psychiatric history
- Current medication (prescription and non prescription)
- Substance use, including alcohol, tobacco and recreational and illicit drugs
- Exposure to violence and intimate partner violence
- Nutrition
- Teratogen; Environmental and occupational exposures
- Immunity and immunization status and offer vaccine if indicated (influenza, measles, mumps, rubella, varicella, hepatitis A & B, meningococcus and pneumococcus). The HPV vaccine can be offered to appropriate non-pregnant women. However, the vaccine is not recommended during pregnancy, completion of the vaccine series may be delayed until the postpartum period. Avoiding pregnancy within 1 month of receiving a live attenuated viral vaccine (e.g. rubella) is recommended.
- Risk factors for sexually transmitted diseases
- Obstetric history
- Gynecologic history
- General physical exam
- Assessment of socioeconomic, educational and cultural context
- Testing for specific diseases can be performed when indicated such as with genetic disorders.

Patients should be counseled regarding exercise, weight, nutrition, prevention of HIV infection, abstaining from alcohol, tobacco and illicit drugs use before and during pregnancy, determining the time of conception by accurate menstrual history, folic acid 0.4mg - 0.8 mg daily while attempting pregnancy and during three months of pregnancy for prevention of neural tube defects

and maintaining good control of any preexisting conditions. Based on racial and ethnic background, screening for genetic disorders may be performed.

References:

1. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Screening for Fetal Chromosomal Abnormalities. Number 77, January 2007. Reaffirmed 2013
2. The U.S. Preventive Services Task Force (USPSTF) Obstetric and Gynecologic Conditions. Available at: http://www.ahrq.gov/clinic/cps3dix.htm#obstetric
3. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 5th edition.
4. Kirkham C, Harris S, Grzybowski S. Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues. American Family Physician. 2005 Apr 1;71(7):1307-16. Available at: http://www.aafp.org/afp/20050401/1307.html
5. Kirkham C, Harris S, Grzybowski S. Evidence-based prenatal care: part II. Third-trimester care and prevention of infectious diseases. Am Fam Physician. 2005 Apr 15; 71(8): 1555-60 Available at: http://www.aafp.org/afp/20050415/1555.html
6. Centers for Disease Control and Prevention. (CDC) Sexually Transmitted Diseases Treatment Guidelines, 2006. August 4, 2006 / 55(RR11);1-94. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm
7. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 6th edition
8. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Invasive Prenatal Testing for Aneuploidy. Number 88, December 2007. Reaffirmed 2009. Reaffirmed 2013
9. Centers for Disease Control and Prevention. 2009 H1N1 Influenza Vaccine and Pregnant Women: Information for Healthcare Providers. Jan 2010. Available at: http://www.cdc.gov/h1n1flu/vaccination/providers_qa.htm
10. The American College of Obstetricians and Gynecologists. Committee Opinion Number 468. Influenza Vaccination during Pregnancy. October 2010.
11. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 7th edition. October 2012
12. The American College of Obstetricians and Gynecologists Committee on Genetics. The Society for Maternal-Fetal Medicine Publications Committee. Committee Opinion Number 545. Noninvasive Prenatal Testing for Fetal Aneuploidy. December 2012.
13. ACOG Practice Bulletin. Gestational Diabetes Mellitus. Number 137. August 2013
14. The American College of Obstetricians and Gynecologists Committee on Genetics. The Society for Maternal-Fetal Medicine Publications Committee. Committee Opinion Number 581. The Use of Chromosomal Microarray Analysis in Prenatal Diagnosis. Dec 2013
15. American College of Obstetricians and Gynecologists Committee Opinion. Influenza Vaccination During Pregnancy. Number 608. Sept 2014 (Replaces No. 468, October 2010)

Important Note
Health Net's Prenatal/Perinatal Health Guidelines provide recommendations are for the general population, based on the best available medical evidence at the time of release. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. Guidelines may also differ from state to state based on state regulations and requirements. As always, the judgment of the treating physician is the final determinant of member care. Your benefit plan may or may not cover all the services listed here. Please refer to your certificate of coverage for complete details or contact the customer service number listed on your ID card.

Review History: February 2007, February 2008, March 2009. February 2010, February 2011, February 2012, February 2013, February 2014, February 2015

Midwives' Association of Washington State
INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN A HOME OR BIRTH CENTER MIDWIFERY PRACTICE

1. INTRODUCTION:

Professional members of the Midwives' Association of Washington State (MAWS) include Licensed Midwives (LMs)[1] and Certified Nurse Midwives (CNMs). In the home or birth center setting LMs and CNMs (herein referred to as 'Midwives') work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. Midwives engage in an ongoing risk screening process that begins at the initial visit and continues through the completion of care. In providing care, midwives take into account their clinical judgment and expertise, a client's own values and informed choice, relevant state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, relevant midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

Professional members of the Midwives' Association of Washington State are advised to discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MAWS document Position Statement: Shared Decision-Making. MAWS recognizes that there are variations in practice specialty and professional members may hold different licenses or qualifications which hold them to a different standard of care than those outlined in this document. (These practitioners may include but are not limited to CNMs, ARNPs, and NDs). In addition, new clinical procedures may be undertaken in accordance with the MAWS document Mechanism for Introducing Expanded Clinical Procedures into Midwifery Practice. MAWS members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document periodically and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of mother and newborn without unduly restricting midwifery practice.

[1] Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.

2. DEFINITIONS:

2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks information from a colleague about a clinical situation, presenting a management plan for feedback.[2]

2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.

2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.

2.1.3 Discussion may occur in person, by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.

2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

2.3 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that the midwife is seeking a consultation.

2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

[2] A MAWS member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions that are within her scope of practice.

2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.

2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from a physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.

2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.

2.2.6 Consultation should be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife should then discuss the consultant's recommendations with the client.

2.2.7 After consultation with a physician, care of the client and responsibility for decision-making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant,[3] or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

2.4 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making, together with the client. For guidance about intrapartum transfers, see also the MAWS document Planned Out-of-Hospital Birth Transport Guideline.

[3] During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the dialogue and plan of care should be documented in the client's chart.

3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (<36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia or HELLP
- history of gestational diabetes requiring oral hypoglycemic or insulin
- no prenatal care prior to third trimester
- BMI > 35
- history of lap band, gastroplasty or other bariatric (weight loss) surgery
- previous unexplained neonatal mortality or stillbirth

Consultation:

- absent prenatal care at term
- history of seizure disorder in adulthood
- history of HELLP
- history of uterine surgery, including myomectomy
- one prior cesarean birth with low transverse incision
- significant history of or current cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease
- significant history of or current endocrine disorder (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/severe asthma
- collagen vascular diseases
- significant hematological disorders
- current or recent diagnosis of cancer requiring chemotherapy
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage)
- significant uterine anomalies
- essential hypertension
- history of eclampsia
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- current seizure disorder

Transfer:

- any serious medical condition associated with increased risk status for mother or fetus, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, uncontrolled asthma, or maternal HIV infection
- isoimmunization with an antibody known to cause hemolytic disease of the

newborn
- prior cesarean with incision other than low transverse (e.g. classical)
- two or more prior cesareans with low transverse incision

3.2 ANTEPARTUM CONDITIONS

Discussion:
- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- significant abnormal laboratory finding
- unresolved size/dates discrepancies
- 42 completed weeks with reassuring fetal surveillance including AFI and BPP with NST

Consultation:
- reportable sexually transmitted infection
- significant abnormal Pap
- significant abnormal breast lump
- pyelonephritis
- thrombosis
- fetal demise after 14 weeks gestation
- anemia unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- hemoglobinopathies
- platelets ≤ 105,000/μL
- persistent abnormal fetal heart rate or rhythm
- non-reassuring fetal surveillance
- significant placental abnormalities
- significant or unresolved polyhydramnios or oligohydramnios
- presentation other than cephalic at 37 weeks
- multiple gestation if co-managing prenatal care (transfer if not co-managing)
- significant infection the treatment of which is beyond the midwife's scope of practice

Transfer:

- ectopic pregnancy
- molar pregnancy
- premature pre-labor rupture of membranes (PPROM)
- documented persistent/unresolved intrauterine growth restriction (IUGR)
- multiple gestation if not co-managing prenatal care
- eclampsia, HELLP, pre-eclampsia, or persistent hypertension
- placenta previa at term
- isoimmunization with an antibody known to cause hemolytic disease of the newborn

- clinically significant placental abruption
- deep vein thrombosis
- cardiac or renal disease with failure
- gestational diabetes requiring management with medication; consultation in lieu of transfer if co-managing metformin with physician
- known fetal anomaly or condition that requires physician management during or immediately after delivery
- 43 weeks completed gestation

3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 and emergency services as appropriate, and transport as able.

Discussion:

- >8 hours of active labor pattern without significant change in cervix and/or station and/or position
- >3 hours of active pushing without significant change
- prolonged rupture of membranes (>48 hours without active labor)

Transfer:

- active labor before 37 completed weeks
- undiagnosed non-cephalic presentation including breech, transverse lie, oblique lie, or compound presentation at onset of labor
-
- undiagnosed multiple gestation
- maternal fever (≥100.4 F) that persists >1 hour
- findings indicative of chorioamnionitis including, but not limited to, maternal tachycardia, fetal tachycardia, temperature ≥100.4 F, uterine tenderness, purulent or malodorous amniotic fluid.
- thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- hypertension (≥140 systolic or 90 diastolic twice 1 hour apart)
- suspected pre-eclampsia (hypertension and proteinuria)
- maternal seizure
- ROM > 72 hours
- ROM > 18 hours with GBS status unknown and no prophylactic antibiotics, or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response

- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's stated desire for transfer to hospital-based care

3.4 POSTPARTUM CONDITIONS

Consultation:

- urinary tract infection unresponsive to treatment
- mastitis (including breast abscess) unresponsive to treatment
- reportable sexually transmitted infections
- retained products/unresolved subinvolution/prolonged or excessive lochia
- hypertension presenting beyond 72 hours postpartum
- significant abnormal Pap
- significant postpartum depression

Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant, enlarging hematoma
- endometritis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion
- maternal fever (≥ 100.4 F) that persists > 1 hour within the first 72 hours postpartum
- persistent hypertension in the first 72 hours postpartum (≥ 140 systolic or 90 diastolic twice 1 hour apart)
- postpartum psychosis

3.5 NEWBORN CONDITIONS

It is recommended that parents establish a relationship with a pediatric provider before the baby is born. It is strongly recommended that all parents be advised to establish care with a pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Consultation:

- low birth weight newborn (< 2500 gm = 5 lbs 8 oz)
- loss of greater than 10% of birth weight
- prolonged asymptomatic jaundice
- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant or symptomatic jaundice beyond the first 24 hours
- positive critical congenital heart disease screening (CCHD)

Transfer:

- seizure
- jaundice in the first 24 hours
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- significant bruising, petechiae or purpura
- Apgar score 6 or less at ten minutes of age
- major congenital anomalies affecting well-being
- birth injury requiring medical attention

WAC 246-834-230

Agency filings affecting this section

Preceptor for midwife-in-training program.

(1) In reviewing a proposed midwife-in-training program, the department shall use the following criteria in assessing the qualifications and determining the responsibilities of the preceptor:

(a) Qualifications of preceptor:

(i) The preceptor shall have demonstrated the ability and skill to provide safe, quality care;

(ii) The preceptor shall have demonstrated continued interest in professional development beyond the requirements of basic licensure;

(iii) The preceptor shall participate in and successfully complete any preceptor workshop or other training deemed necessary by the department; and,

(iv) The preceptor shall be licensed in the state of Washington. Exception to this rule may be granted by the department in unusual circumstances.

(b) Responsibilities of the preceptor:

(i) The preceptor shall monitor the educational activities of the trainee and shall have at least one conference with the trainee quarterly to discuss progress;

(ii) The preceptor shall submit quarterly progress reports on approved forms to the department, and,

(iii) The preceptor shall maintain and submit the checklists as specified in WAC 246-834-220 (4)(b).

[Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-230, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-230, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.040(3) and 18.50.115. WSR 88-12-040 (Order PM 732), § 308-115-230, filed 5/27/88.]

NARM Policies on Preceptor/Apprentice Relationships

In addition to setting mimimum requirements for preceptor qualification, NARM has specific policies that preceptors and applicants must follow while documenting knowledge and skills.

A preceptor for a NARM PEP applicant must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM), or Licensed Midwife who has an additional three years of experience or 50 primary/co-primary births. All preceptors must have an additional ten (10) continuity of care births beyond the primary birth experience requirements for CPM certification. Preceptors must have attended at least 10 out-of-hospital births in the last 3 years.

The preceptor privileges of some midwives have been revoked. It is the student's responsibility to verify their preceptor's status by asking their preceptor or contacting NARM.

The following is a list of policies and requirements for preceptors and CPM applicants:

1. A preceptor for a NARM PEP applicant must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM), or Licensed Midwife who has an additional three years of experience or 50 primary/co-primary births. All preceptors must have an additional ten (10) continuity of care births beyond the primary birth experience requirements for CPM certification. Preceptors must have attended at least 10 out-of-hospital births in the last 3 years. **The preceptor privileges of some midwives have been revoked. It is the student's responsibility to verify the preceptor's status by asking his/her preceptor or contacting NARM.**
2. The clinical components of apprenticeship should include didactic and clinical experience, and the clinical component must be at least 2 years in duration. The average apprenticeship which includes didactic and clinical training typically lasts 3 to 5 years. In the PEP Application, the dates from the earliest clinical documented in Phase 1 or 2 until the last clinical documented in Phase 3 must span at least 2 years, or the applicant should enclose a statement explaining additional clinical experiences that complete the requirement but are not charted on these forms. Additional births may also be reflected on Form 102 Birth Experience Background.
3. It is acceptable, even preferable, for the apprentice to study under more than one preceptor. In the event that more than one preceptor is responsible for the training, each preceptor will sign off on those births and skills which were adequately performed under the supervision of that preceptor. Each preceptor who signs for any clinicals on Forms 111 or 112 must fill out, sign and have notarized the Verification of Birth Experience Form. **All numbers signed for must be equal to or greater than the numbers signed for on Forms 111a-d and 112a-e.** The apprentice should make multiple copies of all blank forms so each preceptor will have a copy to fill out and sign. These forms should be filled out and signed by the preceptor, not the applicant.
4. The preceptor and apprentice should have a clear understanding of the responsibilities of each person to the other, including the time expected to be spent in one-on-one training, classroom or small group study, self-study, clinical observation, opportunities for demonstration of skills, time on call, and financial obligations.
5. The apprentice, if at all possible, should have the NARM application at the beginning of the apprenticeship and should have all relevant documentation signed at the time of the experience rather than waiting until the completion of the apprenticeship.
6. Preceptors are expected to sign the application documentation for the apprentice at the time the skill is performed competently. **Determination of "adequate performance" of the skill is at the discretion of the preceptor, and multiple demonstrations of each skill may be necessary.** Documentation of attendance and performance at births, prenatals, postpartums, etc., should be signed only if the preceptor agrees that expectations have been met. Any misunderstanding regarding expectations for satisfactory completion of experience or skills should be discussed and resolved as soon as possible, however **the preceptor makes the final determination.**

7. The preceptor is expected to provide adequate opportunities for the apprentice to observe clinical skills, to discuss clinical situations away from the clients, to practice clinical skills, and to perform the clinical skills in the capacity of a primary midwife, all while under the direct supervision of the preceptor. This means that **the preceptor must be physically present** when the apprentice performs the midwife skills. The preceptor holds the final responsibility for the safety of the client or baby and should become involved, whenever warranted, in the spirit of positive education and role modeling.
8. **Preceptors who sign off on experiences they did not witness risk losing their ability to sign as a preceptor in the future and also risk losing their NARM Certified Professional Midwife (CPM) credential.**
9. NARM's definition of the Initial Prenatal Exam includes covering an intake interview, history (medical, gynecological, family) and a physical exam. These exams do not have to occur all on the first visit to the midwife, but the apprentice should perform at least 20 of these exams on 1 or more early prenatal visits.
10. Prenatal Exams, Newborn Exams, and Postpartum Exams as Assistant Under Supervision (forms 111b-d) must be completed before the same category of clinicals may be verified as Primary Under Supervision (Forms 112 b-e). However, Prenatals, Newborn Exams, and Postpartum Exams as a Primary Under Supervision may begin before the Primary Under Supervision births occur.
11. Births as Assistant Under Supervision (Form 111) are births where the apprentice is being taught to perform the skills of a midwife. Just observing a birth is not considered Assistant Under Supervision. Charting or other skills, providing labor and birth support, and participating in management discussions may all be done as an assistant in increasing degrees of responsibility. The apprentice should perform some skills at every birth listed on Form 111a and must be present throughout labor, birth, and the immediate postpartum period. The apprentice **must complete 18** of the Assistant Under Supervision births before functioning as Primary Under Supervision at births.
12. Births as a Primary Midwife Under Supervision (Form 112) means that the apprentice demonstrates the ability to perform all aspects of midwifery care to the satisfaction of the preceptor who is physically present and supervising the apprentice's performance of skills and decision making.
13. Catching the baby is a skill that should be taught and performed during the Assistant Under Supervision phase. The Primary Under Supervision births require that the student be responsible but under supervision for all skills needed for labor support and monitoring of mother and baby, risk assessment, the delivery of the infant, newborn exam, and the immediate postpartum assessment of mother and baby. If the mother or father is "catching" the baby, the Primary Under Supervision is responsible for all elements of the delivery. If the preceptor catches the baby, then that birth qualifies as Assistant Under Supervision for the student.
14. Attendance at a birth where either the apprentice or preceptor is also the client will not be accepted for verification of the required clinicals.

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Guidelines for Documentation of Clinical Experience

Preceptors who sign off on experiences they did not witness risk losing their ability to sign as a preceptor in the future and also risk losing their CPM certification.

To help NARM candidates achieve exceptional training and a satisfactory relationship from their apprenticeship, NARM makes the following recommendations:

1. The preceptor and apprentice should have a clear understanding of the responsibilities of each person to the other, including the time expected to be spent in one-on-one training, classroom or small group study, self-study, clinical observation, opportunities for demonstration of skills, time on call, and financial obligations.
2. The apprentice, if at all possible, should have the NARM application at the beginning of the apprenticeship, and should have all relevant documentation signed at the time of the experience rather than waiting until the completion of the apprenticeship.

In response to multiple requests for clarification about the role of the Preceptor in the NARM application/certification process, NARM has developed the following guidelines based on the instructions set forth in the Candidate Information Bulletin. These guidelines are recommendations for successful completion of the application documentation.

1. The preceptor and applicant together should:
   a. Review the three (3) separate practice documents required by NARM—Practice Guidelines, Informed Consent, and Emergency Care Form.

   b. Review all client charts (or clinical verification forms from a MEAC accredited program) referenced on the NARM Application and confirm that the preceptor and applicant names/signatures appear on each part of the chart/form that is being referenced.

   c. Confirm that the signatures/initials of the applicant and preceptor are on every chart/form for: initial exam, history and physical exam, complete prenatal exams, labor, birth and immediate postpartum exam, newborn exam, and complete follow-up post partum exams listed on the NARM Application. Be sure the numbers written on the application forms are the same number of signatures/initials for both the applicant and the preceptor on the charts/forms.

   d. Check all birth dates and dates of all exams for accuracy.

   e. Check all codes to make sure there are no duplicate code numbers. Each client must have their own unique code. If there is more than one birth with any given client, there must be a different code assigned for each subsequent birth.
2. If a preceptor has more than one student (applicant), each chart must have a uniform code that all students will use. Students should not develop different codes for the same client.
3. Preceptors need to be sure their forms show that the student participated as primary under supervision and that the preceptor was present in the room for all items the preceptor signs. For example, the arrival and departure times at the birth should be documented on the chart for both the applicant and the preceptor. At the time of clinical experience, preceptors and students should initial each visit.
4. Applicants should have access to or copies of any charts listed in the application, Form 112a-f and Form 200 with Code in case of audit.

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The North American Registry of Midwives

Certified Professional Midwife (CPM)

Preceptor Handbook

Table of Contents

NARM Preceptor Overview

What is a NARM preceptor?

A NARM preceptor is a credentialed, experienced midwife who agrees to train apprentice midwives intending to apply for the Certified Professional Midwife (CPM) credential.

To serve as a preceptor for a CPM applicant, one must:

- Hold a current North American midwifery credential:
  - Certified Professional Midwife (CPM)
  - Certified Nurse Midwife (CNM)/Certified Midwife (CM)
  - Licensed practitioner legally recognized by the state to provide maternity care
- Meet at least one of the following criteria:
  - Have at least 3 years of experience beyond entry-level CPM requirements, or
  - Have served as a primary/co-primary midwife for at least 50 births, including 10 continuity of care births, beyond the entry-level CPM* requirements
- Have provided continuity of care for at least 10 clients beyond entry-level CPM requirements
- Have attended a minimum of 10 out-of-hospital births in the last three years

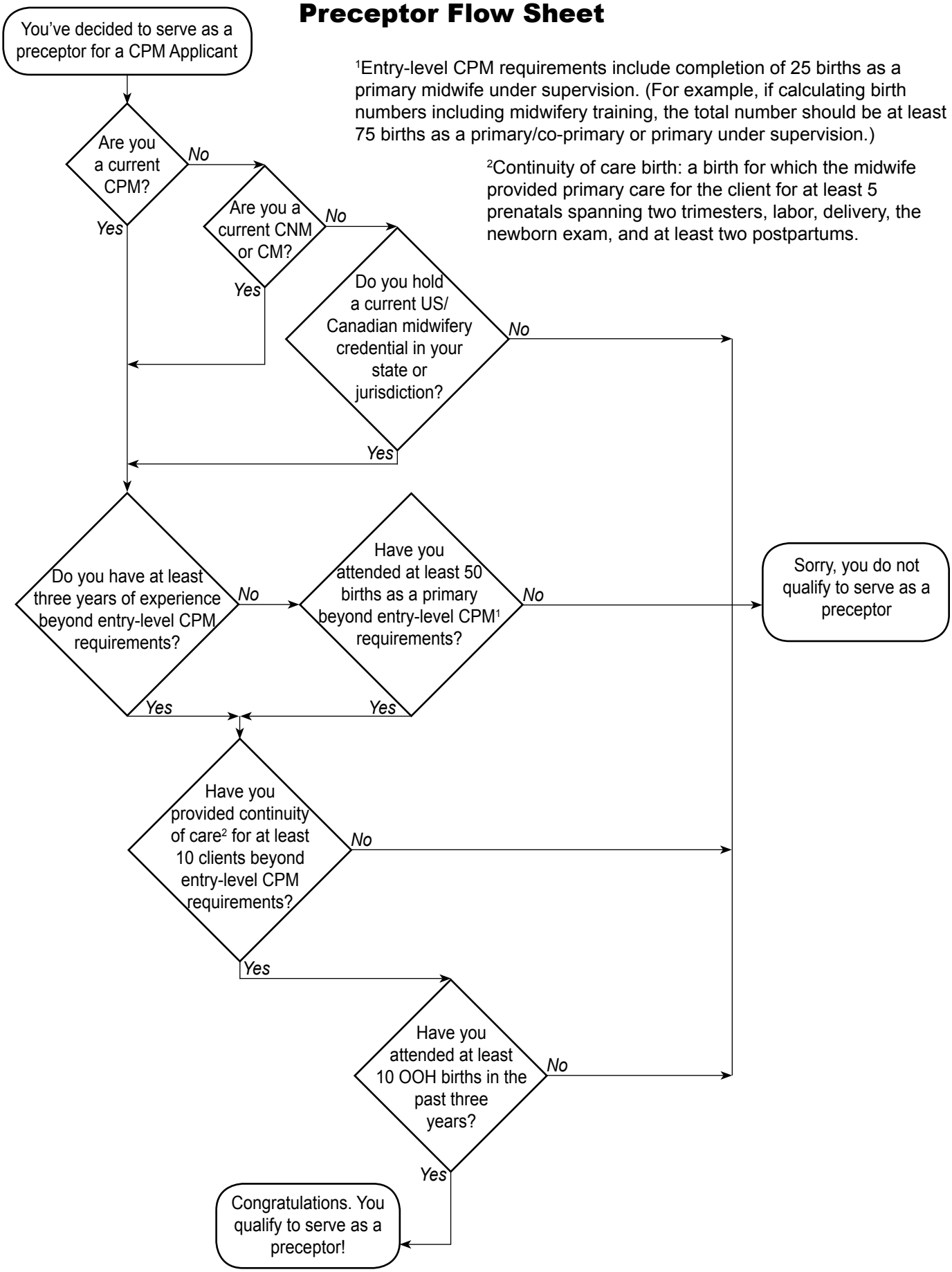
*Entry-level CPM requirements include completion of 25 births as a primary midwife under supervision. (For example, if calculating birth numbers including midwifery training, the total number should be at least 75 births as a primary/co-primary or primary under supervision.)

What are the requirements of a preceptor?

- Preceptors practice the Midwives Model of Care.
- Preceptors must register with NARM. The registration form may be found in this handbook and on our website at narm.org/preceptors.
- A preceptor may only sign for those experiences for which s/he was present and in the room in a supervisory role. Any preceptor who signs off on experiences s/he did not witness risks losing all preceptor privileges.
- A preceptor must only sign for those experiences for which s/he believes the apprentice has performed competently.
- Preceptors must assign a unique code to each client who may be documented on an apprentice's application. All apprentices must use the same codes when documenting care. Client codes must meet HIPAA requirements.

For more detailed information, read "Guidelines for NARM Preceptors."

Preceptor Flow Sheet



[1]Entry-level CPM requirements include completion of 25 births as a primary midwife under supervision. (For example, if calculating birth numbers including midwifery training, the total number should be at least 75 births as a primary/co-primary or primary under supervision.)

[2]Continuity of care birth: a birth for which the midwife provided primary care for the client for at least 5 prenatals spanning two trimesters, labor, delivery, the newborn exam, and at least two postpartums.

Becoming a NARM Preceptor

Anyone who meets the requirements and completes registration with NARM may serve as a preceptor. Here are a few points to take into consideration when deciding whether or not to serve as a preceptor.

Do you have the time and patience to serve as a preceptor?

Many apprentices are new to the field of birth work and well-woman care. The most successful preceptor/apprentice relationships result from a preceptor's ability to be patient and thorough.

Clinical skills must be taught, not just demonstrated, in increasing levels of responsibility. In addition to didactic training, hands-on practice is necessary for the apprentice to be able to advance her/his midwifery skills. It is vital that both preceptor and apprentice are willing to fully commit to the time required for extensive training.

Are you a willing and confident teacher?

Not all credentialed midwives feel that they have a well-rounded background of experience, even if they do meet the requirements of a preceptor. Hopeful preceptors should consider what they have to offer the next generation of midwives before entering into the preceptor role. In order to build confidence, a potential preceptor may benefit from advanced workshops and other training before taking on an apprentice.

Will you be willing to share care of your clients with your apprentice?

As an apprentice advances into the Primary Under Supervision phase of training, s/he must be able to act as the primary care provider, though the preceptor is responsible for care of the client. A preceptor must be willing to allow the apprentice to completely perform procedures as a primary caregiver, only stepping in as necessary for the safety of the client or for training purposes.

Are you willing to share your records for the purposes of the NARM application process?

NARM reserves the right to request charts for any experiences documented on an application. If a preceptor signs off on a clinical experience, s/he must be willing to allow the apprentice access to the charts for that client. CPM applicants are required to submit copies of a minimum of two client charts as a part of the application. It is the preceptor's responsibility to confirm that copies of any charts submitted to NARM meet HIPAA requirements.

Will you be accessible to your apprentice after the CPM application is submitted to NARM?

Upon review of the CPM application, an apprentice may be required to submit corrections, additional documentation, or additional verification. Preceptors are often called upon to assist in verification or providing additional documentation, even if the apprentice is no longer training under that preceptor.

Guidelines for NARM Preceptors

All preceptors are valued for their contributions to the field of midwifery and the continuing practice of the Midwives Model of Care. The preceptor/apprenticeship process relies on the preceptor to oversee and objectively evaluate the apprentice's training.

The training provided by a preceptor may vary widely based on the apprentice's needs. Some preceptor/apprentice relationships develop into long-term working relationships; others may be very brief. Whatever the individual experience may be, NARM has outlined the basic expectations of preceptors.

Preceptors must register with NARM. The registration form may be found in this handbook and on our website at narm.org/preceptors. If a preceptor has more than one apprentice, s/he is not required to submit multiple registration forms. However, registration must be renewed every six years. The preceptor is responsible for ensuring that NARM has a copy of at least one current midwifery credential (CPM, CNM, CM, LM) on file at all times. Preceptor status may be suspended or revoked if a preceptor does not provide proof of a current credential.

Maintain respect and open communication. In upholding the professional demeanor of midwifery, the preceptor should strive to maintain a sense of cooperation and respect for the apprentice. The preceptor should expect cooperation and respect from the apprentice as well. NARM recommends maintaining open communication at all times, with regular discussion of the expectations that each party has of the other. Any misunderstanding regarding expectations for satisfactory performance should be discussed and resolved as soon as possible. The recommended Quarterly Evaluation Form, available in this handbook (see Appendix) and at narm.org/preceptors, may serve as a useful tool for discussing expectations and goals.

Preceptors should have a clear understanding of the CPM educational and training requirements. For more information, refer to "CPM Educational Requirements" in this handbook, as well as the Candidate Information Booklet (CIB) and General Application Instructions, available at narm.org/entry-level-applicants.

Hold responsibility for the client. The preceptor holds the final responsibility for the safety of the client or baby. The preceptor must be physically present when the apprentice is performing clinicals and skills. Preceptors should become involved as needed for the safety of the client or in the spirit of positive education and role modeling.

Practice fair judgment. As part of the training process, the preceptor will be asked to sign for clinical skills and experiences on the apprentice's CPM application. A preceptor must only sign for those experiences for which s/he was present and s/he believes the apprentice has performed competently. **Once a preceptor signs for anything on a NARM application form, it may not be retracted.** NARM relies on preceptors to use fair and unbiased judgment when evaluating an apprentice's abilities, regardless of personal relationships.

Assign client codes. Preceptors must assign codes to all clients who may be documented on an apprentice's application. Each birth must have a unique code assigned to it. For clients with more than one birth, a different code must be assigned for each subsequent birth. Twins must have separate client codes when documenting newborn exams. Preceptors will be asked to share copies of client charts with their apprentices for the purposes of the NARM application. It is the preceptor's responsibility to confirm that client codes and copies of any charts submitted to NARM meet HIPAA requirements.

Carefully review all documentation. Preceptors' records should indicate the presence of apprentices at each clinical and the role of the apprentice (assistant, primary under supervision) at each clinical. Both preceptor and apprentice should sign/initial the chart at the time of the clinical experience. Arrival and departure times should be noted for each person at the birth. When signing for clinical skills and experiences on the application, the preceptor should carefully review all documentation with the apprentice. NARM recommends that all skills and experiences be signed off upon completion of the clinical or skill. However, in some cases the documentation may need to be signed at a later date. In those instances, it is recommended that both apprentice and preceptor carefully review the documentation, referring to client charts and other records to verify accuracy of client codes, clinical numbers, and all dates. Preceptors who sign for any clinical experiences or skills on an application are also required to complete the accompanying preceptor verification forms. NARM strongly urges

all preceptors to keep a copy of any application form s/he signs for her records. If any experiences submitted on an application come into question, preceptors may be asked to verify those experiences. Preceptors may be contacted directly by NARM for consultation during the application process.

CPM Educational Requirements

Based on Job Analysis of current CPMs, NARM has set forth the basic educational and training requirements for becoming a CPM. While these are requirements that must be met in order to receive the CPM credential, NARM understands that individual preceptor requirements vary. For this reason, it is important that the preceptor communicate all expectations to the apprentice.

Preceptors are expected to have a clear understanding of the educational requirements of the entry-level CPM applicant, as outlined in this section. Training should be completed in increasing degrees of responsibility.

Roles of CPM training

The three roles completed in the entry-level educational training process are Observer, Assistant Under Supervision, and Primary Under Supervision.

In the Observer role, the apprentice must witness the birth. As an Observer, the apprentice is not required to participate in hands-on training or application of skills.

As an Assistant Under Supervision, the apprentice should be taught to perform the skills of a midwife. Clinical skills should be performed as an assistant in increasing degrees of responsibility. In order to document a birth as an Assistant Under Supervision, the apprentice must perform some skills and must be present throughout labor, birth, and the immediate postpartum period. Catching the baby is a skill that should be taught and performed in the Assistant Under Supervision Phase.

As Primary Under Supervision, the apprentice should be managing the birth or other clinical while still under supervision of the preceptor. The preceptor should only become involved as necessary for safety or educational purposes. In order to document a birth as Primary Under Supervision, the apprentice must manage the labor, birth, and immediate postpartum period. If the mother or father is catching the baby, the apprentice must be responsible for all elements of the delivery. The apprentice may not count a birth as Primary Under Supervision if the preceptor catches the baby.

A twin birth counts as only one birth on the CPM application.

If the apprentice or preceptor is the also the client, that birth may not be counted on the CPM application.

General requirements for entry-level CPM training:

1. The apprenticeship should include didactic and clinical experience, and the clinical training must span at least two years. Clinical experience includes births and other clinicals attended as an observer, assistant, or primary under supervision. The average apprenticeship process lasts three to five years.
2. All documentation on a CPM application must span no longer than ten years prior to submission of the application.
3. At least 2 planned hospital births and at least 5 planned home births must be included in the total births documented in Phases 1-3. These births may be documented in any combination of any role: Observer, Assistant Under Supervision, or Primary Under Supervision.
4. All CPM applicants must have developed and utilize Practice Guidelines, an Informed Consent Form, and an Emergency Care Form. For more information, please refer to the section on the Informed Consent Process (Shared Decision Making) in the Candidate Information Booklet (CIB).
5. For any birth, only one Primary Under Supervision apprentice and up to two Assistant Under Supervision apprentices may use that birth on the CPM application. For all other clinicals (prenatals, newborn exams, postpartums), only one Primary Under Supervision apprentice and one Assistant Under Supervision apprentice may use that clinical on the CPM application. No two apprentices may count the same prenatal, newborn exam, or postpartum in the same role of assistant or primary under supervision.

Clinical requirements for all entry-level applicants include:

1. Complete at least 10 births as an Observer.
   Births may be signed by any witness, and may be in any setting. Births as an Observer may overlap with births as an Assistant Under Supervision or Primary Under Supervision (Phase 3 only).
2. Complete at least 20 births as an Assistant Under Supervision of a preceptor.
   No more than 4 of the 20 births may be transports. At least 18 births must be completed as an Assistant Under Supervision before completing births as a Primary Under Supervision.
3. Complete at least 25 prenatal exams, including 3 initial prenatals, as an Assistant Under Supervision of a preceptor.
   All 25 prenatal exams must be completed as an Assistant Under Supervision before completing prenatals as a Primary Under Supervision.
4. Complete at least 20 newborn exams as an Assistant Under Supervision of a preceptor.
   All 20 newborn exams must be completed as an Assistant Under Supervision before completing newborn exams as a Primary Under Supervision.
5. Complete at least 10 postpartum exams as an Assistant Under Supervision of a preceptor. All 10 postpartum exams must be completed as an Assistant Under Supervision before completing postpartums as a Primary Under Supervision.
6. Complete at least 20 births as Primary Under Supervision of a preceptor.
   At least 5 of the 20 births must be Continuity of Care (COC) births. In addition to the 5 COC births, at least 10 births must include a minimum of 1 prenatal visit. No more than 2 of the 20 births may be transports. At least 10 of the 20 births must be out-of-hospital births. At least 10 of the 20 births must have occurred within the last three years.
7. Complete at least 75 prenatal exams, including 20 initial prenatals, as Primary Under Supervision of a preceptor.
8. Complete at least 20 newborn exams as Primary Under Supervision of a preceptor.
9. Complete at least 40 postpartum exams as Primary Under Supervision of a preceptor.
10. Complete the Comprehensive Skills, Knowledge, and Abilities Essential for Competent Midwifery Practice.
    Both competent knowledge and practical skill must be competently demonstrated for each skill to be completed.
11. Complete an additional 5 births as Primary Under Supervision of a preceptor.
    No more than 1 of the 5 births may be a transport. These births may be submitted before or after taking the written exam, but must be completed within six months after successfully completing the written exam.

Additional requirements for successful completion of the CPM certification process include:

1. Successful completion of the Second Verification of Skills or the Skills Assessment with a Qualified Evaluator (QE).
2. Successful completion of a course, workshop, or module on cultural competency.
3. Current certification in Adult CPR and Neonatal Resuscitation (NRP/NNR).
   NARM only accepts certifications from courses which include a hands-on skills component. Online-only courses are not accepted. Approved CPR courses include American Heart Association, American Red Cross, and Canadian Red Cross. Neonatal resuscitation courses must be approved by the American Academy of Pediatrics.
4. Successful completion of the NARM written exam.

For more details regarding entry-level education and application requirements, refer to the Candidate Information Booklet (CIB), the General Application Instructions, and the entry-level application forms, all available for download from our website at narm.org/entry-level-applicants.

Preceptor Registration Guidelines

Anyone who wishes to serve as a preceptor for a CPM applicant must register with NARM. Details regarding requirements and guidelines may be found in the Preceptor Handbook, which may be downloaded from the NARM website at narm.org/preceptors.

Instructions for preceptor registration with NARM:

1. Read the Preceptor Handbook. Those who meet the requirements and guidelines may move on to step two.
2. Complete the Preceptor Registration Form 700. Those who hold a credential other than the CPM (such as a CNM/CM or LM) must include a copy of the current credential with the registration form.
3. Submit the Preceptor Registration Form 700 and any required additional documentation to:

   NARM Applications Department
   P.O. Box 420
   Summertown, TN 38483

Original registration forms must be submitted to NARM by USPS mail. However, additional required materials may be submitted by email (applications@narm.org) or fax (931-901-1221). When submitting any documentation to NARM, the registrant must keep a copy for her/his records.

A verification letter will be sent by email or standard mail once the registration packet has been received, processed, and approved. The verification letter will include the preceptor's required renewal date, which will align with the preceptor's birth date. Preceptor registration must be renewed every six years.

If your credential expires prior to the required preceptor renewal date, a copy of the updated credential must be submitted to the NARM Applications Department at the time of renewal of that credential, regardless of the preceptor renewal date. The registered preceptor is responsible for ensuring that NARM always has her/his current credential and contact information on file.

NARM Preceptor Registration Form 700, page 1 of 3

This form must be filled out completely in English in black ink or typed.

First Name: _____ Middle Initial: _____

Last Name: _____ Birth date: _____

Any other names previously submitted to NARM: _____

Please include any names that may have been listed on any documentation submitted to NARM.

Residential address: _____ City: _____

Province/State: _____ Zip Code: _____ Country: _____

Mailing address: _____ City: _____

Complete only if different from residential address.

Province/State: _____ Zip Code: _____ Country: _____

Primary phone: _____ Secondary phone: _____

Fax: _____ Email: _____

Complete information for the credential(s) you hold. Fill in all that apply:

Credential	License/Credential Number	Original Issue Date	Expiration Date	State/Jurisdiction (if applicable)
CPM				
CNM[1]				
CM[1]				
LM[1]				
Other[2]				

[1]Submit a copy of your current non-CPM credential(s) with this form.

[2]Must be a licensed practitioner legally recognized by your state to provide maternity care

If there have been any lapses in your credential(s), please list the dates: _____

_____

What year did you begin practicing as a primary midwife after training? _____

Approximately how many total births have you attended (including training)? _____

How many births did you attend as a primary/primary under supervision midwife during training? _____

How many births have you attended as a primary/co-primary midwife after training? _____

How many Continuity of Care births have you attended as a primary/co-primary midwife? _____

NARM defines Continuity of Care births as a minimum of five prenatals spanning at least two trimesters, the birth, the newborn exam, and at least two postpartums.

How many Out-of-Hospital births have you attended in the last three years? _____

Do you work with a group practice or birth center, or do you work with a co-practitioner? ❑ Yes ❑ No

If yes, please state the name(s): _____

May NARM release your name/contact information to prospective students looking for a preceptor?

❑ Yes ❑ No

NARM Preceptor Registration Form 700, page 2 of 3

First Name: _____ Last Name: _____

How did you receive your midwifery training? Please complete all that apply:

❑ Self-trained, please provide a brief explanation: _____

_____

_____

❑ Apprenticeship towards NARM credential

❑ Apprenticeship towards a credential offered by a state/provincial agency
Name/location of agency: _____

❑ Obtained a degree towards CNM/CM certification

❑ Obtained a vocational/technical certificate
Name of program/certificate: _____

❑ Attended a MEAC-accredited school
Name of school:_____
Did you graduate? ❑ Yes ❑ No

❑ Attended a midwifery school not accredited by MEAC
Name of school:_____
Did you graduate? ❑ Yes ❑ No

❑ Attended a state-approved midwifery program
Name of program: _____
Did you complete the program? ❑ Yes ❑ No

❑ Obtained a credential outside the U.S.
Name/location of credential: _____

❑ Attended a training program outside the U.S.
Name of program: _____

❑ Other, please explain: _____

_____

NARM Preceptor Registration Form 700, page 3 of 3

First Name: _____ Last Name: _____

Affirmation of Honest Intent of Representation

I, _____, in registering for North American Registry of Midwives (NARM) preceptor status, do hereby acknowledge that honesty in relationship to the apprentices I mentor is of utmost importance. I affirm that I, to the best of my ability and professional integrity, will always represent my practice, knowledge, skills, experience and expertise honestly and fairly. *Initial here:* _____

I understand that I will be held liable for the verification of education and training of any CPM applicants who apprentice under my supervision. *Initial here:* _____

I affirm that I have read the Preceptor Handbook and agree to all terms therein. *Initial here:* _____

I affirm I have read the Candidate Information Booklet (CIB) and NARM application instructions.
Initial here: _____

I affirm that, as a NARM preceptor, I will only sign for procedures performed under my direct supervision, for which I was present and in the room. Before signing any NARM application forms, I will thoroughly review the procedures documented on those forms. *Initial here:* _____

I declare and affirm that the statements made on this registration form, including accompanying statements and documents, are true, complete and correct. I understand that any false or misleading information in connection with my registration may be cause for denial or loss of preceptor status.
Initial here: _____

_____
Print Name

_____ _____
Signature Date

_____
Witness Name

_____ _____
Witness Signature Date

Glossary

The terms defined herein are specific to the CPM process.

Accountability: The check and balance system built into the certification process. Accountability includes continuing education, informed consent, peer review, complaint review, and the grievance mechanism.

ACNM: American College of Nurse-Midwives; the professional association that represents Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) in the United States.

AMCB: American Midwifery Certification Board.

Assistant Under Supervision: An apprentice midwife who is being taught to perform the skills of a midwife through hands-on clinical experience in gradually increasing degrees of responsibility.

Audit: A methodical examination and review of application materials, including any additional requested materials, such as practice documents and charts. Audits may be conducted randomly or for multiple discrepancies on any application type, including recertification applications.

Birth: Labor, delivery, and immediate postpartum period.

CIB: Candidate Information Booklet; A booklet published by NARM which outlines educational and application requirements for becoming a Certified Professional Midwife (CPM).

CPR: Cardiopulmonary Resuscitation.

CNM: Certified Nurse Midwife; An advanced practice registered nurse who has specialized education and training in both the disciplines of nursing and midwifery and is certified by the AMCB.

CM: Certified Midwife; A direct entry midwife who is certified by the AMCB.

Certified Professional Midwife (CPM): A professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and adheres to the Midwives Model of Care.

CEU: Continuing Education Unit; continuing education credits which are usually represented as credit hours but sometimes as units. For NARM recertification 1 contact hour equals 1 CEU.

Charts: A record of information about a client. Complete charts include the prenatal care record, labor and delivery records, newborn exam record, and postpartum record.

Client: A person who elects to use midwifery services provided by a professional midwife, which may include care provided by student midwives.

Clinical: Any direct observation or evaluation of a client, e.g. – a birth, prenatal, postpartum, or newborn exam.

Clinical Experience: Any experience involving direct observation or evaluation of a client and signed for by a witness or preceptor.

Complaint Review: A group review by CPMs, conducted locally, regarding a formal complaint filed against a CPM within 18 months of the conclusion of care (or within the time allowed by NARM policy). Complaint Review includes participation of the client whose course of care initiated the complaint, and may result in non-binding educational recommendations for the midwife or initiation of the NARM Grievance Mechanism.

Confidentiality: The protection of individually identifiable information, specifically client information.

Continuing Education: Keeping up with new developments in the field of midwifery, upgrading skills, acquiring new information, and reviewing skills and knowledge.

Continuity of Care (COC): Care provided throughout prenatal, intrapartum and postpartum periods. For the purposes of the NARM application, primary under supervision care must be provided for a minimum of five prenatals spanning at least two trimesters, the birth (including the placenta), the newborn exam, and at least two postpartums for five clients. Transports are not accepted for full Continuity of Care births. An additional ten primary under supervision births must include at least one primary under supervision prenatal.

Co-Primary: A midwife who shares care of a client with another midwife, with each midwife bearing equal responsibility for the actions, inactions and collective decisions.

Core Competencies: The Midwives Alliance of North America Core Competencies; a document of guidelines which establish the essential knowledge, clinical skills and critical thinking necessary for entry-level midwifery practice, providing the basis for the CPM credential.

Currency: Documentation of additional births and/or clinicals, which may be required for applications that have been in process for an extended period of time. Minimum required clinical experiences must span no longer than ten years, with at least ten out of hospital births within the last three years.

Education and Counseling: Information and discussion of components of the CPM Informed Consent Process and Shared Decision Making, provided in verbal and written language understandable to the client.

Eligibility: Process by which one may seek and obtain certification based upon personal, program, organization, state or international qualifications.

Emergency Care Form: A form individualized for each client, which should include the client's name, address, phone number, hospital chosen for transport (with telephone number), name and contact information of anyone who may be involved in the care of the client (such as client doctors or the backup physician for the midwife), and any person that the client lists as an emergency contact.

Expired CPM: One who has previously been issued the CPM credential but, within 90 days after her/his expiration date, has not provided documentation of maintaining the requirements of recertification.

Expired Application: An application which has been submitted to the NARM Applications Department and has been in process or incomplete for longer than the allowed time frame.

Fetal/Neonatal Death: A death from 20 weeks intra-uterine gestational age to 28 days old.

Freestanding Birth Center: A facility, institution, or place not normally used as a residence and not associated with or managed by a hospital, in which births are planned to occur in a home-like setting. Freestanding birth center births are considered out-of-hospital births.

Grievance Mechanism: The process used by the NARM Accountability Committee to handle formal complaints about a midwife, which is put into effect once a second complaint against a CPM or applicant is filed. The outcome is binding, and failing to meet the stated requirements results in the revocation of a CPM's credential, conditional suspension or denial of an application.

HIPAA Requirements: The requirements as laid out in the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), which are intended to protect all "individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral," also known as protected health information. Protected health information may not be used or disclosed unless the individual who is the subject of the information authorizes in writing.

Hospital Birth Center: A birth facility, institution, or place associated with or managed by a hospital, which is equivalent to a hospital setting for a birth.

ICA: International Credentialing Associates; an independent, non-governmental professional organization which provides educational credential evaluation reports to other organizations for individuals who have completed all, or part, of their education outside the United States.

Inactive CPM: Voluntary suspension of CPM credential on an annual basis not to exceed six years; during which time the use of the CPM credential and preceptor/evaluator status is prohibited.

Informed Consent Form: A midwife's documentation of the process leading to the decision made by a client that is outside the Midwife's Plan of Care, which must include evidence, such as the client's signature, that the client was fully informed of the potential risks and benefits of proceeding with the new care plan.

Informed Consent Process: Ongoing verbal and written education about risks, benefits and alternatives to the Midwife's Plan of Care. The midwife utilizes individualized counseling based on her practice guidelines and skill level, the client's medical history, and written documentation of a care plan that includes signatures of the client and midwife when appropriate. The Informed Consent Process necessitates revisiting areas of consent and non-consent over time and as changes occur. Also refer to Shared Decision Making.

Informed Disclosure: A form written in language understandable to the client which includes a place for the client to attest that she understands the content by signing her full name. The form must include a description of the midwife's training and experience (including credentials), philosophy of practice, list of services provided, transfer/consultation protocols, transport plan, the NARM Accountability Process, and HIPAA Privacy and Security Disclosures.

Initial Prenatal Exam: Intake interview, history (medical, gynecological, family) and physical examination. Information may be gathered over one or more early prenatals and should include both an oral/written history and a general overview of normal physical condition.

Licensed Midwife: A midwife who is legally recognized and regulated by her/his state.

MANA: Midwives Alliance of North America.

MEAC: Midwifery Education Accreditation Council.

Mediation: Process utilizing a third agreed upon party to bring about agreement or reconciliation among disputing parties.

Mentor: See Preceptor.

Midwife: One who attends a woman in childbirth as the primary care provider.

Midwife's Plan of Care: A care plan provided by the midwife to her client that is informed by her training, competency, practice guidelines, regional community standards of both medical and midwifery maternity care providers, and legal requirements. The Plan of Care includes both written and verbal communication and is revisited throughout the course of care as changes occur and at the time an exam or procedure is provided. A client may refuse a procedure at any time.

Midwives Model of Care: A midwifery model of care based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes: a) monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; b) providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support; c) minimizing technological interventions; and d) identifying and referring women who require obstetrical attention. The application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

NARM: North American Registry of Midwives.

Newborn Exam: A complete and thorough examination of the infant conducted within 12 hours of the birth.

NNR: Neonatal Resuscitation.

NRP: Neonatal Resuscitation Program.

Observer: One who is physically present and observes a labor and birth.

OOC: Out of Country; specifically, midwifery training conducted outside the US or Canada.

Out-of-hospital (OOH) Birth: A planned birth in a home, freestanding birth center, or other location not connected to a hospital.

PEP-EL: Portfolio Evaluation Process – Entry Level; the application route through which midwifery apprenticeship with one or more preceptors is thoroughly documented for review for the purpose of qualifying for the CPM credential.

PEP-EM: Portfolio Evaluation Process – Experienced Midwife; the application route through which a midwife's experience (a minimum of five years of experience beyond training) is thoroughly documented for review for the purpose of qualifying for the CPM credential.

PEP-IEM: Portfolio Evaluation Process – Internationally Educated Midwife; the application route through which the experiences and training of a midwife licensed or registered outside the US is thoroughly documented for review for the purpose of qualifying for the CPM. Documentation includes an initial report requested by the applicant and compiled by ICA.

Phase 1: The first of four phases of the PEP-EL application, requiring documentation of births attended as an Observer. Phase 1 serves as a beginning apprentice's introduction to the preceptor's practice.

Phase 2: The second of four phases of the PEP-EL application, requiring documentation of midwifery clinical experience as an Assistant Under Supervision. Phase 2 provides the apprentice with appropriate instruction and training in preparation for providing primary midwifery care under the direct supervision of a preceptor during Phase 3.

Phase 3: The third of four phases of the PEP-EL application, requiring documentation of midwifery clinical experience as a Primary Under Supervision, verification of skills, CPR/NRP certifications, verification of utilization of practice documents, and references.

Phase 4: The fourth of four phases of the PEP-EL application, requiring documentation of additional births as a Primary Under Supervision.

Philosophy of Birth: A written or verbal explanation that a midwife provides as part of Informed Disclosure for Midwifery Care in which the midwife explains her/his beliefs and opinions about the process of childbirth and the role of the midwife as care provider.

Plan of Care: See Midwife's Plan of Care.

Planned Home Birth: A birth that, according to the antepartum plans set forth by the client, takes place in a home or similar setting.

Planned Hospital Birth: A birth that, according to the antepartum plans set forth by the client, takes place in a hospital or hospital birth center. A planned hospital birth may be a transfer of care from an out-of-hospital practice.

Postpartum Exam: A physical, nutritional and socio-psychological review of the mother and baby after 24 hours and up to six weeks following the birth, and does not include the immediate postpartum exam.

Practice Guidelines: A specific description of protocols that reflect the care given by a midwife, including the initial visit, prenatal, labor/delivery, immediate postpartum, newborn exam and postpartum care. Practice Guidelines should include an explanation of both routine care and protocols for transports and/or transfers of care.

Preceptor: A midwife who meets requirements for supervising CPM candidates, including current registration with NARM. The midwife must be credentialed as a Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM), Certified Midwife (CM); or s/he must be a licensed practitioner legally recognized by a state/jurisdiction to provide maternity care. A preceptor must have an additional three years of experience after credentialing or fifty primary/co-primary births beyond entry-level CPM requirements. Additionally, s/he must also have ten continuity of care births beyond entry-level CPM requirements. A preceptor must have attended a minimum of ten out-of-hospital births in the last three years.

Prenatal Exam: A complete and thorough routine examination, counseling, and education of the pregnant woman prior to birth.

Primary: A midwife who has full responsibility for provision of all aspects of midwifery care (prenatal, intrapartum, newborn and postpartum) without the need for supervisory personnel.

Primary Under Supervision: An apprentice midwife who provides all aspects of care as if s/he were in practice, although a supervising midwife has primary responsibility and is present in the room during all care provided.

Protocols: See Practice Guidelines.

Qualified Evaluator (QE): An experienced CPM who has been trained and currently qualifies to administer the NARM Skills Assessment.

Recertification: The process through which a CPM renews credentialing every three years by documenting CEUs, peer review, cultural competency (if not previously documented), and current CPR/NRP certifications.

Recertification After Expiration: The process through which an expired CPM may reapply for the CPM credential by documenting birth experience, CEUs, peer review, cultural competency, and current CPR/NRP certifications. The expired CPM will be required to retake the written exam unless s/he holds another current credential (such as a state license) recognized by NARM.

Registered Midwife: See Licensed Midwife.

Second Verification of Skills: One of two options for the secondary evaluation of a PEP applicant's skills, which may be verified either in a clinical setting or demonstrated on live volunteer models. The Second Verification of Skills may only be utilized if the applicant's Phase 3 Forms 112a-e, Form 200, and Form 201a were signed entirely by CPMs. The Second Verification of Skills Form 206 must be completed by a CPM who meets the requirements and did not sign for any skills on Form 201.

Shared Decision Making: The collaborative process that engages the midwife and client in decision making with information about treatment options, and facilitates the incorporation of client preferences and values into the plan of care. Also refer to Informed Consent Process.

Skills Assessment: One of two options for the secondary evaluation of a PEP applicant's skills. The Skills Assessment is administered by a Qualified Evaluator with whom the applicant has not attended more than five births, and must be completed through demonstration with live volunteer models.

Standards of Practice: See Practice Guidelines.

State Licensed: See Licensed Midwife.

Supervisor: See Preceptor.

Transport: Transfer of care during labor to another primary care giver prior to the birth of the baby.

Witness: Anyone other than the applicant present at a birth.

Written Exam: North American Registry of Midwives Written Exam.

The North American Registry of Midwives

Certified Professional Midwife (CPM)

Appendix— Quarterly Evaluations

Guidelines for Quarterly Evaluations

The PEP process for CPM certification requires a successful preceptor/apprenticeship relationship. When entering into a preceptor/apprentice partnership, each party is expected to act in a professional, responsible, and respectful manner towards the other. For the most beneficial relationship, NARM strongly urges each person to maintain an open line of communication with the other. Periodic assessments should be included as a part of regular communications.

The average apprenticeship which includes didactic and clinical training lasts 3-5 years. It is acceptable, even preferable, for apprentices to study under more than one preceptor. Some preceptor/apprentice relationships develop into long-term working relationships; others may be very brief. However long a relationship may last, periodic assessments can prove to be very beneficial for both parties. NARM recommends using the following guidelines and Quarterly Evaluation Report as tools for periodic assessment.

Recommendations:

At the beginning of the preceptor/apprentice relationship, each party should establish goals, such as educational goals and expectations for rate of progress.

A plan should be made for meeting outside of clinical time to discuss didactic study and evaluate clinical and skills experience.

The preceptor and apprentice should strive to meet at least once per quarter for evaluations, to discuss progress, expectations of both parties, and to set new goals. While a “quarter” may typically be defined as once every three months, short-term apprenticeships may benefit from more regular meetings; for example, for a 4-month apprenticeship, evaluation meetings could be scheduled at least once per month.

Completing the Quarterly Evaluation Form:

The following form is recommended by NARM; it is not required as a part of the CPM application process. NARM encourages utilization of this form by both apprentices and their preceptors, particularly those apprentices who plan to apply through the PEP-Entry Level process.

The Quarterly Evaluation Form should be completed by the preceptor and apprentice together. Begin by reviewing the discussion questions. Add any preferred topics of discussion for the next evaluation.

Complete the time period, clinical numbers, and note how many of each clinical may be used on NARM application forms. Both preceptor and apprentice should sign the form.

Submission of Quarterly Evaluations:

The Quarterly Evaluation Form is intended for use by the preceptor and apprentice. Once an evaluation is completed, both apprentice and preceptor should keep a copy for their records. Submission of Quarterly Evaluation Forms is encouraged but not required as a part of the CPM application process. If the preceptor and/or apprentice choose to submit the evaluations to NARM, they will be kept on file as supplemental materials. Quarterly Evaluation Forms may be submitted to:

NARM by email (applications@narm.org), fax (931-901-1221), or standard mail:

NARM Applications Department

P.O. Box 420

Summertown, TN 38483

NARM Quarterly Evaluation Form

Preceptor's Name:_____

Apprentice's Name: _____

Time period covered by evaluation:_____

Discussion Questions:

Notes may be taken on a separate sheet of paper.

1. Have clear goals been outlined, such as educational goals and expected rate of progress?
2. Do the preceptor and apprentice meet outside of clinical time to discuss progress, evaluation of performance and knowledge? Has the meeting time allowed for adequate discussion?
3. Is the apprentice provided with an opportunity to progress in increasing levels of skills and responsibilities? If not, what are the possible impediments?
4. Is the apprentice demonstrating adequate self-study skills, including application of new knowledge in a clinical setting?
5. Is the apprentice progressing through the Assistant Under Supervision clinicals in increasing levels of responsibility? Will the apprentice be prepared to move into a primary role upon meeting the minimum requirements, or should s/he continue to train in an assistant role?
6. Are expectations being met for both preceptor and apprentice? If not, what are the areas requiring more focus?

Additional topics of discussion: _____

Clinical Experience	Number Attended	Number Initialed on CPM Application
Observed Births		
Births as an Assistant		
Initial Prenatals as an Assistant		
Prenatals as an Assistant		
Newborn Exams as an Assistant		
Postpartum Exams as an Assistant		
Births as a Primary		
Continuity of Care Births as a Primary		
Primary Births with at least 1 Prenatal		
Initial Prenatals as a Primary		
Prenatals as a Primary		
Newborn Exams as a Primary		
Postpartum Exams as a Primary		

_____ _____

Preceptor Signature Date

_____ _____

Apprentice Signature Date

Christy,

Attached is the 11-12 school year framework for the Midwifery A.S. degree. I believe this was the last year it was “available”. Miami Dade College was the only college to offer it for a very long time. They may have more information, but they have not offered it since school year 9-10 I think. I hope this is helpful!

Thank you!

Tracy Yacobellis

Health Science Supervisor

Florida Department of Education
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Tracy.Yacobellis1@fldoe.org

2011 - 2012

Florida Department of Education
Curriculum Framework

Program Title: **Midwifery**
Career Cluster: **Health Science**

	AS	AAS
CIP Number	1318110300	0318110300
Program Type	College Credit	College Credit
Standard Length	90 credit hours	90 credit hours
CTSO	HOSA	HOSA
SOC Codes (all applicable)	31-9099, 29-1111	31-9099, 29-1111
Targeted Occupation List	http://www.labormarketinfo.com/wec/TargetOccupationList.htm	
Perkins Technical Skill Attainment Inventory	http://www.fldoe.org/workforce/perkins/perkins_resources.asp	

Purpose

This program offers a sequence of courses that provides coherent and rigorous content aligned with challenging academic standards and relevant technical knowledge and skills needed to prepare for further education and careers in the Health Science career cluster; provides technical skill proficiency, and includes competency-based applied learning that contributes to the academic knowledge, higher-order reasoning and problem-solving skills, work attitudes, general employability skills, technical skills, and occupation-specific skills, and knowledge of all aspects of the Health Science career cluster.

This program is designed to prepare students for employment as licensed midwives SOC Code-29-1111 (Registered Nurses)or to provide supplemental training for persons previously or currently employed in this occupation. The Health Careers Core must be taken by all students (secondary, postsecondary adult and postsecondary vocational) planning to complete any Health Occupations program. Once successfully completed, the core does not need to be repeated at any instructional level.

The content includes but is not limited to all aspects of prenatal, intrapartal, and post-partal care, including obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; epidemiology; genetics; embryology; neonatology; applied pharmacology; the medical and legal aspects of midwifery; gynecology and women's health; family planning; nutrition during pregnancy and lactation; breast feeding and basic nursing skills.

Program Structure

This program is a planned sequence of instruction consisting of 90 credit hours.

Laboratory Activities

Laboratory activities are an integral part of this program. These activities include instruction in the use of safety procedures, tools, equipment, materials, and processes related to these occupations. Equipment and supplies should be provided to enhance hands-on experiences for students.

Special Notes

This program meets the Department of Health HIV/AIDS Domestic Violence and Prevention of Medical Errors education requirements. Upon completion of this program, the instructor will provide a certificate to the student verifying that these requirements have been met.

If students in this program are seeking a licensure, certificate or registration through the Department of Health, please refer to 456.0635 F.S. for more information on disqualification for a license, certificate, or registration through the Department of Health.

Licensed midwives are prepared to provide care for mothers who are expected to have a normal pregnancy, labor, and delivery. Midwifery graduates from approved programs are eligible to take an examination testing proficiency in the core competencies required to practice midwifery as specified in FS 553 - 467.009 CH. 92-179.

Training Requirements (FS 467.009 and Rule CH. 10 D 36)
An approved midwifery program shall include a course of study and clinical practice for a minimum of 3 years. If the applicant is a registered nurse or a licensed practical nurse or has previous nursing education or practical midwifery education experience, the required period of training may be reduced to the extent of the applicant's qualifications. In no case shall the training be reduced to a period of less than two (2) years.

This program focuses on broad, transferable skills and stresses understanding and demonstration of the following elements of the health care industry; planning, management, finance, technical and production skills, underlying principles of technology, labor issues, community issues and health, safety, and environmental issues.

The Health Careers Core must be taken by all students (secondary, postsecondary adult, and postsecondary vocational) planning to complete any Health Occupations program. Once successfully completed, the core does not need to be repeated at any instructional level.

Clinical Experience Rules: (467.009(4) F.S.)

(1) A student midwife, during training, shall undertake (under the supervision of a preceptor) the care of 50 women in each of the prenatal, intrapartal, and postpartal periods [the same women need not be seen through all three periods].

(2) The student midwife shall observe an additional 25 women in the intrapartal period before qualifying for a license.

(3) The training shall be in hospitals, alternative birth settings or both with particular emphasis on learning to differentiate between low-risk pregnancies or high-risk pregnancies.

(4) It shall be the responsibility of the program to obtain and maintain current contractual agreements with each agency utilized for student clinical training.

Students must take a licensing examination (FS 467.011). Minimal acceptable performance will be determined by The Department of Business and Professional Regulation.
The program must be approved by the Agency for Health Care Administration.

Entering students who have completed the program 0317.060500, Practical Nursing or 0318.110100 Associate Degree Nursing or have obtained an RN through another program should be given appropriate advanced standing.

Outcomes 01-11 are referred to as the Health Careers Core and do not have to be completed if the student has previously completed the Core in another health science program.The CORE should be taken first or concurrently with the first course in the program. Following the successful completion of the core, the student is eligible to take the National Health Care Foundation Skill Standards Assessment with instructor approval and the completion of a portfolio.

Career and Technical Student Organization (CTSO)

Health Occupations Students of America, Inc. (HOSA) is the appropriate career and technical student organization for providing leadership training and reinforcing specific career and technical skills. Career and Technical Student Organizations provide activities for students as an integral part of the instruction offered. The activities of such organizations are defined as part of the curriculum in accordance with Rule 6A-6.065, F.A.C.

Accommodations

Federal and state legislation requires the provision of accommodations for students with disabilities as identified on the secondary student's IEP or 504 plan or postsecondary student's accommodations plan to meet individual needs and ensure equal access. Postsecondary students with disabilities must self-identify, present documentation, request accommodations if needed, and develop a plan with their postsecondary service provider. Accommodations received in postsecondary education may differ from those received in secondary education. Accommodations change the way the student is instructed. Students with disabilities may need accommodations in such areas as instructional methods and materials, assignments and assessments, time demands and schedules, learning environment, assistive technology and special communication systems. Documentation of the accommodations requested and provided should be maintained in a confidential file.

Articulation

This program has no statewide articulation agreement approved by the Articulation Coordinating Committee. However, this does not preclude the awarding of credits by any college through local agreements.

For details on statewide articulation agreements which correlate to programs and industry certifications, refer to http://www.fldoe.org/workforce/dwdframe/artic_frame.asp.

Program Length

The AS degree requires the inclusion of a minimum of 15 credits of general education coursework according to SACS, and it must be transferable according to Rule 6A-14.030 (2), F.A.C. The AAS degree requires the inclusion of a minimum of 15 credits of general education coursework according to SACS. The standard length of this program is 90 credit hours according to Rule 6A-14.030, F.A.C.

Standards

01.0 Demonstrate knowledge of the health care delivery system and health occupations.
02.0 Demonstrate the ability to communicate and use interpersonal skills effectively.
03.0 Demonstrate legal and ethical responsibilities.
04.0 Demonstrate an understanding of and apply wellness and disease concepts.
05.0 Recognize and practice safety and security procedures.
06.0 Recognize and respond to emergency situations.
07.0 Recognize and practice infection control procedures.
08.0 Demonstrate an understanding of information technology applications in healthcare.
09.0 Demonstrate employability skills.
10.0 Demonstrate knowledge of blood borne diseases, including HIV/AIDS.
11.0 Apply basic math and science skills.
12.0 Recognize and utilize three aspects of midwifery management of care for pregnant women.
13.0 Assume responsibility for rendering antepartum care.
14.0 Assume responsibility for rendering intrapartum care.
15.0 Assume responsibility for rendering postpartum care.
16.0 Assume responsibility for rendering neonatal care.
17.0 Assumes responsibility for management of care of women seeking family planning and/or gynecologic service.
18.0 Demonstrate knowledge of the professional role and responsibilities of midwifery.
19.0 Demonstrate basic nursing/midwifery skills.

2011 - 2012

Florida Department of Education
Student Performance Standards

Program Title: **Midwifery**
CIP Numbers: **1318110300 AS, 0318110300 AAS**
Program Length: **90 credit hours**
SOC Code(s): **31-9099, 29-1111**

The AS degree requires the inclusion of a minimum of 15 credits of general education coursework according to SACS, and it must be transferable according to Rule 6A-14.030 (2), F.A.C. The AAS degree requires the inclusion of a minimum of 15 credits of general education coursework according to SACS. At the completion of this program, the student will be able to:

Health Careers Core: The Health Careers Core is a core of basic knowledge necessary for any health occupations career. Students who have previously completed the Health Careers Core or any other health occupations program do not have to repeat intended outcomes 01-11.

01.0 Demonstrate knowledge of the health care delivery system and health occupations. – The student will be able to:

- 01.01 Identify the basic components of the health care delivery system including public, private, government and non-profit.
- 01.02 Identify common methods of payment for healthcare services.
- 01.03 Describe the various types of healthcare providers and the range of services available including resources to victims of domestic violence.
- 01.04 Describe the composition and functions of a healthcare team.
- 01.05 Identify the general roles and responsibilities of the individual members of the healthcare team.
- 01.06 Identify the roles and responsibilities of the consumer within the healthcare delivery system.
- 01.07 Identify characteristics of effective teams.
- 01.08 Recognize methods for building positive team relationships.
- 01.09 Analyze attributes and attitudes of an effective leader.
- 01.10 Recognize factors and situations that may lead to conflict.
- 01.11 Demonstrate effective techniques for managing team conflict.
- 01.12 Describe factors that influence the current delivery system of healthcare.
- 01.13 Explain the impact of emerging issues including technology, epidemiology, bioethics and socioeconomics on healthcare delivery systems.

02.0 Demonstrate the ability to communicate and use interpersonal skills effectively. – The student will be able to:

- 02.01 Develop basic speaking and active listening skills.
- 02.02 Develop basic observational skills and related documentation strategies in written and oral form.
- 02.03 Identify characteristics of successful and unsuccessful communication including communication styles and barriers.
- 02.04 Respond to verbal and non-verbal cues.

02.05 Compose written communication using correct spelling, grammar, a formatting and confidentiality and specific formats of letter writing.
02.06 Use appropriate medical terminology and abbreviations.
02.07 Recognize the importance of courtesy and respect for patients and other healthcare workers and maintain good interpersonal relationships.
02.08 Recognize the importance of patient/client educations regarding healthcare.
02.09 Adapt communication skills to varied levels of understanding and cultural orientation including diverse age, cultural, economic, ethnic and religious groups.
02.10 Analyze elements of communication using a sender-receiver model.
02.11 Distinguish between and report subjective and objective information.
02.12 Report relevant information in order of occurrence.

03.0 Demonstrate legal and ethical responsibilities. – The student will be able to:

03.01 Discuss the legal framework of the healthcare occupations including scope of practice legislation.
03.02 Explain practices that could result in malpractice, liability, negligence, abandonment, false imprisonment and fraud.
03.03 Demonstrate procedures for accurate documentation and record keeping.
03.04 Interpret healthcare facility policy and procedures.
03.05 Explain the “Patient’s Bill of Rights”.
03.06 Identify standards of the Health insurance Portability and Accountability Act (HIPAA).
03.07 Describe advance directives.
03.08 Describe informed consent.
03.09 Explain the laws governing harassment, labor and employment.
03.10 Differentiate between legal and ethical issues in healthcare.
03.11 Describe a code of ethics consistent with the healthcare occupation.
03.12 Identify and compare personal, professional, and organizational ethics.
03.13 Recognize the limits of authority and responsibility of health care workers including legislated scope of practice
03.14 Recognize and report illegal and/or unethical practices of healthcare workers.
03.15 Recognize and report abuse including domestic violence and neglect.
03.16 Distinguish among the five schedules of controlled substances.

04.0 Demonstrate an understanding of and apply wellness and disease concepts. – The student will be able to:

04.01 Describe strategies for prevention of diseases including health screenings and examinations.
04.02 Identify personal health practices and environmental factors which affect optimal function of each of the major body systems.
04.03 Identify psychological reactions to illness including defense mechanisms.
04.04 Identify complementary and alternative health practices.
04.05 Discuss the adverse effects of the use of alcohol, tobacco, and both legal and illegal drugs on the human body and apply safety practices related to these and other high risk behaviors.
04.06 Explain the basic concepts of positive self image, wellness and stress.
04.07 Develop a wellness and stress control plan that can be used in personal and professional life.
04.08 Explain the nutrition pyramid.

04.09 Recognize the steps in the grief process.

05.0 Recognize and practice safety and security procedures. – The student will be able to:

05.01 Recognize safe and unsafe working conditions and report safety hazards.
05.02 Demonstrate the safe use of medical equipment.
05.03 Explain and apply the theory of root- cause analysis
05.04 Identify and describe methods in medical error reduction and prevention in the various healthcare settings.
05.05 Identify and practice security procedures for medical supplies and equipment.
05.06 Demonstrate personal safety procedures based on Occupations Safety and Health Administration (OSHA) and Centers for Disease Control (CDC) regulations (including standard precautions.
05.07 Recognize Materials Data Safety Sheets (MSDS) and comply with safety signs, symbols and labels.
05.08 Demonstrate proper body mechanics and ergonomics.
05.09 Demonstrate the procedure for properly identifying patients.
05.10 Demonstrate procedures for the safe transport and transfer of patients.
05.11 Describe fire, safety, disaster and evacuations procedures.
05.12 Discuss The Joint commission patient safety goals (www.jointcommission.org)

06.0 Recognize and respond to emergency situations. – The student will be able to:

06.01 Monitor and record vital signs.
06.02 Describe legal parameters relating to the administration of emergency care.
06.03 Obtain and maintain training or certification on cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), foreign body airway obstruction (FBAO) and first aid.
06.04 Recognize adverse drug related emergencies and take appropriate first aid action.

07.0 Recognize and practice infection control procedures. – The student will be able to:

07.01 Define principles of infection control including standard and transmission based precautions.
07.02 Demonstrate knowledge of medical asepsis and practice procedures such as hand-washing and isolation.
07.03 Demonstrate knowledge of surgical asepsis.
07.04 Describe how to dispose correctly of biohazardous materials according to appropriate government guidelines such as OSHA.

08.0 Demonstrate an understanding of information technology applications in healthcare. – The student will be able to:

08.01 Describe technology applications in healthcare.
08.02 Define terms and demonstrate basic computer skills.
08.03 Recognize technology applications in healthcare.
08.04 Interpret information from electronic medical documents.
08.05 Identify methods of communication to access and distribute data such as fax, e-mail and internet.

09.0 Demonstrate employability skills. – The student will be able to:

09.01 Identify personal traits or attitudes desirable in a member of the healthcare team.
09.02 Exemplify basic professional standards of healthcare workers as they apply to hygiene, dress, language, confidentiality and behavior (i.e. telephone etiquette, courtesy and self-introductions).
09.03 Identify documents that may be required when applying for a job.
09.04 Write an appropriate resume.
09.05 Conduct a job search.
09.06 Complete a job application form correctly.
09.07 Examine levels of education, credentialing requirements including licensure and certification, employment opportunities, workplace environments and career growth potential.
09.08 Recognize levels of education, credentialing requirements, employment opportunities, workplace environments and career growth potential.
09.09 Identify acceptable work habits.
09.10 Recognize appropriate affective/professional behavior.
09.11 Compare careers within the health science career pathways (diagnostic services, therapeutic services, health informatics, support services or biotechnology research and development).

10.0 Demonstrate knowledge of blood borne diseases, including HIV/AIDS. – The student will be able to:

10.01 Recognize emerging diseases and disorders
10.02 Distinguish between fact and fallacy about the transmission and treatment of diseases caused by blood borne pathogens including Hepatitis B.
10.03 Identify community resources and services available to the individuals with diseases caused by blood borne pathogens.
10.04 Identify "at risk" behaviors which promote the spread of diseases caused by blood borne pathogens and the public education necessary to combat the spread of these diseases.
10.05 Apply infection control techniques designed to prevent the spread of diseases caused by blood borne pathogens to the care of all patients following Centers for Disease Control (CDC) guidelines.
10.06 Demonstrate knowledge of the legal aspects of HIV/AIDS, including testing.

11.0 Apply basic math and science skills. – The student will be able to:

11.01 Draw, read, and report on graphs, charts and tables.
11.02 Measure time, temperature, distance, capacity, and mass/weight.
11.03 Make, use and convert using both traditional and metric units.
11.04 Make estimations and approximations and judge the reasonableness of the result.
11.05 Convert from regular to 24 hour time.
11.06 Demonstrate ability to evaluate and draw conclusions.
11.07 Organize and communicate the results obtained by observation and experimentation.
11.08 Ask appropriate scientific questions and recognize what is involved in experimental approaches to the solution of such questions.
11.09 Calculate ratios.

Midwifery: Students completing this module achieve the occupational completion point of Midwife.

12.0 Recognize & utilize three aspects of midwifery management of care for pregnant women. – The student will be able to:

- 12.01 Provide safe, effective basic health care monitoring, management, teaching and referral service for healthy women throughout the normal uncomplicated childbearing experience.
  - 12.01.01 Apply therapeutic communication techniques, including interviewing, counseling, and client teaching.
  - 12.01.02 Demonstrate basic physical assessment skills of observation, palpation, percussion, auscultation and measurement in collecting data describing current health status.
  - 12.01.03 Perform basic laboratory assessment, including hematocrit, hemoglobin, urine analysis, and vaginal/cervical smears.
- 12.02 Interpret data to identify current and potential health problems and needs.
- 12.03 Formulate a complete needs/problem list and establish health care goals in collaboration with the client and her family.
- 12.04 Identify need for consultation or referral to appropriate members of the health care team in meeting health care goals.
- 12.05 Provide information and support to enable clients to actively participate in their own health care management.
- 12.06 Develop, implement and evaluate a comprehensive plan of care with the client based on supportive, scientific rationale.
- 12.07 Identify those current or potential client problems requiring consultation, referral and/or co-management and obtain consultation promptly or plan and implement collaborative management with other providers.
- 12.08 Utilize appropriate consultation, collaboration or referral for deviations from normal and potential complications.
- 12.09 Establish a written protocol with a physician who maintains supervision for directing the specific course of medical treatment for the "at-risk" client.
- 12.10 Refer and/or transfer care of the client when the need is identified for management outside the scope of the midwife's practice.
- 12.11 Implement appropriate Joint Commission patient safety goals.

13.0 Assume responsibility for rendering antepartum care. – The student will be able to:

- 13.01 Utilize principles of basic sciences in rendering antepartum care.
- 13.02 Provide basic health surveillance, anticipatory guidance and health teaching for healthy women experiencing normal, uncomplicated pregnancies.
- 13.03 Determine pregnancy accurately by history, physical and laboratory findings.
- 13.04 Assess the physical health status of the client, including preconceptual factors likely to influence this pregnancy.
- 13.05 Assess the psychosocial status of the client and her support system.
- 13.06 Identify social, cultural, environmental and occupational factors that influence the client's response to pregnancy and pregnancy related behaviors.
- 13.07 Assess nutritional status and provide nutritional counseling.
- 13.08 Differentiate between normal and pathologic adaptations to pregnancy, including hematologic changes and intervene appropriately.
- 13.09 Identify risk factors requiring consultation and/or referral.

13.10 Demonstrate knowledge of pharmacokinetics in administration of medications commonly used in pregnancy.
13.11 Identify current, potential and emergent problems and needs affecting pregnancy.
13.12 Differentiate between normal physiologic pregnancy, common pregnancy-related discomforts, and pathologic disorders.
13.13 Assist client in managing common minor pregnancy-related discomforts such as fatigue, nausea, heartburn, backache, leg cramps, vaginal discharge, and constipation.
13.14 Provide anticipatory guidance regarding developmental tasks of childbearing, prepared childbirth, lactation/breastfeeding and parenthood.
13.15 Assess fetal well-being, including intrauterine growth, fetal heart rate, and fetal movement through various methods such as fetal movement records, ultrasonography, NST, and OCT.
13.16 Interpret assessment data accurately to determine client and fetal health status.
13.17 Initiate consultation and/or referral as needed to safeguard health of the client and the fetus.
13.18 Discuss options in childbearing sites and practitioners to facilitate client informed choice and consent.
13.19 Refer client to appropriate community agencies, resources and educational referral services as needed.

14.0 Assume responsibility for rendering intrapartum care. – The student will be able to:

14.01 Utilize principles of the basic sciences in rendering intrapartum care.
14.02 Describe the normal labor process, including mechanisms of labor and birth.
- 14.02.01 Differentiate between Braxton Hicks contractions, preterm labor and prodromal labor.
- 14.02.02 Assess frequency, duration, intensity of and interval between contractions.
- 14.02.03 Identify the status of the membranes.
- 14.02.04 Identify fetal presenting, position, and heart rate.
- 14.02.05 Assess cervical effacement and dilation and station of the presentating part.
- 14.02.06 Differentiate between bloody show and uterine/placental bleeding.

14.03 Demonstrate knowledge of the fetal skull and its critical landmarks.
14.04 Describe parameters and methods for assessing and managing the process of labor and delivery.
14.05 Describe parameters and methods for assessing maternal and fetal status during the stages of labor.
14.06 Demonstrate knowledge of the emotional changes during labor and delivery.
14.07 Provide comfort and support during labor and delivery including non-pharmacologic pain management techniques.
14.08 Describe and demonstrate techniques for spontaneous vaginal delivery and placental expulsion.
14.09 Identify indicators of deviations from normal labor and delivery and utilize appropriate interventions.
14.10 Assess and manage care of the perineum and surrounding tissues.
14.11 Provide immediate care to the newborn, including assessment, maintaining a patent airway and managing thermal instability.

14.12 Demonstrate knowledge of pharmacokinetics and administration of medications commonly used during labor and birth.
14.13 Explain the role and function of the midwife in relation to emergency management.

15.0 Assume responsibility for rendering postpartum care. – The student will be able to:

15.01 Demonstrate a knowledge of and utilize principles of the basic sciences in rendering postpartum care.
15.02 Demonstrate a knowledge of anatomy and physiology of the puerperium.
15.03 Describe involution, recognize indicators of deviation from normal, and utilize appropriate intervention.
15.04 Teach methods of breast care and lactation to client utilizing anatomy and physiology of lactation.
15.05 Identify the etiology, and manage discomforts of puerperium.
15.06 Identify indicators of deviations from the normal puerperium and utilize appropriate intervention, including consultation and referral.
15.07 Demonstrate knowledge of the pharmacokinetics and administration of medications commonly used during the puerperium.
15.08 Describe the nutritional requirements of the postpartum period.
15.09 Describe the purpose and process of completing and filing a birth certificate according to Florida law.
15.10 Recognize and respond appropriately to the emotional and psychosocial changes during the puerperium.
15.11 Provide anticipatory guidance regarding client self care, infant care, family planning and alterations in family roles and expectations.
15.12 Describe and utilize appropriate screening/diagnostic tests during puerperium.

16.0 Assume responsibility for rendering neonatal care. – The student will be able to:

16.01 Demonstrate a knowledge and utilize principles of the basic sciences in rendering neonatal care.
16.02 Manage the health care of the normal infant during the neonatal period and initiate consultation and referral as appropriate.
16.03 Explain anatomical and physiological adaptation to extrauterine life and stabilization of the neonate.
16.04 Facilitate adaptation to extra-uterine life including resuscitation and emergency care of the newborn.
16.05 Assess neonatal status (physical, emotional and psychosocial).
16.06 Recognize deviations from normal neonatal status and initiate appropriate intervention, management and/or referral.
16.07 Describe the components of breast milk and formula, the nutritional needs of the neonate and relationship of feeding methods to physiological, immunological and psychological development.
16.08 Demonstrate the pharmacokinetics and administration of medications and the treatments commonly used for the neonate.
16.09 Describe the rationale and methodology for the common screening/diagnostic tests performed on the neonate and utilize those appropriate to scope of practice.
16.10 Describe the factors influencing neonatal behavior and parental interaction and attachment.

16.11 Anticipate need for and provide appropriate guidance regarding infant care, breast feeding and family relationships, to include referral to community resources.

17.0 Assume responsibility for management of care of women seeking family planning and/or gynecologic service. – The student will be able to:

17.01 Demonstrate a knowledge of and utilize principles of the basic sciences in rendering family planning and/or gynecologic service.
17.02 Explain anatomy and physiology of male and female reproductive systems throughout the life cycle.
17.03 Explain anatomy, physiology and psychosocial components of human sexuality.
17.04 Recognize and respond appropriately to indications of need for sexual counseling and/or referral.
17.05 Provide counseling regarding general health promotion, as well as measures related to developmental changes throughout the life cycle.
17.06 Describe rationale and methods for common gynecological and pregnancy screening and diagnostic tests, utilizing those appropriate to scope of practice.
17.07 Describe factors relating to male and female barrier, steroidal, mechanical, chemical, physiologic and surgical conception control methods, including fertility awareness.
17.08 Explain factors involved in decision making regarding unplanned or undesired pregnancies and resources for counseling and referral, including preconceptual counseling.
17.09 Identify and describe deviations from normal status and provide appropriate preventive measures and/or interventions for selected pathology.

18.0 Demonstrate knowledge of the professional role and responsibilities of midwifery. – The student will be able to:

18.01 Describe the historical development and present status of midwifery in Florida, nationally, and internationally.
18.02 Describe and practice within the laws, rules, regulations and public policies affecting midwifery practice including malpractice and litigation issues.
18.03 Utilize codes and guidelines for ethical and professional behavior, including those set by state and national professional organizations.
18.04 Describe the midwife's responsibility for ongoing self evaluation, participation in quality assurance and maintenance of currency in practice, including continuing education.
18.05 Demonstrate understanding of various sites, styles and modes of practice within midwifery - the delivery of ethnic and culturally sensitive care.
18.06 Promote health care as educator, client advocate, health care provider, social/political change agent and collaborator with other health team members.
18.07 Explain the implications of HIV infection and seropositive tests in pregnancy, childbirth, lactation, child care and seroconversion among children of HIV positive parents.

19.0 Demonstrate basic nursing/midwifery skills. – The student will be able to:

19.01 Collect appropriate data base describing current health status, including complete history, physical and psychosocial assessment.

19.02 Obtain and interpret relevant laboratory data.
19.03 Promote and maintain a safe and therapeutic environment.
19.04 Implement and maintain medical and surgical asepsis.
19.05 Use proper body mechanics.
19.06 Recognize changes in a client's condition requiring intervention with basic safety measures, including emergency interventions as specified by statute/rule.
19.07 Administer and/or supervise complete hygienic care.
19.08 Perform comfort measures such as backrub, relaxation techniques, and diversional activities.
19.09 Assess nutritional status and utilize therapeutic principles of nutrition.
19.10 Assess client elimination needs and utilize therapeutic principles of elimination such as catheterization and enemas.
19.11 Prepare and administer medications as specified by statute/rule and assess client response.
19.12 Utilize appropriate medical terminology and abbreviations.
19.13 Chart and maintain client files.
19.14 Utilize problem solving skills and judgment in midwifery practice.

WAC 246-834-140
Curriculum.

Agency filings affecting this section

(1) The basic curriculum shall be at least three academic years, and shall consist of both didactic and clinical instruction sufficient to meet the educational standards of the school and of chapter 18.50 RCW. However, the school may shorten the length of time for the program after consideration of the student's documented education and experience in the required subjects, if the applicant is a registered nurse under chapter 18.88 RCW, a licensed practical nurse under chapter 18.78 RCW, or has had previous nursing education or practical midwifery experience. The midwifery training shall not be reduced to a period of less than two academic years. Each student must undertake the care of not less than fifty women in each of the prenatal, intrapartum and early postpartum periods. The care of up to thirty five women in each of the periods may be undertaken as a part of previous nursing education or practical midwifery experience as defined in WAC 246-834-010(5). No less than fifteen women must be cared for in each period while enrolled in the school from which the student graduates. The student need not see the same women throughout each of the periods. A candidate for licensure must observe an additional fifty women in the intrapartum period in order to qualify for licensure. Up to thirty five of these observations may be as a part of previous nursing education or practical midwifery experience as defined in WAC 246-834-010(5). No less than fifteen women must be observed in the intrapartum period while enrolled in the school from which the student graduates.

(2) Each school must ensure that the students receive instructions in the following instruction area:

(a) Instruction in basic sciences (including biology, physiology, microbiology, anatomy with emphasis on female reproductive anatomy, genetics and embryology) normal and abnormal obstetrics and gynecology, family planning techniques, childbirth education, nutrition both during pregnancy and lactation, breast feeding, neonatology, epidemiology, community care, and medicolegal aspects of midwifery.

(b) Instruction in basic nursing skills and clinical skills, including but not limited to vital signs, perineal prep, enema, catheterization, aseptic techniques, administration of medications both orally and by injection, local infiltration for anesthesia, venipuncture, administration of intravenous fluids, infant and adult resuscitation, and charting.

(c) Clinical practice in midwifery which includes care of women in the prenatal, intrapartal and early postpartum periods, in compliance with RCW 18.50.040.

(3) Provision shall be made for systematic, periodic evaluation of the curriculum.

(4) Any proposed major curriculum revision shall be presented to the secretary at least three months prior to implementation.

[Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-140, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-140, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 87-21-011 (Order PM 686), § 308-115-140, filed 10/9/87; WSR 85-23-044 (Order PL 566), § 308-115-140, filed 11/18/85; WSR 82-19-079 (Order PL 406), § 308-115-140, filed 9/21/82.]

WAC 246-834-130

Agency filings affecting this section

Staffing and teacher qualifications.

At the time of application for accreditation pursuant to WAC 246-834-180, the school shall provide proof of the following:

(1) That the academic director for the midwifery program is either (a) a midwife licensed under chapter 18.50 RCW or (b) a nurse midwife (ARNP) licensed under chapter 18.88 RCW or (c) has been educated in a midwifery program having standards comparable to standards in Washington and has experience in legal midwifery clinical practice.

(2) That the clinical faculty and preceptors either (a) hold a current license in the jurisdiction where they practice and demonstrate expertise in the subject area to be taught, or (b) are legally engaged in an active clinical practice and demonstrate expertise in the subject area to be taught.

(3) That each member of the faculty either (a) holds a certificate or degree in midwifery or the subject area to be taught, or (b) has no less than three years of experience in the subject area to be taught.

[Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-130, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-130, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.045. WSR 86-16-012 (Order PM 608), § 308-115-130, filed 7/25/86. Statutory Authority: RCW 18.50.135. WSR 82-19-079 (Order PL 406), § 308-115-130, filed 9/21/82.]

WAC 246-834-150

Agency filings affecting this section

Students.

(1) Written policies and procedures for selection, admission, promotion, graduation and withdrawal of students shall be available.

(2) Courses completed prior to enrollment in the midwifery school should have been completed within ten years of enrollment and must be documented by official transcript in order for reduction of basic requirements to be considered.

(3) Students who seek admission by transfer from another midwifery educational program shall meet the equivalent of the school's current standards for those regularly enrolled. The school may grant credit for the care of up to thirty five women in each of the periods undertaken as a part of previous midwifery education. No less than fifteen women must be cared for in each period while enrolled in the school from which the student graduates. The student need not see the same women throughout each of the periods. A candidate for licensure must observe an additional fifty women in the intrapartum period in order to qualify for licensure. Up to thirty five of these observations may be as a part of previous midwifery education. No less than fifteen women must be observed in the intrapartum period while enrolled in the school from which the student graduates.

(4) Individuals may request advanced placement on the basis of their previous practical midwifery experience as specified in RCW 18.50.040(2) and WAC 246-834-010(5) but in no case shall a school grant credit for more than thirty-five of the fifty required managed births. At least fifteen of the managed births must be undertaken while enrolled in the school granting advanced placement.

(5) Each school shall maintain a comprehensive system of student records.

[Statutory Authority: RCW 18.50.135 and 18.50.045. WSR 92-02-018 (Order 224), § 246-834-150, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. WSR 91-02-049 (Order 121), recodified as § 246-834-150, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.50.135. WSR 85-23-044 (Order PL 566), § 308-115-150, filed 11/18/85; WSR 82-19-079 (Order PL 406), § 308-115-150, filed 9/21/82.]

EMERGENCY CARE PLAN

Midwife Name Charlie Rae Young Phone # (813) 944-9120

Personal Data

Mother's Name _____ Partner Name _____

Address & Directions _____

_____

Home Ph. _____ Wk Ph _____ Cell Ph _____

EDD _____ Allergies _____ G/ P _____

Health Care Provider/Facilities/Services

Obstetrician Hospitalist or OB on call at nearest L& D unit Office Phone _____

Nearest L& D Unit /Address _____

L&D Phone/FAX _____ NICU Ph _____ ER Phone _____

Pediatrician _____ Phone _____ Fax _____

Address _____

Affirmation

In the event of complications during my pregnancy, labor, birth or postpartum recovery or my newborn's initial transition period, the Licensed Midwife will transfer my care to the appropriate health care facility/provider. I understand that my midwife or her representative will accompany me to the hospital and continue to provide supportive care whenever possible. I understand that I am responsible for any expenses incurred as a result of this hospitalization and will make arrangements of the payment of the hospital bill. I further understand that, if I delay or refuse to accept emergency care as advised, the Licensed Midwife may discontinue her service to me. I certify that I have provided input and participated in the development of this Emergency Care Plan and accept my responsibility for its implementation should complications arise. I have received a copy of this plan and will keep it readily available to myself and my support people.

_____ _____

Client Signature Date

_____ _____

Midwife Signature Date

PURSUANT TO F.S. 467.017, THE MIDWIFE SHALL COMPLETE AN EMERGENCY CARE PLAN FOR EACH CLIENT

Rule Suggestions for 64B24 - Licensed Midwifery
By the Midwives Association of Florida 2015

64B24-2.004 Licensure by Endorsement.
The document which renders the foreign trained applicant eligible to practice Obstetrics or midwifery in the country in which that document was issued;
2. The completed midwifery or medical program with a specialty in obstetric equivalent to a three year program, offered the equivalent to 90 credit hours, and included minimum required exposure to course work and practicum areas as demonstrated by use of the Form DH-MQA 1111, 8/07, EVALUATION TOOL – Four Month Pre-Licensure Course Foreign-Trained Midwife Applicant for Licensure By Endorsement, incorporated herein by reference.

(2)(a) Persons trained in another state for licensure by endorsement shall make application to the department pursuant to Rule 64B24-2.001, F.A.C., and shall in addition submit to the department:

2. A certificate or diploma awarded by a midwifery program which was **ACCREDITED BY MEAC OR ACCREDITED BY A ENTITY RECOGNIZED BY THE US DEPARTMENT OF EDUCATION AND was approved by the certifying body of the state in which it was located, or an authenticated copy of thatcertificate or diploma;**

64B24-4.010 Four-month Pre-licensure Course.
(1) The four (4) month pre-licensure course shall be approved by the department and shall include, at a minimum:
(a) Content review and demonstration of proficiency in the core competencies established by the American
College of Nurse Midwives and the Midwives Alliance of North America;
(b) A Florida Laws and Rules Component;
(c) Provisions for supervised labor, supervised post-partum, supervised newborn exams, and deliveries
and supervised prenatal visits equivalent or exceeding the NARM requirements by each course participant
with a florida preceptor and completed within the state of Florida.

64B24-4.007 Clinical Training.

(5) The student midwife, during training, shall undertake, under the supervision of a preceptor, the care of 50 women in each of the antepartal, intrapartal and postpartal periods, but the same women need not be seen through all 3 periods. **The student shall undertake, under the supervision of a preceptor 5 vaginal repairs using appropriate suture techniques,** The intrapartum period includes labor, birth, and the immediate postpartum. No more than five percent (5%) of the required intrapartal managements shall include transfers in active labor.

64B24-4.007 Clinical Training.
(2) Clinical learning experiences based on program objectives shall include a variety of clinical settings andfacilities within the State of Florida such as homes, birth centers, clinics, offices and hospitals. **80% of all clinical experiances must occur under the supervision of a Florida Licensed Midwife and must occur within the state of Florida.**

64B24-3.005 Initial License Fee.
The initial license fee whether by examination or endorsement shall be $500. **If the initial application for licensure is made after the 365 th day of the biennium the fee shall be $250 for the remainder of the licensing period.**

64B24-7.001 Definitions.
As used in this rule chapter, the term:
(1) "Discussion" A discussion refers to a situation in which the midwife seeks advice or information from a another Licensed midwife, an ARNP, or a physician about a clinical situation, presenting her management plan for feedback.

(2) "Consultation" A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation. In providing care, licensed midwives and physicians will take into account their patient's own informed choices

(3) **"Transfer" When care is transferred permanently or temporarily from the midwife to a qualified hospital- based provider, the receiving practitioner assumes full responsibility for subsequent decisionmaking, together with the client.**

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. **These conditions that a licensed midwife may encounter in practice for which discussion,**
consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

INDICATIONS:

I. Pre-existing Conditions and Initial History

Discussion:
•family history of significant genetic disorders, hereditary disease, or congenital anomalies
•history of pre-term birth (< 36 weeks)

• history of IUGR
•history of severe postpartum hemorrhage
•history of severe pre-eclampsia
•history of gestational diabetes
• history of uterine surgery, including: myomectomy, or prior cesarean birth with subsequent uncomplicated
vaginal birth.
• history of asthma
• Congenital heart defects or heart disease assessed by a cardiologist which places the mother or fetus at no
risk
• history of postpartum hemorrhage not requiring transfusion

Consultation:
•history of uterine surgery, including: myomectomy, or prior cesarean birth without subsequent uncomplicated vaginal birth.
•current or significant history of cardiovascular disease, renal disease, hepatic disorders, neurological
disorders, severe gastrointestinal disease
•current or significant history of endocrine disorders (excluding controlled mild hypothyroidism)
•pulmonary disease/active tuberculosis
•collagen-vascular diseases
•significant hematological disorders
•current or significant history of cancer
•history of cervical cerclage
•history of 3 consecutive spontaneous abortions
•significant uterine anomalies
•essential hypertension
•history of eclampsia or HELLP
•previous unexplained neonatal mortality or stillbirth
•isoimmunization with an antibody known to cause hemolytic disease of the newborn
•history of postpartum hemorrhage requiring transfusion
•current mental health problems requiring drug therapy
•no prenatal care prior to third trimester
•history of seizures in the last 2 years or current use of anticonvulsent medications.

Transfer:
•absent prenatal care at term
•any serious medical condition, for example: uncontolled cardiac disease, renal disease with failure, insulindependent
diabetes mellitus, or uncontrolled asthma

II. Antepartum Conditions

Discussion:
•urinary tract infection unresponsive to treatment
•well-controlled gestational diabetes
•persistent size/dates discrepancies

Consultation:
•significant abnormal Pap in the current pregnancy
•significant abnormal breast lump
•pyelonephritis
•thrombosis
•fetal demise after 14 weeks gestation
•persistent anemia of < 10 hgb, unresponsive to treatment
•primary herpes infection
•significant vaginal bleeding
•isoimmunization, hemoglobinopathies
•persistent and/or abnormal fetal heart rate or rhythm
•significant placental abnormalities
•documented intrauterine growth restriction
•unresolved polyhydramnios or oligohydramnios
•completion of 41 to 42 weeks gestation with reassuring surveillance of fetus
•presentation other than cephalic at 37 weeks
•multiple gestation
persistent gestational hypertension absent of other symptoms

Transfer:
•premature pre-labor rupture of membranes (PPROM)
• HELLP, pre-eclampsia, or eclampsia
•placenta previa 32 weeks gestation
•ectopic pregnancy
•molar pregnancy
•clinically significant placental abruption
•cardiac or renal disease with failure
•uncontrolled gestational diabetes
•known fetal anomaly or condition that requires physician management during or immediately after delivery

III. Intrapartum Conditions

Discussion:
•arrested active phase of labor (>6 hours of regular, strong contractions without any significant change in
cervix and/or station and/or position)
• arrested 2nd stage of labor (2 hours of active pushing without any significant change)

Consult:
• arrested 2nd stage of labor (>3 hours of active pushing without any significant change)
• moderate meconium
• ROM > 18 documented without active labor GBS negative mother or GBS positive with tx prophylactic
antibiotics

Transfer:
• thick meconium
•labor before 37 weeks
•transverse lie, oblique lie
•sustained maternal fever (>100.4 F) or other evidence of maternal infection
• persistent non-reassuring fetal heart rate pattern
• maternal exhaustion unresponsive to rest/hydration
• abnormal bleeding during labor
• suspected placental abruption
• suspected uterine rupture
• pre-eclampsia
•maternal seizure
•ROM >48 hours or ROM >18 hours with unknown GBS status and no prophylactic antibiotics or GBS+ and
no prophylactic antibiotics
•prolapsed cord or cord presentation
•significant allergic response
•active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
•client's clear desire for pain relief or hospital transport

IV. Postpartum Conditions

Consultation:
• subinvolution
•retained products/unresolved subinvolution
•sustained hypertension
•significant abnormal Pap
•postpartum depression
•retained placenta (>1 hour)

Transfer:
•significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign
instability or shock
•retained placenta (90 minutes or active bleeding and manual removal unsuccessful)
• 3th or 4th lacerations, or laceration beyond the ability of the midwife to repair
•unusual or unexplained significant pain or dyspnea
• significant hematoma
•endometritis
•postpartum psychosis
•maternal seizure
• anaphylaxis
•persistent uterine prolapse or inversion

V. Newborn Conditions

Discussion:
•low birth weight infant (< 2500 gm = 5 lbs 8 oz)

Consultation:
•persistent cardiac arrhythmias or murmurs
•significant clinical evidence of prematurity
•failure to thrive
•hypoglycemia

Transfer:
•seizure
•persistent respiratory distress
•persistent central cyanosis or pallor
•persistent temperature instability
•persistent hypoglycemia
•Apgar score less than 7 at five minutes of age and not improving
•major apparent congenital anomalies
•birth injury requiring immediate medical attention
•significant jaundice in first 24 hours or pathologic jaundice at any time

64B24-7.006 Preparation for Home Delivery.
(1) For home births, the licensed midwife shall:
(a) Encourage each patient to have medical care available by a health care practitioner experienced in obstetrics
throughout the prenatal, intrapartal and postpartal periods, and
(b) Make a home visit by 36 weeks of pregnancy. The licensed midwife **or her staff** shall ensure that the setting
in which the infant is to be delivered is safe, clean and conducive to the establishment and maintenance of health.
(2) The midwife shall prepare or cause to be prepared the following facilities to be used for delivery:
(a) The area used for labor shall be cleaned, well lighted, well ventilated and close to the toilet.
(b) The delivery area should be large enough to allow ample work space and provide privacy.
(c) The delivery area must be organized, well lighted, clean, free from drafts and insects, near handwashing
facilities and clear of unnecessary furnishings.
(d) A safe, clean sleeping arrangement for the infant.
(3) The midwife shall instruct the expectant parents and ensure that appropriate supplies are on hand for use by
the mother and infant at the time of delivery and early postpartum.
(4) The midwife shall have the following equipment and supplies clean and ready for use at delivery:
(a) Sterile obstetrical pack.
(b) Suction device.
(c) Oxygen
(d) Eye prophylaxis pursuant to Section 383.04, F.S.
(e) !

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

(1) The licensed midwife shall:

(a) Require each patient to have a complete history and physical examination which includes: !

1. HIV
2. Hep B
3. Blood group including Rh factor and antibody screen.
4. Complete blood count (CBC).
5. GBS testing at 36 weeks gestation
6. Other testing as deemed appropriate by the midwife based on risk, assesment or request of patient. !

(b) give the patient informed consent and the right to refuse any screening as per F.S. 381.026
(c) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.
(d) Provide counseling and offer screening related to the following:
1. Neural tube defects.
2. UA with Culture
3. CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.
4. Nutritional counseling.
5. Childbirth preparation.
6. Risk Factors.
7. Common discomforts of pregnancy.
8. Danger signs of pregnancy.
9. Gonorrhea and chlamydia screening.
10. Rubella titer.
11. Gonorrhea and chlamydia screening.
12. Serological screen for syphilis.
13. Hep C screening

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. Repeat screenings as per rule 64D-3.042 (Public Health law) 28 and 32 weeks.
(e) Require prenatal visits every four weeks until 28 weeks gestation, every two weeks 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 patient gives consent, or twenty weeks with a fetoscope.**
(d) Recording of quickening date.
(e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.

!

(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 licensed midwife shall continue to evaluate a patient during the antepartum, intrapartum and postpartum. If the patient has indications for transport pursuent to **64B24-7.004 Risk Assessment** and 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.
(6) 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.