FLORIDA | Council of Licensed Midwifery

DRAFT
October 14, 2015

Omni Orlando Resort at Championsgate
1500 Masters Boulevard
Championsgate, Florida

Melissa Conord-Morrow, LM
Chair

Susan "Robyn" Mattox, LM
Vice Chair

Claudia J. Kemp, JD
Executive Director

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

General Business started: 9:07 a.m.

MEMBERS PRESENT
Melissa Conord-Morrow, LM, Chair
Susan Robyn Mattox, LM, Vice Chair
Charlie Young, LM
Tania Mondesir, RN, LM
Dana Barnes, MD
David S. Stewart, MD
Kathy Bradley, Consumer Member

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

MEMBERS EXCUSED
Robert Pearson-Martinez, MD
Stephanie Wombles, CNM
Dr. Stewart moved that the absences be unexcused since this is the second absence for each. Ms. Maddox seconded.
Vote: unanimous.

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

COURT REPORTER
American Court Reporting
Suzette Bragg
407-896-1813

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

General Business started: 9:07 a.m.

1. APPROVAL OF MINUTES

July 13, 2015 – Full Council Meeting

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

Approval of Minutes ended: 9:12 a.m.
Rule Discussion started: 9:12 a.m.

Part 2 through 22: RULE DISCUSSION

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

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

Discussion:
Ms. Mattox handed out a suggested checklist and new format for risk assessment, rule 64B24-7.004, F.A.C., which incorporated the comments of Dr. Barnes with regard to antepartum care. This handout grouped risk screening by risk factors instead of the current grouping of systems and history.
Ms. Young felt Dr. Barnes' comments were on point, especially in regard to informed refusal and informed consent in rule 7.005, F.A.C.

Dr. Barnes informed the council that her suggestion for "medical consultation for "non-vertex" presentation" should read "medical consultation for "non-cephalic" presentation."
Discussion commenced regarding Ms. Mattox's hand out.

Ms. Conord-Morrow commented that the existing list in the rule would have to be deleted and the "checklist" format incorporated.
The council agreed to have a single form for the practice.
The council discussed the issue of low BMI in pregnancy and recommended adding a consult for BMI less than 18.5 for initial visit risk assessment.
Dr. Stewart commented that excessive weight gain should be a part of 28 week visit evaluation.
Ms. Mattox explained that her "checklist" was intended for ongoing risk assessment not specific to a particular visit or period in the pregnancy.

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

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

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

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

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

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

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

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

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

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

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

The council discussed that the risk acceptance for care appropriate to be delivered outside of the hospital (extramural) won't be added by most referral or consulting doctors. The midwives on the council asked if collaboration can be with a specialist and not just an obstetrician. Dr. Stewart opined that an obstetrician is necessary but the midwife may also bring in a specialist particular to the pathology involved. Dr. Stewart opined that the phrase "normal labor" leaves a wide gap since the expectation is that every patient will have a normal labor.
Strike "normal pregnancy" and substitute "not at an increased risk for labor complications" and then it wouldn't require the physician to say it's OK. Ms. Mattox not in favor of any change in the language. If made binding, then most patients would not have an extramural birth (see ACOG position statement).

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

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

10:42 Council break
10:58 Council returned

Discussion ensued as to whether intrapartum, postpartum and newborn care recommendations should be added to a December teleconference or whether the council should stay later today and complete the recommendations.
Council questioned how information regarding new rules or other matters of interest to the profession is disseminated. Ms. Rodgers informed the council about notification by active campaign or US postal service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Break for lunch 12:43 pm
Return 1:34 pm

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

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

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

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

Rule 64B24-7.001, F.A.C., "Consult" definition should add: formal written communication between midwife and physician licensed under chapter 458 or 459, F.S., documented in the patient record.
Collaborative management means the midwife works in conjunction with the physician
Referral – a written communication for a face-to-face appointment for the patient with a physician licensed under chapter 458 or 459, F.S., if anything of itself is a risk factor 3, but not a three in the aggregate

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

Rule 64B24-7.008, F.A.C., discussion:
7.008(1) – no change
7.008(2) – no change
7.008(3) – pulse and temp taken every two hours
– two hours for edema

– Fetal heart tones the earlier of every 5 minutes and adjust for contractions (of after every other contraction)
[ACOG defines active labor at 6 cm]

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

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

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

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

No other changes.

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

Break 3:45
Resumed 4:02

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

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

3. 64B24-1.004 Terms, Meetings, Quorum, and Absences
4. 64B24-2.001 Licensure to Practice Midwifery
5. 64B24-2.0011 Forms
6. 64B24-2.002 Examination
7. 64B24-2.003 Licensure by Examination
8. 64B24-2.004 Licensure by Endorsement
9. 64B24-3.002 Application Fees
10. 64B24-3.003 Examination Fee
11. 64B24-3.004 Endorsement Fee
12. 64B24-3.005 Initial License Fee
13. 64B24-3.006 Temporary Certificate Fee
14. 64B24-3.007 Active Biennial Renewal Fee
15. 64B24-3.008 Delinquent Fee
16. 64B24-3.009 Reactivation Fee
17. 64B24-3.011 Duplicate License Fee
18. 64B24-3.013 Continuing Education Provider Application Fee
19. 64B24-3.014 Unlicensed Activity Fee
20. 64B24-3.015 Change of Status Fee
21. 64B24-3.016 Inactive Renewal Fee
22. 64B24-3.017 Retired Status Fee

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

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

The council members agreed that there is no definition of "classroom hours" but the classroom hours must be taken in a "brick and mortar" school.

Rules discussion ended: 4:17 p.m.
Annual Report started: 4:17 p.m.

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

Discussion:
Dr. Barnes – annual report form

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

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

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

Annual Report ended: 4:38 p.m.
Old Business started: 4:38 p.m.

24. OLD BUSINESS

Unlicensed activity - Ms. Mattox

Discussion from last meeting:
Whether it is appropriate for students to be taken out of country for clinical experience.

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

Discussion from last meeting:

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

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

Old Business ended: 5:00 p.m.
New Business started: 5:00 p.m.

25. NEW BUSINESS: None

NEXT MEETING DATE – Board staff to send out December meeting dates for consideration.
Next in-person meeting is February 8, 2016. Board staff to send out possible locations for consideration.

ADJOURNMENT

General Business concluded at: 5:02 p.m.
The Council adjourned at 5:02 p.m.