

# CNM Advisory Council Memo

To: Certified Nurse Midwife Advisory Council  
From: Kelli Stevens, General Counsel  
Stacy Bond, Assistant General Counsel  
Date: July 12, 2016  
Re: Materials and Items for Discussion at Meeting on July 14, 2016

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The materials for this meeting are bookmarked and include the following resources:

- Kansas Independent Practice of Midwifery Act (HB 2615, beginning New Sec. 88)
- Healing Arts Board Duties regarding new Independent Practice of Midwifery Act
- Comparison Chart of CNM practice under Board of Nursing vs. Board of Healing Arts
- Kansas Birthing Center regulations
- Core Competencies for Basic Midwifery Practice
- Standards for Practice of Midwifery
- ACOG Obstetric Care Consensus- Levels of Maternal Care
- Sampled midwifery license language from other states' statutes and regulation
- Link for Commission on Accreditation of Birth Centers Compliance Standards  
<https://www.birthcenteraccreditation.org/go/get-cabc-indicators/>  
(Note Section 7 is detailed on identifying "RISK" —examples of low-risk women and when to consult/refer)

The primary purpose of this Council meeting is to begin regulation development for the scope of practice of independent CNMs who will be licensed by the Board of Healing Arts beginning January 1, 2017. The regulations will implement the new Independent Practice of Midwifery Act and set minimum standards for practice. The regulations developed should not conflict with the Kansas Birthing Center regulations, but may be more or less detailed in definitions, requirements, etc.

Some items/issues for which the Council may wish to consider developing regulations are:

- A threshold requirement for licensure (ex. 1 year of collaborative practice)
- Informed consent requirements
- Transfer and referral criteria and requirements

- VBACs
- Maternal/fetal testing requirements
- Prescription, dispensing and administration authority incidental to scope of practice
- Defining “family planning services” (include procedures such as IUD insertion?)
- Defining “uncomplicated pregnancy”
- Determining the period of “normal newborn” care
- CNM delegation authority to unlicensed individuals

upon the withdrawing state reenacting the compact or upon such later date as determined by the interstate commission.

(g) The interstate commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22  
DISSOLUTION

(a) The compact shall dissolve effective upon the date of the withdrawal or default of the member state, which reduces the membership in the compact to one member state.

(b) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the interstate commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23  
SEVERABILITY AND CONSTRUCTION

(a) The provisions of the compact shall be severable, and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of the compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24  
BINDING EFFECT OF COMPACT  
AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the compact.

(b) All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

(c) All lawful actions of the interstate commission, including all rules and bylaws promulgated by the commission, are binding upon the member states.

(d) All agreements between the interstate commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

New Sec. 88. The provisions of sections 88 through 97, and amendments thereto, shall be known and may be cited as the independent practice of midwifery act.

New Sec. 89. As used in the independent practice of midwifery act:

(a) “Board” means the state board of healing arts.

(b) “Certified nurse-midwife” means an individual who:

(1) Is educated in the two disciplines of nursing and midwifery;

(2) is currently certified by a certifying board approved by the state board of nursing; and

(3) is currently licensed under the Kansas nurse practice act.

(c) “Independent practice of midwifery” means the provision of clinical services by a certified nurse-midwife without the requirement of a collaborative practice agreement with a person licensed to practice medicine and surgery when such clinical services are limited to those associated with a normal, uncomplicated pregnancy and delivery, including:

(1) The prescription of drugs and diagnostic tests;

(2) the performance of episiotomy or repair of a minor vaginal laceration;

(3) the initial care of the normal newborn; and

(4) family planning services, including treatment or referral of male partners for sexually-transmitted infections.

(d) The provisions of this section shall become effective on January 1, 2017.

New Sec. 90. (a) In order to obtain authorization to engage in the

independent practice of midwifery, a certified nurse-midwife must meet the following requirements:

- (1) Be licensed to practice professional nursing under the Kansas nurse practice act;
  - (2) have successfully completed a course of study in nurse-midwifery in a school of nurse-midwifery approved by the board;
  - (3) have successfully completed a national certification approved by the board;
  - (4) have successfully completed a refresher course as defined by rules and regulations of the board, if the individual has not been in active midwifery practice for five years immediately preceding the application;
  - (5) be authorized to perform the duties of a certified nurse-midwife by the state board of nursing;
  - (6) be licensed as an advanced practice registered nurse by the state board of nursing; and
  - (7) have paid all fees for licensure prescribed in section 92, and amendments thereto.
- (b) Upon application to the board by any certified nurse-midwife and upon satisfaction of the standards and requirements established under this act, the board shall grant an authorization to the applicant to engage in the independent practice of midwifery.
- (c) A person whose licensure has been revoked may make written application to the board requesting reinstatement of the license in a manner prescribed by the board, which application shall be accompanied by the fee prescribed in section 92, and amendments thereto.
- (d) The provisions of this section shall become effective on January 1, 2017.

New Sec. 91. (a) Licenses issued under this act shall expire on the date of expiration established by rules and regulations of the board, unless renewed in the manner prescribed by the board. The request for renewal shall be accompanied by the fee prescribed in section 92, and amendments thereto.

- (b) At least 30 days before the expiration of a licensee's license, the board shall notify the licensee of the expiration, by mail, addressed to the licensee's last known mailing address. If the licensee fails to submit an application for renewal on a form provided by the board, or fails to pay the renewal fee by the date of expiration, the board shall give a second notice to the licensee that the license has expired and the license may be renewed only if the application for renewal, the renewal fee, and the late renewal fee are received by the board within the 30-day period following the date of expiration and that, if both fees are not received within the 30-day period, the license shall be deemed canceled by operation of law and without further proceedings.
- (c) The board may require any licensee, as a condition of renewal, to submit with the application of renewal evidence of satisfactory completion of a program of continuing education as required by rules and regulations of the board.
- (d) The provisions of this section shall become effective on January 1, 2017.

New Sec. 92. (a) The board shall charge and collect, in advance, fees for certified nurse-midwives, as established by the board, not to exceed:

Application for license.....	\$100
License renewal.....	\$100
Late license renewal.....	\$100
License reinstatement fee.....	\$100
Revoked license fee.....	\$100
Certified copy of license.....	\$50
Verified copy of license.....	\$25

(b) The board shall remit all moneys received by or for the board from fees, charges or penalties to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury. Ten percent of each such amount shall be credited to the state general fund, and the balance shall be credited to the healing arts fee fund. All expenditures from the healing arts fee fund shall be made in accordance with appropriation acts upon warrants of the

director of accounts and reports issued pursuant to vouchers approved by the president of the board or persons designated by the president.

(c) The provisions of this section shall become effective on January 1, 2017.

New Sec. 93. (a) It shall be unlawful for a person to engage in the independent practice of midwifery without a collaborative practice agreement with a person licensed to practice medicine and surgery, unless such certified nurse-midwife holds a license from the state board of nursing and the board.

(b) The provisions of this section shall become effective on January 1, 2017.

New Sec. 94. (a) The board, in consultation with the state board of nursing, shall adopt rules and regulations pertaining to certified nurse-midwives engaging in the independent practice of midwifery and governing the ordering of tests, diagnostic services and prescribing of drugs and referral or transfer to physicians in the event of complications or emergencies. Such rules and regulations shall not be adopted until the state board of nursing and the board have consulted and concurred on the content of each rule and regulation. Such rules and regulations shall be adopted no later than January 1, 2017.

(b) A certified nurse midwife engaging in the independent practice of midwifery shall be subject to the provisions of the independent practice of midwifery act with respect to the ordering of tests, diagnostic services and prescribing of drugs, and shall not be subject to the provisions of K.S.A. 65-1130, and amendments thereto.

(c) The standards of care for certified nurse-midwives in the ordering of tests, diagnostic services and the prescribing of drugs shall be those standards which protect patients and shall be standards comparable to persons licensed to practice medicine and surgery providing the same services.

(d) The board is hereby authorized to solely adopt those rules and regulations necessary to administer the administrative provisions of this act.

New Sec. 95. (a) The board may deny, revoke, limit or suspend any license or authorization issued to a certified nurse-midwife to engage in the independent practice of midwifery that is issued by the board or applied for under this act, or may publicly censure a licensee or holder of a temporary permit or authorization, if the applicant or licensee is found after a hearing:

(1) To be guilty of fraud or deceit while engaging in the independent practice of midwifery or in procuring or attempting to procure a license to engage in the independent practice of midwifery;

(2) to have been found guilty of a felony or to have been found guilty of a misdemeanor involving an illegal drug offense unless the applicant or licensee establishes sufficient rehabilitation to warrant the public trust, except that notwithstanding K.S.A. 74-120, and amendments thereto, no license or authorization to practice and engage in the independent practice of midwifery shall be granted to a person with a felony conviction for a crime against persons as specified in article 34 of chapter 21 of the Kansas Statutes Annotated, prior to its repeal, or article 54 of chapter 21 of the Kansas Statutes Annotated, and amendments thereto, or K.S.A. 2015 Supp. 21-6104, 21-6325, 21-6326 or 21-6418, and amendments thereto;

(3) to have committed an act of professional incompetence as defined in subsection (c);

(4) to be unable to practice the healing arts with reasonable skill and safety by reason of impairment due to physical or mental illness or condition or use of alcohol, drugs or controlled substances. All information, reports, findings and other records relating to impairment shall be confidential and not subject to discovery or release to any person or entity outside of a board proceeding. The provisions of this paragraph providing confidentiality of records shall expire on July 1, 2022, unless the legislature reviews and reenacts such provisions pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2022;

(5) to be a person who has been adjudged in need of a guardian or conservator, or both, under the act for obtaining a guardian or conservator, or both, and who has not been restored to capacity under that act;

(6) to be guilty of unprofessional conduct as defined by rules and regulations of the board;

(7) to have willfully or repeatedly violated the provisions of the Kansas nurse practice act or any rules and regulations adopted pursuant to that act;

(8) to have a license to practice nursing as a registered nurse or as a practical nurse denied, revoked, limited or suspended, or to have been publicly or privately censured, by a licensing authority of another state, agency of the United States government, territory of the United States or country, or to have other disciplinary action taken against the applicant or licensee by a licensing authority of another state, agency of the United States government, territory of the United States or country. A certified copy of the record or order of public or private censure, denial, suspension, limitation, revocation or other disciplinary action of the licensing authority of another state, agency of the United States government, territory of the United States or country shall constitute prima facie evidence of such a fact for purposes of this paragraph; or

(9) to have assisted suicide in violation of K.S.A. 21-3406, prior to its repeal, or K.S.A. 2015 Supp. 21-5407, and amendments thereto, as established by any of the following:

(A) A copy of the record of criminal conviction or plea of guilty to a felony in violation of K.S.A. 21-3406, prior to its repeal, or K.S.A. 2015 Supp. 21-5407, and amendments thereto;

(B) a copy of the record of a judgment of contempt of court for violating an injunction issued under K.S.A. 60-4404, and amendments thereto; or

(C) a copy of the record of a judgment assessing damages under K.S.A. 60-4405, and amendments thereto.

(b) No person shall be excused from testifying in any proceedings before the board under this act or in any civil proceedings under this act before a court of competent jurisdiction on the ground that such testimony may incriminate the person testifying, but such testimony shall not be used against the person for the prosecution of any crime under the laws of this state, except the crime of perjury as defined in K.S.A. 2015 Supp. 21-5903, and amendments thereto.

(c) As used in this section, “professional incompetency” means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

(2) repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board; or

(3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to engage in the independent practice of midwifery.

(d) The board, upon request, shall receive from the Kansas bureau of investigation such criminal history record information relating to arrests and criminal convictions, as necessary, for the purpose of determining initial and continuing qualifications of licensees and applicants for licensure by the board.

(e) The provisions of this section shall become effective on January 1, 2017.

New Sec. 96. (a) There is hereby established a nurse-midwives council to advise the board in carrying out the provisions of this act. The council shall consist of seven members, all residents of the state of Kansas appointed as follows: Two members shall be licensees of the board, appointed by the board, who are licensed to practice medicine and surgery and whose specialty and customary practice includes obstetrics; one member shall be the president of the board or a board member designated by the president; and four members shall be licensed certified nurse-midwives appointed by the board of nursing.

(b) If a vacancy occurs on the council, the appointing authority of the position which has become vacant shall appoint a person of like qualifications to fill the vacant position for the unexpired term, if any.

New Sec. 97. (a) Nothing in the independent practice of midwifery act should be construed to authorize a certified nurse-midwife engaging

in the independent practice of midwifery under such act to perform, induce or prescribe drugs for an abortion.

(b) The provisions of this section shall become effective on January 1, 2017.

Sec. 98. On and after January 1, 2017, K.S.A. 2015 Supp. 65-1130 is hereby amended to read as follows: (a) No professional nurse shall announce or represent to the public that such person is an advanced practice registered nurse unless such professional nurse has complied with requirements established by the board and holds a valid license as an advanced practice registered nurse in accordance with the provisions of this section.

(b) The board shall establish standards and requirements for any professional nurse who desires to obtain licensure as an advanced practice registered nurse. Such standards and requirements shall include, but not be limited to, standards and requirements relating to the education of advanced practice registered nurses. The board may give such examinations and secure such assistance as it deems necessary to determine the qualifications of applicants.

(c) The board shall adopt rules and regulations applicable to advanced practice registered nurses which:

(1) Establish roles and identify titles and abbreviations of advanced practice registered nurses which are consistent with nursing practice specialties recognized by the nursing profession.

(2) Establish education and qualifications necessary for licensure for each role of advanced practice registered nurse established by the board at a level adequate to assure the competent performance by advanced practice registered nurses of functions and procedures which advanced practice registered nurses are authorized to perform. Advanced practice registered nursing is based on knowledge and skills acquired in basic nursing education, licensure as a registered nurse and graduation from or completion of a master's or higher degree in one of the advanced practice registered nurse roles approved by the board of nursing.

(3) Define the role of advanced practice registered nurses and establish limitations and restrictions on such role. The board shall adopt a definition of the role under this ~~subsection (c)(3)~~ *paragraph* which is consistent with the education and qualifications required to obtain a license as an advanced practice registered nurse, which protects the public from persons performing functions and procedures as advanced practice registered nurses for which they lack adequate education and qualifications and which authorizes advanced practice registered nurses to perform acts generally recognized by the profession of nursing as capable of being performed, in a manner consistent with the public health and safety, by persons with postbasic education in nursing. In defining such role the board shall consider: (A) The education required for a licensure as an advanced practice registered nurse; (B) the type of nursing practice and preparation in specialized advanced practice skills involved in each role of advanced practice registered nurse established by the board; (C) the scope and limitations of advanced practice nursing prescribed by national advanced practice organizations; and (D) acts recognized by the nursing profession as appropriate to be performed by persons with postbasic education in nursing.

(d) An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Any written prescription order shall include the name, address and telephone number of the responsible physician. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced practice registered nurse shall: (1) Register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and custom-

ary practice of the responsible physician. An advanced practice registered nurse certified in the role of registered nurse anesthetist while functioning as a registered nurse anesthetist under K.S.A. 65-1151 ~~to through~~ 65-1164, ~~inclusive~~, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 ~~to through~~ 65-1164, ~~inclusive~~, and amendments thereto, with respect to drugs and anesthetic agents and shall not be subject to the provisions of this subsection. For the purposes of this subsection, “responsible physician” means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced practice registered nurse when prescribing drugs.

(e) As used in this section, “drug” means those articles and substances defined as drugs in K.S.A. 65-1626 and 65-4101, and amendments thereto.

(f) A person registered to practice as an advanced registered nurse practitioner in the state of Kansas immediately prior to the effective date of this act shall be deemed to be licensed to practice as an advanced practice registered nurse under this act and such person shall not be required to file an original application for licensure under this act. Any application for registration filed which has not been granted prior to the effective date of this act shall be processed as an application for licensure under this act.

(g) *An advanced practice registered nurse certified in the role of certified nurse-midwife and engaging in the independent practice of midwifery under the independent practice of midwifery act with respect to prescribing drugs shall be subject to the provisions of the independent practice of midwifery act and shall not be subject to the provisions of this section.*

Sec. 99. On and after January 1, 2017, K.S.A. 2015 Supp. 65-1626 is hereby amended to read as follows: 65-1626. For the purposes of this act:

(a) “Administer” means the direct application of a drug, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by:

- (1) A practitioner or pursuant to the lawful direction of a practitioner;
- (2) the patient or research subject at the direction and in the presence of the practitioner; or
- (3) a pharmacist as authorized in K.S.A. 65-1635a, and amendments thereto.

(b) “Agent” means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor or dispenser but shall not include a common carrier, public warehouseman or employee of the carrier or warehouseman when acting in the usual and lawful course of the carrier’s or warehouseman’s business.

(c) “Application service provider” means an entity that sells electronic prescription or pharmacy prescription applications as a hosted service where the entity controls access to the application and maintains the software and records on its server.

(d) “Authorized distributor of record” means a wholesale distributor with whom a manufacturer has established an ongoing relationship to distribute the manufacturer’s prescription drug. An ongoing relationship is deemed to exist between such wholesale distributor and a manufacturer when the wholesale distributor, including any affiliated group of the wholesale distributor, as defined in section 1504 of the internal revenue code, complies with any one of the following: (1) The wholesale distributor has a written agreement currently in effect with the manufacturer evidencing such ongoing relationship; and (2) the wholesale distributor is listed on the manufacturer’s current list of authorized distributors of record, which is updated by the manufacturer on no less than a monthly basis.

(e) “Board” means the state board of pharmacy created by K.S.A. 74-1603, and amendments thereto.

(f) “Brand exchange” means the dispensing of a different drug product of the same dosage form and strength and of the same generic name as the brand name drug product prescribed.

(g) “Brand name” means the registered trademark name given to a drug product by its manufacturer, labeler or distributor.

(h) “Chain pharmacy warehouse” means a permanent physical loca-

## **Healing Arts Board duties regarding nurse midwives pursuant to HB 2615**

The board, in consultation with the state board of nursing, shall adopt rules and regulations pertaining to certified nurse midwives engaging in the independent practice of midwifery and governing the ordering of tests, diagnostic services and prescribing of drugs and referral or transfer to physicians in the event of complications or emergencies. Such rules and regulations shall not be adopted until the state board of nursing and the board have consulted and concurred on the content of each rule and regulation. Such rules and regulations shall be adopted no later than January 1, 2017 (New Section 94).

### **Role and Duties of the Nurse Midwives Council**

The Nurse Midwives Council shall advise the Board in carrying out its duties under the Act, including making recommendations on the regulations which must be adopted by the Board after consultation and concurrence with the Board of Nursing.

The regulations must cover the ordering of tests, diagnostic services, prescribing of drugs, and referral or transfer to physicians in the event of complications or emergencies related to the “independent practice of midwifery”, as defined in the act, as follows:

“Independent practice of midwifery” means the provision of clinical services by a certified nurse-midwife without the requirement of a collaborative practice agreement with a person licensed to practice medicine and surgery when such clinical services are limited to those associated with a normal, uncomplicated pregnancy and delivery, including:

- (1) The prescription of drugs and diagnostic tests;
- (2) the performance of episiotomy or repair of a minor vaginal laceration;
- (3) the initial care of the normal newborn; and
- (4) family planning services, including treatment or referral of male partners for sexually-transmitted infections.

The Council should be prepared to:

- recommend with appropriate specificity, what tests, diagnostic services and prescription drugs are authorized for use by CNMs in order for licensees to provide services associated with normal, uncomplicated pregnancy and delivery;
- provide guidance on what services are involved in the “initial care of the normal newborn”;
- provide guidance on what constitutes a “minor vaginal laceration” and episiotomy; and
- provide guidance on what constitutes “family planning services, including treatment or referral of male partners for sexually-transmitted infections.”

<b>CNM (KSBN)</b>	<b>CNM-I (KSBHA)</b>
Collaboration with a physician required. See K.A.R. 100-11-101(b)	Independent practice. See HB 2615, New Sec. 89(c).
Scope of practice- health care for women, focusing on gynecological needs, pregnancy, childbirth, the postpartum period, care of the newborn, and family planning, including indicated partner evaluation, treatment and referral for infertility and STDs. See K.A.R. 100-11-105(d) for inclusive list.	Scope of practice- the provision of clinical services limited to those associated with a normal, uncomplicated pregnancy and delivery, including: prescription of drugs and diagnostic tests, episiotomy or repair of minor vaginal laceration, initial care of normal newborn, and family planning services, including treatment or referral of male partners for sexually-transmitted diseases. See HB 2615, New Sec. 89(c).
Prescribing- by written protocol. Includes controlled substances. See K.S.A. 65-1130(d).	Independent prescribing. Scope determined in regulations to be developed.
Can distribute professional samples	?
Dispensing and administration if pursuant to order of a physician	?

Appendix “A”

**State of Kansas, Department of Health and Environment, Permanent Administrative Regulations of Birth Centers**

**Article 4.—MATERNAL AND CHILD HEALTH**

**28-4-1300. Definitions.** For the purposes of K.A.R. 28-4-1300 through K.A.R. 28-4-1318, the following terms shall have the meanings specified in this regulation:

- (a) “Apgar scores” means a measure of a newborn’s physical condition at one, five, and 10 minutes after birth.
- (b) “Applicant” means a person who has applied for a license but who has not yet been granted a license to operate a birth center. This term shall include an applicant who has been granted a temporary permit to operate a birth center.
- (c) “Birthing room” means a room designed, equipped, and arranged to provide for the care of a patient, a newborn, and the patient’s support person or persons during and following childbirth.
- (d) “Certified midwife” means an individual who is educated in the discipline of midwifery and who is currently certified by the American college of nurse-midwives or the American midwifery certification board, inc.
- (e) “Certified nurse-midwife” means an individual who meets the following requirements:
  - (1) Is educated in the two disciplines of nursing and midwifery;
  - (2) is currently certified by the American college of nurse-midwives or the American midwifery certification board, inc; and
  - (3) has a current nursing license in Kansas.
- (f) “Certified professional midwife” means an individual who is educated in the discipline of midwifery and who is currently certified by the North American registry of midwives.
- (g) “Clinical director” means an individual who is appointed by the licensee and is responsible for the direction and oversight of clinical services at a birth center as specified in K.A.R. 28-4-1305.
- (h) “Clinical staff member” means an individual employed by or serving as a consultant to the birth center who is one of the following:
  - (1) The clinical director or acting clinical director;
  - (2) a licensed physician;
  - (3) a certified nurse-midwife;
  - (4) a certified professional midwife;
  - (5) a certified midwife; or
  - (6) a registered professional nurse.
- (i) “Department” means Kansas department of health and environment.
- (j) “Exception” means a waiver of an applicant’s or a licensee’s compliance with a specific birth center regulation or any portion of a specific birth center regulation, granted by the secretary to the applicant or licensee.
- (k) “License capacity” means the maximum number of patients that can be cared for in a birth center during labor, delivery, and recovery.
- (l) “Licensee” means a person who has been granted a license to operate a birth center.
- (m) “Maternity center” has the meaning specified in K.S.A. 65-502, and amendments thereto, and may also be referred to as a “birth center.”
- (n) “Normal, uncomplicated delivery” means a delivery that results in a vaginal birth and that does not require the use of general, spinal, or epidural anesthesia.
- (o) “Normal, uncomplicated pregnancy” means a pregnancy that is initially determined to be at a low risk for a poor pregnancy outcome and that remains at a low risk throughout the pregnancy.

- (p) “Patient” means a woman who has been accepted for services at a birth center during pregnancy, labor, delivery, and recovery.
- (q) “Poor pregnancy outcome” means any outcome other than a live, healthy patient and newborn.
- (r) “Premises” means the location, including each building and any adjoining grounds, of a birth center.
- (s) “Secretary” means secretary of the Kansas department of health and environment. (Authorized by K.S.A. 65-508 and 65-510; implementing K.S.A. 65-502 and 65-508; effective July 9, 2010.)

**28-4-1301. Applicant and licensee requirements.**

- (a) Each applicant, if an individual, shall be at least 21 years of age at the time of application.
- (b) Each applicant and each licensee, if a corporation, shall be in good standing with the Kansas secretary of state. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-504 and 65-508; effective July 9, 2010.)

**28-4-1302. Application procedures.**

- (a) Each person, in order to obtain a license, shall submit a complete application on the form provided by the department. The application shall be submitted at least 90 calendar days before the planned opening date of the birth center and shall include all of the following:
  - (1) A detailed description of the services to be provided;
  - (2) a detailed floor plan and site plan for the premises to be licensed; and
  - (3) the nonrefundable license fee specified in K.A.R. 28-4-92.
- (b) At the time of the initial inspection, each applicant shall have the following information on file:
  - (1) Written verification from the applicable local authorities showing that the premises are in compliance with all local codes and ordinances, including all building, fire, and zoning requirements;
  - (2) written verification from the state fire marshal showing that the premises are in compliance with all applicable fire codes and regulations;
  - (3) written verification from local or state authorities showing that the private water supply and sewerage systems conform to all state and local laws; and
  - (4) documentation of the specific arrangements that have been made for the removal of biomedical waste and human tissue from the premises.
- (c) The granting of a license to any applicant may be refused by the secretary if the applicant is not in compliance with the requirements of the following:
  - (1) K.S.A. 65-504 through 65-508, and amendments thereto;
  - (2) K.S.A. 65-512 and 65-513, and amendments thereto;
  - (3) K.S.A. 65-531, and amendments thereto; and
  - (4) all regulations governing birth centers. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-501, 65-504, 65-505, and 65-508; effective July 9, 2010.)

**28-4-1303. Terms of a temporary permit or a license.**

- (a) License capacity. The maximum number of patients authorized by a temporary permit or a license shall not be exceeded.
- (b) Posting temporary permit or license. The current temporary permit or the current license shall be posted conspicuously within the birth center.
- (c) Validity of temporary permit or a license. Each temporary permit or license shall be valid for the applicant or licensee and the address specified on the temporary permit or the license. When

an initial or amended license becomes effective, all temporary permits or licenses previously granted to the applicant or licensee at the same address shall become invalid.

(d) Advertising. The advertising for each birth center shall conform to the statement of services included with the application. A claim for specialized services, even if specified on the application for a birth center, shall not be made unless the birth center is staffed and equipped to offer those services. No general claim of being “state approved” shall be made until the applicant has been issued a temporary permit or a license by the secretary.

(e) Withdrawal of application or request to close. Any applicant may withdraw the application for a license. Any licensee may, at any time, request to close a birth center. If an application is withdrawn or a birth center is closed, each temporary permit or license granted for that birth center shall become invalid. (Authorized by K.S.A.

65-508; implementing K.S.A. 65-504 and 65-508; effective July 9, 2010.)

**28-4-1304. Temporary permit or license; amended license; exceptions; notification; renewal.**

(a) Temporary permit or license required. Each person shall obtain a temporary permit or a license from the secretary to operate a birth center before providing any birth center services.

(b) New temporary permit or license required. Each applicant or licensee shall submit a new application, the required verifications and documentation, and license fee and shall obtain a temporary permit or a license from the

secretary under any of the following circumstances:

- (1) Before a birth center that has been closed is reopened;
- (2) if there is a change in the location of the birth center; or
- (3) if there is a change of ownership of the birth center.

(c) Amended license.

(1) Any licensee may submit a request for an amended license. Each licensee who intends to change the terms of the license, including the maximum number of patients to be served, shall submit a request for an amended license on a form provided by the department and a nonrefundable amendment fee of \$35. An amendment fee shall not be required if the request to change the terms of the license is made at the time of the renewal.

(2) The licensee shall make no change to the terms of the license unless permission is granted, in writing, by the secretary. If granted, the licensee shall post the amended license, and the previous license shall no longer be in effect.

(d) Exceptions.

(1) Any applicant or licensee may request an exception from the secretary. Any request for an exception may be granted if the secretary determines that the exception is in the best interest of one or more patients or newborns and the exception does not violate statutory requirements.

(2) Written notice from the secretary stating the nature of the exception and the duration of the exception shall be kept on file at the birth center and shall be readily accessible to the department.

(e) Notification. Each applicant and each licensee shall notify the secretary, in writing, before changing any of the following:

- (1) The clinical services or activities offered by the birth center;
- (2) the physical structure of the birth center due to new construction or substantial remodeling; or
- (3) the use of any part of the premises that affects the use of the space or affects the license capacity.

(f) Renewal. No earlier than 90 days before but no later than the renewal date, each licensee wishing to renew the license shall submit the following:

- (1) The nonrefundable license fee specified in K.A.R. 28-4-92; and

- (2) an application to renew the license on the form provided by the department.
- (g) Late renewal. Failure to submit the renewal application and fee as required by subsection (f) shall result in an assessment of a late renewal fee specified in K.S.A. 65- 505, and amendments thereto, and may result in closure of the birth center.
- (h) Copy of current regulations. A copy of the current Kansas administrative regulations governing birth centers shall be kept on the premises and shall be available to all employees. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-504, 65-505, and 65-508; effective July 9, 2010.)

**28-4-1305. Administration.** (a) Each licensee shall be responsible for the operation of the birth center, including the following:

- (1) Establishing and maintaining a written organizational plan, including an organizational chart designating the lines of authority;
- (2) providing employees, facilities, equipment, supplies, and services to patients, newborns, and families;
- (3) developing and implementing administrative policies and procedures for the operation of the birth center;
- (4) developing and implementing policies and procedures for quality assurance;
- (5) appointing an administrator to oversee the operation of the birth center;
- (6) appointing a clinical director and hiring employees;
- (7) appointing an acting clinical director to provide direction and oversight of clinical services in the absence of the clinical director; and
- (8) documenting all of the information specified in this subsection.

(b) Each licensee shall ensure that all birth center contracts, agreements, policies, and procedures are reviewed annually and updated as needed.

(c) Each licensee shall ensure the development and implementation of written policies that set out the necessary qualifications for each position and govern employee selection. A job description for each position shall be available at the birth center.

(d) Each licensee shall ensure that all employees are informed of and follow all written policies, procedures, and clinical protocols necessary to carry out their job duties.

(e) Each administrator shall oversee the daily operation and maintenance of the birth center and implement the policies and procedures in compliance with licensing requirements for birth centers.

(f) Each clinical director shall provide direction and oversight of clinical services, including the development and implementation of policies, procedures, and signed protocols regarding all matters related to the medical management of pregnancy, birth, postpartum care, newborn care, and gynecologic health care.

(g) Each licensee shall develop and implement written policies and procedures regarding a patient's options for the disposition or taking of fetal remains if a fetal death occurs. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-508 and K.S.A. 2009 Supp. 65-67a10; effective July 9, 2010.)

**28-4-1306. Clinical staff member qualifications; employee schedules; training.**

(a) Clinical staff member qualifications. Each licensee shall ensure that the following requirements for the clinical staff members are met:

- (1) The clinical director and the acting clinical director shall be one of the following:
  - (A) A physician with a current license to practice in Kansas; or
  - (B) a certified nurse-midwife.

(2) Each clinical staff member attending labor and delivery shall meet the following qualifications:

- (A) Practice within the scope of the clinical staff member's training and experience; and
- (B) hold, at a minimum, current certification in adult CPR equivalent to American heart association class C basic life support and current certification in neonatal CPR equivalent to that of the American academy of pediatrics or the American heart association.

(b) Employee schedules.

(1) Each licensee shall ensure that there are sufficient qualified employees on duty and on call for the safe maintenance and operation of the birth center and for the provision of clinical services.

(2) Each licensee shall ensure that a written work schedule is readily accessible to all employees.

(c) Training.

(1) Each licensee shall develop and provide an orientation for all new employees and ongoing in-service training for all employees that shall meet the following requirements:

- (A) Is based on individual job duties and responsibilities;
- (B) is designed to meet individual employee training needs; and (C) is designed to maintain the knowledge and skills necessary to ensure compliance with policies, procedures, and clinical protocols of the birth center.

(2) Orientation and in-service training shall include the following: (A) Emergency clinical procedures;

(B) recognition of the signs and symptoms of infectious diseases, infection control, and universal precautions;

(C) recognition of signs and symptoms of domestic violence; and (D) recognition of the signs and symptoms and the reporting of child abuse and neglect. (3) The documentation of the orientation and the in-service training shall be maintained in each employee's individual record. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

#### **28-4-1307. Records.**

(a) Policies and procedures.

Each licensee shall ensure that there is an organized recordkeeping system, with policies and procedures that provide for identification, security, confidentiality, control, retrieval, and preservation of all employee records, patient records, and birth center information. All records shall be available at the birth center for review by the secretary.

(b) Employee records. Each licensee shall ensure that an individual record is maintained at the birth center for each employee that includes the following information:

(1) A description of the terms of employment or the volunteer agreement and a copy of the job description;

(2) a copy of the job application detailing the employee's qualifications and employment dates;

(3) copies of current professional licenses, certifications, or registrations;

(4) documentation of the results of any health assessments and tuberculin tests specified in K.A.R. 28-4-1312;

(5) documentation of the orientation and the in-service training specified in K.A.R. 28-4-1306; and

(6) documentation that each employee has access to the following:

(A) The current regulations governing birth centers; and

(B) the birth center policies, procedures, and clinical protocols.

(c) Patient records.

(1) Each licensee shall ensure that a current and complete clinical record for each patient accepted for care in the birth center includes the following:

- (A) Identifying information, including the patient's name, address, and telephone number;
- (B) documentation of the initial history and physical examination, including laboratory findings and dates;
- (C) a signed and dated informed consent form;
- (D) all obstetrical risk assessments, including the dates of the assessments;
- (E) documentation of instruction and education related to the childbearing process;
- (F) the date and time of the onset of labor;
- (G) the course of labor, including all pertinent examinations and findings;
- (H) the exact date and time of birth, the presenting part of the newborn's body, the sex of the newborn, the numerical order of birth in the event of more than one newborn, and the Apgar scores;
- (I) the time of expulsion and the condition of the placenta;
- (J) all treatments rendered to the patient and newborn, including prescribing medications and the time, type, and dose of eye prophylaxis;
- (K) documentation of metabolic and any other screening tests completed by a clinical staff member;
- (L) the condition of the patient and newborn, including any complications and action taken at the birth center;
- (M) all medical consultations concerning the patient and the newborn;
- (N) all referrals for medical care and transfers to medical care facilities, including the reasons for each referral or transfer;
- (O) the results of all examinations of the newborn and of the postpartum patient; and
- (P) the written instructions given to the patient regarding postpartum care, family planning, care of the newborn, arrangements for metabolic testing, immunizations, and follow-up pediatric care.

(2) Each entry in each patient's record shall be dated and signed by the attending clinical staff member.

(3) The patient record shall be confidential and shall not be released without the written consent of the patient. Nothing in this regulation shall preclude the review of patient records by the secretary.

(4) All patient records shall be retained for at least 25 years from the date of discharge.

(d) Quality assurance documentation. Each licensee shall maintain on file for at least three calendar years all documentation required for the quality assurance findings specified in K.A.R. 28-4-1309.

(e) Inventory. Each licensee shall maintain on file an inventory of the birth center furnishings, equipment, and supplies.

(f) Drills. Each licensee shall maintain on file for at least one calendar year a record of all disaster and evacuation drills.

(g) Changes. Each applicant and each licensee shall maintain on file at the birth center the documentation of any changes specified in K.A.R. 28-4-1304 and approved by the secretary.

(Authorized by K.S.A. 65-508; implementing K.S.A. 65-507 and 65-508; effective July 9, 2010.)

**28-4-1308. Reporting requirements.** (a) Each licensee shall ensure that the following incidents are reported to the department by the next working day, on a form provided by the department, and to any other authorities in accordance with state statute:

- (1) A stillbirth or the death of a patient or a newborn;
  - (2) the death of an employee while on duty;
  - (3) any intentional or unintentional injuries sustained by any patient, newborn, or employee while on duty;
  - (4) any fire damage or other damage to the premises that affects the safety of any patient, newborn, or employee;
  - (5) any other incident that, in the judgment of the clinical director or the acting clinical director, compromises the ability of the birth center to provide appropriate and safe care to patients and newborns.
- (b) If a licensee, employee, patient, or newborn contracts a reportable infectious or contagious disease specified in K.A.R. 28-1-2, the licensee shall ensure that the disease is reported to the county health department as specified in K.A.R. 28-1-2. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1309. Quality assurance.** (a) Each licensee shall develop and implement a quality assurance program to evaluate, at least annually, the quality of patient care and the appropriateness of clinical services.

(b) The quality assurance program shall include a system for the assessment of patient and newborn outcomes, clinical protocols, recordkeeping, and infection control. (c) The quality assurance findings shall be documented and used for the ongoing assessment of clinical services, problem resolution, and plans for service improvement.

(d) All quality assurance findings shall be available at the birth center for review by the secretary. Nothing in this regulation shall preclude the review of patient records by the secretary. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-507, 65-508, and 65-512; effective July 9, 2010.)

**28-4-1310. Clinical services and patient care.**

(a) Each licensee shall ensure that the clinical services provided at the birth center are limited to those services associated with a normal, uncomplicated pregnancy and a normal, uncomplicated delivery.

(b) Each licensee shall ensure that only the clinical services approved by the clinical director are performed at the birth center.

(c) Each clinical staff member providing services shall work under the direction of and in consultation with the clinical director or the acting clinical director.

(d) Each clinical staff member shall have access to patient diagnostic facilities and services, including a clinical laboratory, sonography, radiology, and electronic monitoring.

(e) Each licensee shall make available to each patient, in writing, information concerning the following:

- (1) The clinical services provided by the birth center;
- (2) the rights and responsibilities of the patient and the patient's family, including confidentiality, privacy, and consent;
- (3) information on the qualifications of the clinical staff members;
- (4) the risks and benefits of childbirth at the birth center;
- (5) the possibility of patient or newborn transfer if complications arise during pregnancy, labor, or delivery and the procedures for transfer; and
- (6) if a fetal death occurs, the patient's options for the taking or disposition of the fetal remains.

(f) Each licensee shall limit patients to those women who are initially determined to be at low maternity risk by a clinical staff member and who are evaluated regularly throughout the pregnancy to ensure that each patient continues to be at low risk for a poor pregnancy outcome.

Each clinical director shall establish a written maternity risk assessment, including screening criteria, which shall be a part of the approved policies.

(g) When conducting the maternity risk assessment, each clinical staff member shall assess the health status and maternity risk factors of each patient after obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances and psychological factors.

(h) The screening criteria of the maternity risk assessment shall be used as a baseline on which the risk status of each potential patient or patient is determined. The screening criteria shall apply to each potential patient before acceptance for birth center services and throughout the pregnancy for continuation of services. The screening criteria shall include the specific qualifications of the clinical staff members and the availability of supplies and equipment needed to provide clinical services safely.

(i) The factors to be considered in the development of the maternity risk assessment shall include the following:

(1) Age of the patient as a possible factor in determining the potential additional risk of poor pregnancy outcome;

(2) major medical problems including any of the following:

(A) Chronic hypertension, heart disease, or pulmonary embolus;

(B) any congenital heart defect assessed as pathological by a cardiologist that places the patient or fetus at risk;

(C) a renal disease;

(D) a drug addiction or required use of anticonvulsant drugs;

(E) diabetes mellitus;

(F) thyroid disease; or

(G) a bleeding disorder or hemolytic disease;

(3) previous history of significant obstetrical complications, including any of the following:

(A) RH sensitization;

(B) a previous uterine wall surgery, including caesarean section;

(C) seven or more term pregnancies;

(D) a previous placental abruption; or

(E) a previous preterm birth; and

(4) medical indication of any of the following:

(A) Pregnancy-induced hypertension;

(B) polyhydramnios or oligohydramnios;

(C) a placental abruption;

(D) chorioamnionitis;

(E) a known fetal anomaly;

(F) multiple gestations;

(G) an intrauterine growth restriction;

(H) fetal distress;

(I) alcoholism or drug addiction;

(J) thrombophlebitis; or

(K) pyelonephritis.

(j) Each patient found to be at high obstetrical risk based on the maternity risk assessment shall be referred to a qualified physician.

(k) Each licensee shall ensure that the policies and procedures include a program of education that prepares patients and their families for childbirth, including the following:

(1) Anticipated changes during pregnancy;

(2) the need for prenatal care;

(3) nutritional requirements during pregnancy;

- (4) the effects of smoking, alcohol, and substance use;
  - (5) the signs of preterm labor;
  - (6) preparation for labor and delivery, including pain management and obstetrical complications and procedures;
  - (7) breast-feeding and care of the newborn;
  - (8) signs of depression during pregnancy and after childbirth and instructions for treatment;
  - (9) instruction on understanding the patient and newborn health record information;
  - (10) sibling preparation; and
  - (11) preparation needed for discharge of the patient and the newborn following delivery.
- (l) Each licensee shall ensure that the policies, procedures, and clinical protocols are followed for each patient during labor, delivery, and postpartum care.
- (m) Each patient shall be admitted for labor and delivery by a physician, a certified nurse-midwife, a certified professional midwife, or a certified midwife.
- (n) At least one clinical staff member shall be available for each patient in labor.
- (o) At least two employees shall be available for each patient during delivery. One shall be a clinical staff member. The other shall be another clinical staff member or a licensed practical nurse (LPN) practicing within the scope of the LPN's training and experience and working under the direct supervision of a licensed physician, a certified nurse-midwife, or a registered professional nurse.
- (p) A clinical staff member shall monitor the progress of the labor and the condition of each patient and fetus as clinically indicated to identify abnormalities or complications at the earliest possible time.
- (q) The patient or newborn shall be transferred to a medical care facility if a clinical staff member determines that medical or surgical intervention is needed.
- (r) The patient's family or support persons shall be instructed as needed to assist the patient during labor and delivery.
- (s) The surgical procedures performed at the birth center shall be limited to the following:
- (1) Episiotomy;
  - (2) repair of episiotomy or laceration; and
  - (3) circumcision.
- (t) Each clinical director shall develop and implement policies and procedures for the discharge of postpartum patients and their newborns, which shall be followed by all clinical staff members.
- (1) An individual, written discharge plan shall be developed for each patient and newborn, including follow up visits and needed referrals. Each patient shall receive a copy of the plan at the time of discharge.
  - (2) Each patient and each newborn shall be discharged no later than 24 hours after birth and in accordance with policies, procedures, and clinical protocols.
  - (3) Each birth or death certificate shall be completed and filed as required by state law.
- (4) A follow-up visit shall be conducted by a designated clinical staff member between 24 hours and 72 hours after discharge of the patient to perform the following:
- (A) A health assessment of the patient;
  - (B) a health assessment of the newborn; and
  - (C) the required newborn screening tests.
- (5) The policies and procedures shall include a program of postpartum education and care, including the following:
- (A) Newborn care;
  - (B) postpartum examinations;
  - (C) family planning; and

(D) a plan for well-woman routine gynecologic health care. (Authorized by K.S.A. 65-508; implementing K.S.A. 65-507, K.S.A. 65-508, and K.S.A. 2009 Supp. 65-67a10; effective July 9, 2010.)

**28-4-1311. Transfers.**

- (a) Each licensee shall develop and implement policies, procedures, and clinical protocols for the transfer of patients and newborns. Each licensee shall ensure that these policies, procedures, and clinical protocols are readily accessible and followed.
- (b) The policies, procedures, and clinical protocols shall include a written plan on file designating who will be responsible for the transfer of a patient or newborn. The plan shall include the following:
  - (1) (A) A written agreement with an obstetrician and a pediatrician or with a group of practitioners that includes at least one obstetrician and at least one pediatrician; or (B) a written agreement with a medical care facility providing obstetrical and neonatal services; and
  - (2) a plan for transporting a patient or a newborn by an emergency medical services (EMS) entity.
- (c) Each licensee shall ensure that all employees attending labor and delivery have immediate access to a working telephone or another communication device and to contact information for transferring a patient or a newborn in case of an emergency. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1312. Health-related requirements.**

- (a) Tobacco use prohibited. Each licensee shall ensure that tobacco products are not used at any time in the birth center.
- (b) Health of licensee and employees working in the birth center.
  - (1) Each licensee, if an individual, and each individual working at the birth center shall meet the following requirements:
    - (A) Be free from physical, mental, and emotional conditions to the extent necessary to protect the health, safety, and welfare of the patients and newborns;
    - (B) be free from the influence of alcohol or illegal substances, or impairment due to the use of prescription or nonprescription drugs; and
    - (C) be free from all infectious or contagious diseases, as specified in K.A.R. 28-1-6.
  - (2) Each licensee, if an individual, and each individual working in the birth center shall have a health assessment conducted within six months before employment or upon employment. Subsequent health assessments shall be given periodically in accordance with the policies of the birth center.
  - (3) The results of each health assessment shall be recorded on forms provided by the department, and a copy shall be kept in each licensee's or employee's record at the birth center.
  - (4) If an individual who works in the birth center experiences a significant change in physical, mental, or emotional health, including any indication of substance abuse, an assessment of the individual's current health status may be required by the secretary or the licensee. A licensed health care provider qualified to diagnose and treat the condition shall conduct the health assessment. A written report of the assessment shall be kept in the individual's employee record and shall be submitted to the secretary on request.
- (c) Tuberculin testing of licensee and employees working in the birth center.
  - (1) Each licensee, if an individual, and each individual working in the birth center shall have a record of a tuberculin test or chest X-ray obtained not more than six months before

employment or upon employment. The results of the tuberculin test or chest X-ray shall be recorded on the health assessment form.

(2) Additional tuberculin testing shall be required if any individual working in the birth center is exposed to an active case of tuberculosis or if the birth center serves an area identified by the local health department or the secretary as a high-risk area for tuberculosis exposure.(d) Hepatitis B. Each licensee, if an individual, and each individual working in the birth center whose job duties include exposure to or the handling of blood shall be immunized against hepatitis B or shall provide written documentation of refusal of the immunization. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

### **28-4-1313. Environmental standards.**

#### **(a) Premises.**

(1) Each licensee shall ensure that the birth center is connected to public water and sewerage systems where available.

(2) If a center uses a nonpublic source for the water supply, the water shall be safe for drinking and shall be tested annually by a department-certified laboratory. If a well is used, the well shall be approved by an agent of the local environmental protection program (LEPP).

(A) A copy of the test results and the approval shall be kept on file at the birth center.

(B) Each private sewerage system shall be maintained in compliance with all applicable state and local laws.

(3) Outdoor areas on the premises shall be well drained and kept free of hazards, litter, and trash.

#### **(b) General building requirements.**

(1) Each licensee shall ensure that the birth center is located in a building that meets the following criteria:

(A) Meets the requirements specified in K.S.A. 65-508 and amendments thereto, all applicable building codes, and local ordinances;

(B) is a permanent structure; and

(C) is free from known environmental hazards.

(2) Each birth center shall be accessible to and usable by individuals with disabilities.

#### **(c) Structural requirements. Each licensee shall ensure that the following requirements are met:**

(1) Space shall be provided for the services to be offered, including the following:

(A) A secure space for the storage of medical records;

(B) waiting or reception area;

(C) family area, including play space for children;

(D) designated toilet and lavatory facilities for employees, families of patients, or the public separate from designated toilet, lavatory, and bathing facilities for each patient;

(E) a birthing room or rooms;

(F) employee area;

(G) utility and work room;

(H) a designated storage area;

(I) space for the provision of laboratory services; and

(J) space for food preparation and storage.

(2) The birth center shall be heated, cooled, and ventilated for the comfort of the patients and newborns and shall be designed to maintain a minimum temperature of 68 degrees Fahrenheit and a maximum temperature of 90 degrees Fahrenheit. If natural ventilation is

used, all opened windows or doors shall be screened. If mechanical ventilation or cooling systems are employed, the system shall be maintained in working order and kept clean. Intake air ducts shall be designed and installed so that dust and filters can be readily removed.

- (3) Each interior door that can be locked shall be designed to permit the door to be opened from each side in case of an emergency.
- (4) All floors shall be smooth and free from cracks, easily cleanable, and not slippery. All floor coverings shall be kept clean and maintained in good repair.
- (5) All walls shall be smooth, easily cleanable, and sound. Lead-free paint shall be used on all painted surfaces.
- (6) All areas of the birth center shall have light fixtures capable of providing at least 20 foot-candles of illumination. Additional illumination shall be available to permit observation of the patient and the newborn, cleaning, and maintenance. The light fixtures shall be maintained in working order and kept clean.
- (7) Each birthing room shall have emergency lighting for use during a power outage.
- (8) Each birth center shall be equipped with a scrub sink equipped with an elbow, knee, or foot control.
- (9) Each birthing room shall be located on the ground level and shall provide unimpeded, rapid access to an exit of the building that will accommodate patients, newborns, emergency personnel, emergency transportation vehicles, and equipment.
- (10) Each birthing room shall meet the following requirements:
  - (A) Have at least 180 square feet of floor space; and
  - (B) provide enough space for the equipment, employees, supplies, and emergency procedures necessary for the physical and emotional care of the patient and the newborn. (Authorized by and implementing K.S.A. 65- 508; effective July 9, 2010.)

**28-4-1314. Birth center and birthing room furnishings, equipment, and supplies.**

- (a) Each licensee shall provide furnishings, equipment, and other supplies in the quantity necessary to meet the needs of patients, newborns, and employees and to provide a safe, homelike environment.
- (b) Each licensee shall provide the specialized furnishings, equipment, and supplies necessary for the clinical staff members to perform the clinical services offered by the birth center. No specialized clinical services shall be provided unless the birth center is equipped to allow the clinical staff members to safely perform those services.
- (c) All furnishings, equipment, and supplies shall be kept clean and free from safety hazards.
- (d) The furnishings shall include, at a minimum, the following:
  - (1) A bed or table for delivery;
  - (2) at least one chair; and
  - (3) a wall clock with a second hand.
- (e) The equipment and supplies shall include, at a minimum, the following:
  - (1) An examination light;
  - (2) a sphygmomanometer;
  - (3) a stethoscope;
  - (4) a doppler unit or fetoscope;
  - (5) a clinical thermometer;
  - (6) disposable nonporous gloves in assorted sizes;
  - (7) an infant scale;
  - (8) a mechanical suction device or a bulb suction device;
  - (9) a tank of oxygen with a flowmeter and a mask, a cannula, or an equivalent;

- (10) all necessary emergency medications and intravenous fluids with supplies and equipment for administration;
  - (11) resuscitation equipment for patients and newborns, which shall include resuscitation bags and oral airways;
  - (12) a laryngoscope and a supply of endotracheal tubes of assorted sizes appropriate for a newborn;
  - (13) a firm surface suitable for resuscitation;
  - (14) sterilized instruments for delivery, episiotomy, and repair of an episiotomy or a laceration;
  - (15) an infant warmer that provides radiant heat;
  - (16) a readily accessible emergency cart or tray for the patient and for the newborn that meets the following requirements:
    - (A) Is equipped for the clinical staff members to carry out the written emergency procedures of the birth center;
    - (B) is securely placed; and
    - (C) has a written log of routine maintenance;
  - (17) clean bed linens and towels; and
  - (18) emergency lighting.
- (f) All equipment, furnishings, and supplies shall be used as intended and shall be securely stored when not in use to prevent injury or misuse. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1315. Maintenance.**

- (a) Each licensee shall ensure that the building is kept clean at all times and free from accumulated dirt and from vermin infestation.
- (b) Each licensee shall develop and implement a maintenance plan to ensure that all of the following conditions are met:
  - (1) A schedule for cleaning the birth center is established.
  - (2) All floors and walking surfaces are kept free of hazards, maintained in good repair, and kept clean at all times.
  - (3) Housekeeping services are provided to maintain a sanitary environment.
  - (4) Each birthing room, including equipment, is cleaned after each delivery and before reuse.
  - (5) The toilets, lavatories, sinks, and other facilities are clean at all times.
  - (6) The mops and other cleaning tools are cleaned after each use and stored in a well-ventilated place on racks.
  - (7) All pesticides and other poisons are used in accordance with product instructions and stored in a locked area.
  - (8) Safe storage for cleaning and laundry supplies is provided.
  - (9) Each indoor trash container is emptied, as needed, to control odor and to prevent the overflowing of contents.
  - (10) The methods used to dispose of trash, including biomedical waste, human tissue, and sharp instruments, are safe and sanitary.
  - (11) Hot and cold running water is supplied to each sink and all bathing facilities.
  - (12) The hot water temperature does not exceed 120 degrees Fahrenheit.
  - (13) Toilet paper, soap, and either paper towels or hand dryers are available in each restroom and each bathroom in the birth center. (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1316. Safety.**

- (a) Each licensee shall ensure the safety of all patients, newborns, employees, and visitors

according to the following requirements:

- (1) Each birth center shall have a working telephone on the premises and available for use at all times. Emergency telephone numbers shall be posted by each telephone or shall be readily accessible. These telephone numbers shall include telephone numbers for the fire department, hospital, ambulance, and police.
  - (2) Each exit shall be marked. No exit shall be blocked at any time.
  - (3) All drugs, chemicals, and medications shall be kept in locked storage and secured in specifically designated and labeled cabinets, drawers, closets, storerooms, or refrigerators and shall be made accessible only to authorized employees.
- (b) Each licensee shall ensure the development and implementation of a disaster plan to provide for the evacuation and safety of patients, newborns, employees, and visitors in case of fire, tornadoes, storms, floods, power outages, and other types of emergencies specific to the geographic area in which the birth center is located.
- (1) The disaster plan shall be posted in a conspicuous place in each indoor room.
  - (2) Each employee shall be informed of and shall follow the disaster plan.
  - (3) A review of the disaster plan, including fire and tornado drills, shall be conducted with the employees at least once every six months, and the date of each review shall be recorded.
  - (4) Fire and tornado drills shall be conducted with the employees at least quarterly, and the date of each drill shall be recorded.
- (c) Heating appliances, when used, shall be used as intended, safely located, equipped with a protective barrier as needed to prevent injury, and maintained in operating condition. If combustible fuel is used, the appliance shall be vented to the outside.
- (d) Each licensee shall develop and implement policies and procedures regarding the storage and handling of firearms and other weapons on the premises.
- (e) Pets and any other animals shall be prohibited in the birth center, with the exception of service animals.
- (Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1317. Food service.**

- (a) Each licensee shall ensure that the birth center has arrangements to provide patients with nutritious liquids and foods. Foods may be provided by means of any of the following:
- (1) Obtained from a food service establishment or a catering service licensed by the secretary of the Kansas department of agriculture;
  - (2) prepared on-site by employees; or
  - (3) provided by any patient's family for the sole use of that patient and the patient's family.
- (b) All food that is designed to be served hot and is prepared on-site by employees shall be heated, maintained, and served at a temperature of at least 140 degrees Fahrenheit. A tip-sensitive thermometer shall be used to determine whether food is cooked and held at the proper temperature.
- (c) Each licensee shall ensure that the food is handled and stored in a sanitary manner, which shall include meeting all of the following requirements:
- (1) All perishable foods and liquids shall be continuously maintained at 41 degrees Fahrenheit or lower in the refrigerator or 0 degrees Fahrenheit or lower in a freezer. A clearly visible, accurate thermometer shall be provided in each refrigerator and in each freezer.
  - (2) At least one refrigerator shall be designated for only food storage.
  - (3) All food stored in the refrigerator shall be covered, wrapped, or otherwise protected from cross-contamination. Raw meat shall be stored in the refrigerator in a manner that

prevents meat fluids from dripping on other foods. Unused, leftover perishable foods shall be dated, refrigerated immediately after service, and eaten within three days.

(4) Surfaces used for food preparation or eating shall be made of smooth, nonporous material.

(5) All table service designed for repeat use shall be made of smooth, durable, and nonabsorbent material and shall be free from cracks or chips.

(6) All nondisposable table service shall be sanitized using either a manual method or a mechanical dishwasher.

(A) If using a manual washing method, each licensee shall meet both of the following requirements:

(i) A three-compartment sink with hot and cold running water to each compartment and a drain board shall be used for washing, rinsing, sanitizing, and air-drying. (ii) An appropriate chemical test kit, a thermometer, or another device shall be used for testing the sanitizing solution and the water temperature.

(B) If using a mechanical dishwashing machine, each licensee shall ensure that the machine is installed and operated in accordance with the manufacturer's instructions and shall be maintained in good repair.

(d) Prepackaged, disposable formula units shall be used when newborns are not breast-fed.

(Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

**28-4-1318. Laundry.** Each licensee shall ensure that all of the following requirements are met:

(a) If laundry is done at the birth center, the laundry sinks, appliances, and countertops or tables used for laundry shall be located in an area separate from food preparation areas and shall be installed and used in a manner that safeguards the health and safety of the patients, newborns, employees, and visitors.

(b) Space shall be provided and areas shall be designated for the separation of clean and soiled clothing, linen, and towels.

(c) If laundry facilities are not available at the birth center, all laundry shall be cleaned by a commercial laundry.

(Authorized by and implementing K.S.A. 65-508; effective July 9, 2010.)

Roderick L. Bremby, Secretary of Health and Environment **Doc. No. 038422**



## CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

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

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

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

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

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

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

## **I. Hallmarks of Midwifery**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## REFERENCES

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

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Source: Basic Competency Section, Division of Education

Approved by the ACNM Board of Directors: December 2012

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



# STANDARDS FOR THE PRACTICE OF MIDWIFERY

Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

## STANDARD I

### *MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS*

The midwife:

1. Is certified by the ACNM designated certifying agent.
2. Shows evidence of continuing competency as required by the ACNM designated certifying agent.
3. Is in compliance with the legal requirements of the jurisdiction where the midwifery practice occurs.

## STANDARD II

### *MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE.*

The midwife:

1. Demonstrates knowledge of and utilizes federal and state regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting.

## STANDARD III

### *MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY*

The midwife:

1. Practices in accord with the Philosophy and the Code of Ethics of the American College of Nurse-Midwives.
2. Provides clients with a description of the scope of midwifery services and information regarding the client's rights and responsibilities.

3. Provides clients with information regarding, and/or referral to, other providers and services when requested or when care required is not within the midwife's scope of practice.
4. Provides clients with information regarding health care decisions and the state of the science regarding these choices to allow for informed decision-making.

#### **STANDARD IV**

*MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE.*

The midwife:

1. Collects and assesses client care data, develops and implements an individualized plan of management, and evaluates outcome of care.
2. Demonstrates the clinical skills and judgments described in the ACNM Core Competencies for Basic Midwifery Practice.
3. Practices in accord with the ACNM Standards for the Practice of Midwifery.

#### **STANDARD V**

*MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES AND ARE USED TO GUIDE THE SCOPE OF MIDWIFERY CARE AND SERVICES PROVIDED TO CLIENTS.*

The midwife:

1. Maintains written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
2. Has accessible resources to provide evidence based clinical practice for each specialty area which may include, but is not limited to, primary health care of women, care of the childbearing family, and newborn care.

#### **STANDARD VI**

*MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE.*

The midwife:

1. Uses records that facilitate communication of information to clients, consultants, and institutions.
2. Provides prompt and complete documentation of evaluation, course of management, and outcome of care.
3. Promotes a documentation system that provides for confidentiality and transmissibility of health records.
4. Maintains confidentiality in verbal and written communications.

#### **STANDARD VII**

*MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS.*

The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.

2. Provides for a systematic collection of practice data as part of a program of quality management.
3. Seeks consultation to review problems, including peer review of care.
4. Acts to resolve problems identified.

## **STANDARD VIII**

*MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE ACNM CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES.*

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
  - a) Knowledge of risks, benefits, and client selection criteria.
  - b) Process for acquisition of required skills.
  - c) Identification and management of complications.
  - d) Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures.

Source: Division of Standards and Practice

Approved: ACNM Board of Directors, March 8, 2003;

Revised and Approved: ACNM Board of Directors, December 4, 2009

Revised and Approved: ACNM Board of Directors, September 24, 2011

(Supersedes the ACNM's Functions, Standards and Qualifications, 1983 and Standards for the Practice of Nurse-Midwifery 1987, 1993. Standard VIII has been adapted from the ACNM's Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice)

This document contains excerpts from statutes and regulations of other states that may be considered for promulgation as regulations pursuant to the Kansas Independent Practice of Midwifery Act, New Sec. 94 “. . . in consultation with the state board of nursing, shall adopt rules and regulation pertaining to certified nurse-midwives engaging in the independent practice of midwifery and governing the ordering of tests, diagnostic services and prescribing of drug and referral or transfer to physician in the event of complication or emergencies.”

These statutes are primarily designed to allow the safe practice of midwifery when the person is not an CNM (CM, CPM, LM). Therefore, they may be more restrictive than needed. However, it appears in some of these states an RN can choose to operate as a Licensed midwife with the limited scope specified in the LM statutes, the broader scope of the collaborative agreement, or both. In this way they may serve as a guide, particularly in that they define clinical services “associated with a normal, uncomplicated pregnancy and delivery.”

***California (Licensed Midwife) CA imbeds consultation and referral into scope of practice.***

(1) Except as provided in paragraph (2), a licensed midwife shall only assist a woman in normal pregnancy and childbirth, which is defined as meeting all of the following conditions:

(A) There is an absence of both of the following:

(i) Any preexisting maternal disease or condition likely to affect the pregnancy.

(ii) Significant disease arising from the pregnancy.

(B) There is a singleton fetus.

(C) There is a cephalic presentation.

(D) The gestational age of the fetus is greater than 37<sup>0</sup>/<sub>7</sub> weeks and less than 42<sup>0</sup>/<sub>7</sub> completed weeks of pregnancy.

(E) Labor is spontaneous or induced in an outpatient setting.

(2) If a potential midwife client meets the conditions specified in subparagraphs (B) to (E), inclusive, of paragraph (1), but fails to meet the conditions specified in subparagraph (A) of paragraph (1), and the woman still desires to be a client of the licensed midwife, the licensed midwife shall provide the woman with a referral for an examination by a physician and surgeon trained in obstetrics and gynecology. A licensed midwife may assist the woman in pregnancy and childbirth only if an examination by a physician and surgeon trained in obstetrics and gynecology is obtained and the physician and surgeon who examined the woman determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy and childbirth.

(3) The board shall adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) specifying the conditions described in subparagraph (A) of paragraph (1).

(c) (1) If at any point during pregnancy, childbirth, or postpartum care a client's condition deviates from normal, the licensed midwife shall immediately refer or transfer the client to a physician and surgeon. The licensed midwife may consult and remain in consultation with the physician and surgeon after the referral or transfer.

(2) If a physician and surgeon determines that the client's condition or concern has been resolved such that the risk factors presented by a woman's disease or condition are not likely to significantly affect the course of pregnancy or childbirth, the licensed midwife may resume

primary care of the client and resume assisting the client during her pregnancy, childbirth, or postpartum care.

(3) If a physician and surgeon determines the client's condition or concern has not been resolved as specified in paragraph (2), the licensed midwife may provide concurrent care with a physician and surgeon and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. A licensed midwife shall not resume primary care of the client.

(d) A licensed midwife shall not provide or continue to provide midwifery care to a woman with a risk factor that will significantly affect the course of pregnancy and childbirth, regardless of whether the woman has consented to this care or refused care by a physician or surgeon, except as provided in paragraph (3) of subdivision (c).

(e) The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version of these means.

#### ***California (Licensed midwife) tests, diagnostics, and drugs.***

(f) A midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.

(g) This article does not authorize a midwife to practice medicine or to perform surgery.

#### ***Additional CA regulations***

With respect to the care of a client who has previously had a caesarean section ("C-section") but who meets the criteria set forth in the SCCLM, the licensed midwife shall provide the client with written informed consent (and document that written consent in the client's midwifery record) that includes but is not limited to all of the following:

(1) The current statement by the American College of Obstetricians and Gynecologists regarding its recommendations for vaginal birth after caesarean section ("VBAC").

(2) A description of the licensed midwife's level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs.

(3) A list of educational materials provided to the client.

(4) The client's agreement to: provide a copy of the dictated operative report regarding the prior C-section; permit increased monitoring; and, upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.

(5) A detailed description of the material risks and benefits of VBAC and elective repeat C-section.

#### ***Physician Requirements.***

A physician described in Section 2508 (prior arrangements for referral of patients who become high risk or otherwise experience complication) of the code shall have hospital privileges in obstetrics and shall be located in reasonable geographic and/or temporal proximity to the patient whose care the physician will assume should complications arise.

#### ***District of Columbia "Scope of Practice"***

5808.1 In addition to the general function specified in D.C. Official Code § 3-1206.04 the nurse-midwife may perform any of the acts listed below, including:

(a) Manage the care of the normal obstetrical patient;

- (b) Perform minor surgical procedure;
- (c) Manage the normal obstetrical patient during labor and delivery to include amniotomy, episiotomy, and repair;
- (d) Initiate and perform local anesthetic procedures and order the necessary anesthetic agents to perform the procedures;
- (e) Manage care of the newborn;
- (f) Perform post-partum examination;
- (g) Provide gynecological care for women;
- (h) Prescribe appropriate medications;
- (i) Provide family planning and STD services;
- (j) Provide primary health care; and
- (k) Such other functions and services the Board deems appropriate upon review and analysis of professional and association literature which articulates scopes and standards for nurse-midwifery practice.

5808.2 Repealed

5808.3 Repealed

5808.4 Repealed

5808.5 A nurse-midwife may not perform a cesarean section or surgical abortion.

5808.6 For purposes of this section, “normal patient” means a healthy individual who meets the criteria established in practice protocols as normal.

#### ***District of Columbia “Prescriptive Authority”***

5809.1 A certified nurse-midwife shall have authority to prescribe legend drugs and controlled substances subject to the limitations set forth in § 5810.

5809.2 A certified nurse-midwife shall have authority to prescribe drugs only while licensed in accordance with this chapter.

5809.3 Prescriptions for drugs shall comply with all applicable District of Columbia and federal laws.

5809.4 A certified nurse-midwife who administers or prescribes a prescription drug shall enter into the patient's chart on the date of the transaction, or if the chart is not available, within a reasonable time but no later than the next office day the following information:

- (a) Each prescription that a certified nurse-midwife orders; and
- (b) The name, strength, and amount of each drug that a certified nurse-midwife prescribes and/or dispenses.

5809.5 Pursuant to § 514 of the Act, D.C. Code § 2-3305.14(a)(19) (1988), the Board may suspend or revoke the license or certification of, or take other disciplinary action against any applicant or licensee who prescribes, dispenses, or administers drugs when not authorized to do so.

5810.1 A certified nurse-midwife shall have authority to prescribe those drugs in Schedules II through V, established pursuant to the District of Columbia Uniform Controlled Substances Act of 1981, D.C. Law 4-29, D.C. Official Code §§ 48-901.02 et seq.

5810.2 A certified nurse-midwife shall not prescribe a controlled substance unless a certified nurse-midwife meets the following requirements:

- (a) Possesses a valid controlled substances certificate of registration from the United States Drug Enforcement Administration (DEA); and

(b) Possesses a valid District of Columbia controlled substances registration pursuant to D.C. Official Code §§ 48-901.02 et seq., the District of Columbia Uniform Controlled Substances Act. 5810.3 A certified nurse-midwife shall not issue a refillable prescription for a controlled substance.

5810.4 A certified nurse-midwife shall maintain a current and complete log of all controlled substances that a certified nurse-midwife prescribes, in accordance with regulations for record keeping promulgated by the United States Drug Enforcement Administration.

***Florida Statutes “definitions”***

(2) “Certified nurse midwife” means a person who is licensed as an advanced registered nurse practitioner under part I of chapter 464 and who is certified to practice midwifery by the American College of Nurse Midwives.

(5) “Intrapartal” means occurring during the process of giving birth.

(8) “Midwifery” means the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent; the practice of advising the parents as to the progress of the childbirth; and the practice of rendering prenatal and postpartal care.

(9) “Normal labor and childbirth” means the physiological process of a healthy woman giving birth to a healthy infant and expelling an intact placenta, without injury, complications, or undue strain to the mother.

(10) “Physician” means a person licensed to practice medicine as authorized in chapter 458 or chapter 459.

(11) “Postpartal” or “postpartum” means existing or occurring subsequent to birth.

(13) “Prenatal” or “antepartal” means occurring during pregnancy up to the point of onset of labor.

(14) “Stillbirth” means the death of a fetus of more than 20 weeks’ gestation.

(3) A midwife licensed under this chapter may administer prophylactic ophthalmic medication, oxygen, postpartum oxytocin, vitamin K, rho immune globulin (human), and local anesthetic

Prepare a written plan of action with the family to ensure continuity of medical care throughout labor and delivery and to provide for immediate medical care if an emergency arises. The family should have specific plans for medical care throughout the prenatal, intrapartal, and postpartal periods.

**Emergency care plan; immunity.—**

(1) Every licensed midwife shall develop a written plan for the appropriate delivery of emergency care. A copy of the plan shall accompany any application for license issuance or renewal. The plan shall address the following:

(a) Consultation with other health care providers.

(b) Emergency transfer.

(c) Access to neonatal intensive care units and obstetrical units or other patient care areas.

(2) Any physician licensed under chapter 458 or chapter 459, or any certified nurse midwife, or any hospital licensed under chapter 395, or any osteopathic hospital, providing medical care or treatment to a woman or infant due to an emergency arising during delivery or birth as a consequence of the care received by a midwife licensed under chapter 467 shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances

demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

**Florida “risk assessment”**

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

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

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

	Score
(a) Socio-Demographic Factors.	
1. Chronological age under 16, or older than 40.	1
2. Residence of anticipated birth more than 30 minutes from emergency care.	3
(b) Documented Problems in Maternal Medical History.	
1. Cardiovascular System	
a. Chronic hypertension.	3
b. Heart disease.	3
c. Heart disease assessed by a cardiologist which places the mother or fetus at no risk.	1
d. Pulmonary embolus.	3
e. Congenital heart defects.	3
(i) Congenital heart defects assessed by a cardiologist which places the mother or fetus at no risk.	1
2. Urinary System	
a. Renal disease.	3
b. History of pyelonephritis.	1
3. Psycho-Neurological	
a. History of psychotic episode adjudged by psychiatric evaluation and which required use of drugs related to its management, but not currently on medication.	1
b. Current mental health problems requiring drug therapy.	3
c. Epilepsy or seizures in the last two years.	3
d. Required use of anticonvulsant drugs.	3
e. During the current pregnancy, drug or alcohol addiction, use of addicting drugs.	3
f. Severe undiagnosed headache.	3
4. Endocrine System	
a. Diabetes mellitus.	3

b. History of gestational diabetes.	1
c. Current thyroid disease.	
(i) Euthyroid.	1
(ii) Non-Euthyroid	3
5. Respiratory System	
a. Chronic bronchitis.	1
(i) Current or chronic or with medication.	3
(ii) Without medication or current problems.	1
b. Smoking.	
(i) 10 or less cigarettes per day.	1
(ii) More than 10 cigarettes per day.	3
6. Other Systems	
a. Bleeding disorder or hemolytic disease.	3
b. Cancer of the breast in the past five years.	3
7. Documented Problems in Obstetrical History	
a. Expected Date of Delivery (EDD) less than 12 months from date of previous delivery.	1
b. Previous Rh sensitization.	3
c. 5 or more term pregnancies.	3
d. Previous abortions.	
(i) 3 or more consecutive spontaneous abortions.	3
(ii) Two consecutive spontaneous abortions or more than three spontaneous abortions.	1
(iii) 1 septic abortion.	3
e. Uterus.	
(i) Incompetent cervix, with related medical treatment.	3
(ii) Prior uterine surgery	3
(iii) Prior uterine surgery followed by an uncomplicated vaginal birth.	2
f. Previous placenta abruptio.	3
g. Previous placenta previa.	1
h. Severe pregnancy induced hypertension during last pregnancy.	2
i. Postpartum hemorrhage apparently unrelated to management.	3
8. Physical Findings of Previous Births	
a. Stillbirth occurring at more than 20 weeks gestation or neonatal loss (other than cord accident).	3
b. Birthweight.	
(i) Less than 2500 grams or two or more previous premature labors without a subsequent low risk pregnancy and full term appropriate for gestational age (AGA) infant.	3
(ii) Less than 2500 grams or two or more previous premature labors with one or more full term AGA infant(s) subsequently delivered, after a low risk pregnancy.	1
(iii) More than 4000 grams.	1
c. Major congenital malformations, genetic, or metabolic disorder.	3
9. Maternal Physical Findings	
a. Gestation.	
(i) Of more than 22 weeks in the patient's first pregnancy (nullipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care.	3

- (ii) Of more than 28 weeks if the patient has had at least one previous viable birth (multipara), unless the patient provides a copy of a medical record documenting a prenatal physical examination and prenatal care by a licensed physician, advanced registered nurse practitioner, or licensed midwife trained in obstetrics and gynecology who regularly provides maternity care. 3
- b. Prepregnant weight is not within the range of the following weights by height: 2

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

- c. Evidence of clinically diagnosed pathological uterine myoma or malformations, abdominal or adnexal masses. 3
- d. Polyhydramnios or oligohydramnios.
  - (i) Prior pregnancy. 2
  - (ii) Current pregnancy. 3
- e. Cardiac diastolic murmur, systolic murmur grade III or above, or cardiac enlargement. 3
- 10. Current Laboratory Findings
  - a. Hematocrit/Hemoglobin.
    - (i) Less than 31% or 10.3 gm/100 ml. 1
    - (ii) Less than 28% or 9.3 gm/100 ml. 3
  - b. Sickle cell anemia. 3
  - c. Pap smear suggestive of dysplasia. 3
  - d. Evidence of active tuberculosis. 3
  - e. Positive serologic test for syphilis confirmed active. 3
  - f. HIV positive. 3

***Florida 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 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) Bulb syringe.
  - (c) Oxygen.
  - (d) Eye prophylaxis pursuant to Section 383.04, F.S.

***Florida “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. Pap smear.
    2. Serological screen for syphilis.
    3. Gonorrhea and chlamydia screening.
    4. Blood group including Rh factor and antibody screen.
    5. Complete blood count (CBC).
    6. Rubella titer.
    7. Urinalysis with culture.
    8. Sickle cell screening for at risk population.
    9. Screen for hepatitis B surface antigen (HBsAG).
    10. Screen for HIV/AIDS.
  - (b) Conduct the Healthy Start Prenatal Screen interview or assure that each patient has been previously screened.
  - (c) Provide counseling and offer screening related to the following:
    1. Neural tube defects.
    2. Group B Streptococcus.
    3. CVS or genetic amniocentesis for women 35 years of age or older at the time of delivery.
    4. Nutritional counseling.
    5. Childbirth preparation.
    6. Risk Factors.
    7. Common discomforts of pregnancy.
    8. Danger signs of pregnancy.

(d) Follow-up screening:

1. Hematocrit or hemoglobin levels at 28 and 36 weeks gestation.
2. Diabetic screening between 24 and 28 weeks gestation.
3. Antibody screen for Rh negative mothers, at 28 weeks gestation. Counsel and encourage RhoGAM prophylaxis. In those clients declining RhoGAM prophylaxis repeat antibody screen at 36 weeks.

(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 one is available, and patient gives consent.
- (d) Recording of quickening date.
- (e) Recording weeks of gestation by dates and measuring in centimeters the height of the uterine fundus.
- (f) Hearing the fetal heart tones at twenty weeks with a fetoscope.

(4) If a reliable EDD cannot be established by the above criteria, then the licensed midwife shall encourage the patient to have an ultrasound for EDD.

(5) The midwife shall refer a patient for consultation to a physician with hospital obstetrical privileges if any of the following conditions occur during the pregnancy:

- (a) Hematocrit of less than 33% at 37th week gestation or hemoglobin less than 11 gms/100 ml.
- (b) Unexplained vaginal bleeding.
- (c) Abnormal weight change defined as less than 12 or more than 50 pounds at term.
- (d) Non-vertex presentation persisting past 37th week of gestation.
- (e) Gestational age between 41 and 42 weeks.
- (f) Genital herpes confirmed clinically or by culture at term.
- (g) Documented asthma attack.
- (h) Hyperemesis not responsive to supportive care.
- (i) Any other severe obstetrical, medical or surgical problem.

(6) The midwife shall transfer a patient if any of the following conditions occur during the pregnancy:

- (a) Genetic or congenital abnormalities or fetal chromosomal disorder.
  - (b) Multiple gestation.
  - (c) Pre-eclampsia.
  - (d) Intrauterine growth retardation.
  - (e) Thrombophlebitis.
  - (f) Pyelonephritis.
  - (g) Gestational diabetes confirmed by abnormal glucose tolerance test.
  - (h) Laboratory evidence of Rh sensitization.
- (7) If the conditions listed pursuant to this section are resolved satisfactorily and the physician and midwife deem that the patient is expected to have a normal pregnancy, labor and delivery, then the care of the patient shall continue with the licensed midwife.

***Florida “Responsibilities of Midwives During Intrapartum.”***

- (1) Upon initial assessment, the midwife shall:
  - (a) Determine onset of labor.
  - (b) Review patient’s prenatal records.
  - (c) Assess condition of the mother and fetus.
  - (d) Assess delivery environment.
  - (e) Perform sterile vaginal examinations to initially assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.
- (2) Throughout active labor the midwife shall:
  - (a) Maintain a safe and hygienic environment.
  - (b) Provide nourishment, rest and support as indicated by patient’s condition.
  - (c) Monitor, assess and record the status of labor and the maternal and fetal condition.
  - (d) Measure the blood pressure every hour unless significant changes or symptoms require more frequent assessments.
  - (e) Take the patient’s pulse every 2 hours while membranes are intact and temperature is normal, then every hour after rupture of membranes.
  - (f) Take the temperature every 4 hours, or more frequently if maternal condition warrants, and every hour if elevated to 100° F or above.
  - (g) Estimate fluid intake and urinary output at least every 2 hours.
  - (h) Assess for hydration and edema.
- (3) The midwife shall assess and record the status of labor as follows:
  - (a) Measure the frequency, duration and intensity of the contractions every half hour and more frequently if indicated.
  - (b) Observe and record vaginal discharge.
  - (c) Monitor fetal heart tones during and following contractions to assess fetal condition according to the following schedule after admission to care for labor:
    1. Every hour during the latent phase.
    2. Every 30 minutes during the active phase of the first stage.
    3. Every 15 minutes during transition.
    4. Every five minutes during the second stage.
    5. Immediately after the appearance of amniotic fluid in the vaginal discharge.
  - (d) Palpate the abdomen for the position and level of the presenting part.
  - (e) Perform sterile vaginal examinations to assess cervical dilation and effacement, presentation, position and station of the fetus, and the status of the membranes.

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

- (a) Premature labor, meaning labor occurring at less than 37 weeks of gestation.
  - (b) Premature rupture of membranes, meaning rupture occurring more than 12 hours before onset of regular active labor.
  - (c) Non-vertex presentation.
  - (d) Evidence of fetal distress.
  - (e) Abnormal heart tones.
  - (f) Moderate or severe meconium staining.
  - (g) Estimated fetal weight less than 2500 grams or greater than 4000 grams.
  - (h) Pregnancy induced hypertension which is defined as 140/90, or an increase of 30 mm hg systolic or 15 mm hg diastolic above baseline.
  - (i) Failure to progress in active labor:
    - 1. First stage: lack of steady progress in dilation and descent after 24 hours in primipara and 18 hours in multipara.
    - 2. Second stage: more than 2 hours without progress in descent.
    - 3. Third stage: more than 1 hour.
  - (j) Severe vulvar varicosities.
  - (k) Marked edema of cervix.
  - (l) Active bleeding.
  - (m) Prolapse of the cord.
  - (n) Active infectious process.
  - (o) Other medical or surgical problems.
- (5) The midwife shall not perform any operative procedure other than:
- (a) Artificial rupture of the membranes when the fetal head is engaged and well applied to the cervix in active labor and four or more centimeters dilated.
  - (b) Clamping and cutting the umbilical cord.
  - (c) Episiotomy when indicated.
  - (d) Suture to repair first and second degree lacerations.
- (6) The midwife shall not attempt to correct fetal presentations by external or internal version.
- (7) The midwife shall use only prescription drugs pursuant to Rule 64B24-7.011, F.A.C.
- (8) The midwife shall not use artificial, forcible or mechanical means to assist the birth.

***Arizona “Definitions” regulations.***

- 1. “Abnormal presentation” means the fetus is not in a head-down position with the crown of the head being the leading body part.
- 2. “Addiction” means a condition that results when a person ingests a substance that becomes compulsive and interferes with ordinary life responsibilities, such as work, relationships, or health.
- 3. “Amniotic” means the fluid surrounding the fetus while in the mother's uterus.
- 4. “Apgar score” means the number indicating a newborn's physical condition attained by rating selected body functions.
- 5. “Aseptic” means free of germs.
- 6. “Breech” means a complete breech, a frank breech, or an incomplete breech.

7. "Certified nurse midwife" means an individual who meets the criteria in 4 A.A.C. 19, Article 5 and is certified by the Arizona State Board of Nursing.
8. "Complete breech" means that at the time of birth the buttocks of a fetus is pointing downward with both legs folded at the knees and the feet near the buttocks.
9. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
10. "Cervix" means the narrow lower end of the uterus which protrudes into the cavity of the vagina.
11. "Consultation" means communication between a midwife and a physician or a midwife and a certified nurse midwife for the purpose of receiving a written or verbal recommendation and implementing prospective advice regarding the care of a pregnant woman or the woman's child.
13. "Dilation" means opening of the cervix during the mechanism of labor to allow for passage of the fetus.
14. "Effacement" means the gradual thinning of the cervix during the mechanism of labor and indicates progress in labor.
15. "Emergency care plan" means the arrangements established by a midwife for a client's transfer of care in a situation in which the health or safety of the client or newborn are determined to be at risk.
16. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
17. "Episiotomy" means the cutting of the perineum, center, middle, or midline, in order to enlarge the vaginal opening for delivery.
18. "Fetus" means a child in utero from conception to birth.
19. "Frank breech" means that at the time of birth the buttocks of a fetus is pointing downward with both legs folded flat up against the head.
20. "Gestation" means the length of time from conception to birth, as calculated from the first day of the last normal menstrual period.
21. "Gravida" means the number of times the mother has been pregnant, including a current pregnancy, regardless of whether these pregnancies were carried to term.
22. "Incomplete breech" means that at the time of birth the buttocks of a fetus is pointing downward with one leg folded at the knee with the foot near the buttocks.
23. "Infant" has the same meaning as in A.R.S. § 36-694.
24. "Informed consent" means a document signed by a client, as provided in R9-16-109, agreeing to the provision of midwifery services.
25. "Intrapartum" means occurring from the onset of labor until after the delivery of the placenta.
27. "Ketones" means certain harmful chemical elements which are present in the body in excessive amounts when there is a compromised bodily function.
29. "Meconium" means the first bowel movement of the newborn, which is greenish black in color and tarry in consistency.
30. "Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery or postpartum care.
31. "Newborn" has the same meaning as in A.R.S. § 36-694.
32. "Para" means the number of births that are greater than 20 weeks of gestation, including viable and non-viable births, where multiples are counted as one birth.
33. "Parity" means the number of newborns a woman has delivered.

34. "Perineum" means the muscular region in the female between the vaginal opening and the anus.
35. "Physician" means an allopathic, an osteopathic, or a naturopathic practitioner licensed according to A.R.S. Title 32, Chapters 13, 14, or 17.
36. "Postpartum" means the six-week period following delivery of a newborn and placenta.
37. "Prenatal" means the period from conception to the onset of labor and birth.
38. "Prenatal care" means the on-going risk assessments, clinical examinations, and prenatal, nutritional, and anticipatory guidance offered to a pregnant woman.
39. "Prenatal visit" means each clinical examination of a pregnant woman for the purpose of monitoring the course of gestation and the overall health of the woman.
40. "Primigravida" means a woman who is pregnant for the first time.
41. "Primipara" means a woman who has given birth to her first newborn.
42. "Quickening" means the first perceptible movement of the fetus in the uterus, occurring usually in the 16th to the 20th week of gestation.
43. "Rh" means a blood antigen.
44. "Serious mental illness" means a condition in an individual who is 18 years of age or older and who exhibits emotional or behavioral functioning, as a result of a mental disorder as defined in A.R.S. § 36-501, that:
  - a. Is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation; and
  - b. Impairs or substantially interferes with the capacity of the individual to remain in the community without supportive treatment or services of a long-term or indefinite duration.
45. "Substance abuse" means the continued use of alcohol or other drugs in spite of negative consequences.
46. "Shoulder dystocia" means the shoulders of the fetus are wedged in the mother's pelvis in such a way that the fetus is unable to be born without emergency action.
47. "Transfer of care" means that a midwife refers the care of a client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.

***Arizona "Responsibilities of a Midwife, Scope of Practice"***

- A. A midwife shall provide midwifery services only to a healthy woman, determined through a physical assessment and review of the woman's obstetrical history, whose expected outcome of pregnancy is most likely to be the delivery of a healthy new-born and an intact placenta.
- B. Except as provided in R9-16-111(C) or (D), a midwife who is certified by the North American Registry of Midwives as a Certified Professional Midwife may accept a client for a vaginal delivery:
  1. After prior Cesarean section, or
  2. Of a fetus in a complete breech or frank breech presentation.
- C. Before providing services to a client, a midwife shall:
  1. Inform a client, both orally and in writing, of:
    - a. The midwife's scope of practice, educational background, and credentials;
    - b. If applicable to the client's condition, the midwife's experience with:
      - i. Vaginal birth after prior Cesarean section delivery, or
      - ii. Delivery of a fetus in a complete breech or frank breech presentation;

- c. The potential risks; adverse outcomes; neonatal or maternal complications, including death; and alternatives associated with an at-home delivery specific to the client's condition, including the conditions described in subsection (C)(1)(b);
- d. The requirement for tests specified in subsections (I) and (K)(4)(c), and the potential risks for declining a test, and, if a test is declined, the need for a written assertion of a client's decision to decline testing;
- e. The requirement for consultation for a condition specified in R9-16-112; and
- f. The requirement for the transfer of care for a condition specified in R9-16-111; and
- 2. Obtain a written informed consent for midwifery services according to R9-16-109.
- D. A midwife shall establish an emergency care plan for the client that includes:
  - 1. The name, address, and phone number of:
    - a. The hospital closest to the birthing location that provides obstetrical services, and
    - b. An emergency medical services provider that provides service between the birthing location and the hospital identified in subsection (D)(1)(a);
  - 2. The hospital identified in subsection (D)(1)(a) is within 25 miles of the birthing location for a delivery identified in subsection (B);
  - 3. The signature of the client and the date signed; and
  - 4. The signature of the midwife and the date signed.
- E. A midwife shall ensure the client receives a copy of the emergency care plan required in subsection (D).
- F. A midwife shall implement the emergency care plan by immediately calling the emergency medical services provider identified in subsection (D)(1)(b) for any condition that threatens the life of the client or the client's child.
- G. A midwife shall maintain all instruments used for delivery in an aseptic manner and other birthing equipment and supplies in clean and good condition.
- H. A midwife shall assess a client's physical condition in order to establish the client's continuing eligibility to receive midwifery services.
- I. During the prenatal period, the midwife shall:
  - 1. Until October 1, 2013, schedule or arrange for the following tests for the client within 28 weeks gestation:
    - a. Blood type, including ABO and Rh, with antibody screen;
    - b. Urinalysis;
    - c. HIV;
    - d. Hepatitis B;
    - e. Hepatitis C;
    - f. Syphilis as required in A.R.S. § 36-693;
    - g. Rubella titer;
    - h. Chlamydia; and
    - i. Gonorrhea;
  - 2. Until October 1, 2013, schedule or arrange for the following tests for the client:
    - a. A blood glucose screening test for diabetes completed between 24 and 28 weeks of gestation;
    - b. A hematocrit and hemoglobin or complete blood count test completed between 28 and 36 weeks of gestation;
    - c. A vaginal-rectal swab for Group B Strep Streptococcus culture completed between 35 and 37 weeks of gestation;

- d. At least one ultrasound and recommended follow-up testing to determine placental location and risk for placenta previa and placenta accrete; and
- e. An ultrasound at 36-37 weeks gestation to confirm fetal presentation and estimated fetal weight for a breech pregnancy;
- 3. As of October 1, 2013, except as provided in R9-16-110, ensure that the tests in section (I)(1) are completed by the client within 28 weeks gestation;
- 4. As of October 1, 2013, except as provided in R9-16-110, ensure that the tests in subsection (I)(2) are completed by the client;
- 5. Conduct a prenatal visit at least once every 4 weeks until the beginning of 28 weeks of gestation, once every 2 weeks from the beginning of 28 weeks until the end of 36 weeks of gestation, and once a week after 36 weeks of gestation that includes:
  - a. Taking the client's weight, urinalysis for protein, nitrites, glucose and ketones; blood pressure; and assessment of the lower extremities for swelling;
  - b. Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus;
  - c. Documentation of fetal movement beginning at 28 weeks of gestation;
  - d. Document of:
    - i. The occurrence of bleeding or invasive uterine procedures, and
    - ii. Any medications taken during the pregnancy that are specific to the needs of an Rh negative client;
  - e. Referral of a client for lab tests or other assessments, if applicable, based upon examination or history; and
  - f. Recommendation of administration of the drug RhoGam to unsensitized Rh negative mothers after 28 weeks, or any time bleeding or invasive uterine procedures are done, or midwife administration of RhoGam under a physician's written orders;
- 6. Monitor fetal heart tones with fetoscope and document the client's report of first quickening, between 18 and 20 weeks of gestation;
- 7. Conduct weekly visits until signs of first quickening have occurred if first quickening has not been reported by 20 weeks of gestation;
- 8. Initiate a consultation if first quickening has not occurred by the end of 22 weeks of gestation; and
- 9. Conduct a prenatal visit of the birthing location before the end of 35 weeks of gestation to ensure that the birthing environment is appropriate for birth and that communication is available to the hospital and emergency medical services provider identified in subsection(D)(1).
- J. During the intrapartum period, a midwife shall:
  - 1. Determine if the client is in labor and the appropriate course of action to be taken by:
    - a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
    - b. Determining the condition of the membranes, whether intact or ruptured, and the amount and color of fluid;
    - c. Reviewing with the client the need for an adequate fluid intake, relaxation, activity, and emergency management; and
    - d. Deciding whether to go to client's home, remain in telephone contact, or arrange for transfer of care or consultation;
  - 2. Contact the hospital identified in subsection (D)(1)(a) according to the policies and procedures established by the hospital regarding communication with midwives when the client begins labor and ends labor;

3. During labor, assess the condition of the client and fetus upon initial contact, every half hour in active labor until completely dilated, and every 15 to 20 minutes during pushing, following rupture of the amniotic bag, or until the newborn is delivered, including:
    - a. Initial physical assessment and checking of vital signs every 2 to 4 hours of the client;
    - b. Assessing fetal heart tones every 30 minutes in active first stage labor, and every 15 minutes during second stage, following rupture of the amniotic bag, or with any significant change in labor patterns;
    - c. Periodically assessing contractions, fetal presentation, dilation, effacement, and fetal position by vaginal examination;
    - d. Maintaining proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones; and
    - e. Assisting in support and comfort measures to the client and family;
  4. For deliveries described in subsection (B), during labor determine:
    - a. For primiparas, the progress of active labor by monitoring whether dilation occurs at an average of 1 centimeter per hour until completely dilated, and a second stage does not exceed 2 hours, if applicable;
    - b. Normal progress of active labor for multigravidas by monitoring whether dilation occurs at an average of 1.5 to 2 centimeters per hour until completely dilated, and a second stage does not exceed 1 hour, if applicable; or
    - c. The progress of active labor according to the Management Guidelines recommended by the American Congress of Obstetricians and Gynecologists;
  5. After delivery of the newborn:
    - a. Assess the newborn at 1 minute and 5 minutes to determine the Apgar scores;
    - b. Physically assess the newborn for any abnormalities;
    - c. Inspect the client's perineum, vagina, and cervix for lacerations;
    - d. Deliver the placenta within 1 hour and assess the client for signs of separation, frank or occult bleeding; and
    - e. Examine the placenta for intactness and to determine the number of umbilical cord vessels; and
  6. Recognize and respond to any situation requiring immediate intervention.
- K. During the postpartum period, the midwife shall:
1. During the 2 hours after delivery of the placenta, provide the following care to the client:
    - a. Every 15 to 20 minutes for the first hour and every 30 minutes for the second hour:
      - i. Take vital signs of the client,
      - ii. Perform external massage of the uterus, and
      - iii. Evaluate bleeding;
    - b. Assist the client to urinate within 2 hours following the birth, if applicable;
    - c. Evaluate the perineum, vagina, and cervix for tears, bleeding, or blood clots;
    - d. Assist with maternal newborn and infant bonding;
    - e. Assist with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate;
    - f. Provide instruction to the family about adequate fluid and nutritional intake, rest, and the types of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, signs and symptoms of postpartum depression, and any symptoms that may pose a threat to the health or life of the client or the client's newborn and appropriate emergency phone numbers;

- g. Recommend or administer under physician's written orders, the drug RhoGam to an unsensitized Rh-negative mother who delivers an Rh-positive newborn. Administration shall occur not later than 72 hours after birth; and
- h. Document any medications taken by the client in the client's record to an unsensitized Rh-negative client who delivers an Rh-positive newborn;
- 2. During the 2 hours after delivery of the placenta, provide the following care to the newborn:
  - a. Perform a newborn physical exam to determine the newborn's gestational age and any abnormalities;
  - b. Comply with the requirements in A.A.C. R9-6-332;
  - c. Recommend or administer Vitamin K under physician's written orders to the newborn. Administration shall occur not later than 72 hours after birth; and
  - d. Document the administration of any medications or vitamins to the newborn in the newborn's record according to the physician's written orders;
- 3. Evaluate the client or newborn for any abnormal or emergency situation and seek consultation or intervention, if applicable, according to these rules; and
- 4. Re-evaluate the condition of the client and newborn between 24 and 72 hours after delivery to determine whether the recovery is following a normal course, including:
  - a. Assessing baseline indicators such as the client's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, activity with any recommendations for change;
  - b. Assessing baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, and bowel and bladder function with documentation of meconium, and providing any recommendations for changes made to the family;
  - c. Submitting blood obtained from a heel stick to the newborn to the state laboratory for screening according to A.R.S. § 36-694(B) and 9 A.A.C. 13, Article 2, unless a written refusal is obtained from the client and documented in the client's record and the newborn's record; and
  - d. Recommending to the client that the client secure medical follow-up for her newborn.
- L. A midwife shall file a birth certificate with the local registrar within seven calendar days after the birth of the newborn.
- M. Subsections (B), (C)(1)(b), (C)(1)(d) and (J)(2) and (4) are effective July 1, 2014.

***Arizona Prohibited Practice, Transfer of care***

- A. A midwife shall not provide midwifery services in a location that has the potential to cause harm to the client or the client's child.
- B. A midwife shall not accept for midwifery services or continue midwifery services for a client who has or develops any of the following:
  - 1. A previous surgery that involved:
    - a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
    - b. A previous uterine surgery that enters the myometrium;
  - 2. Multiple fetuses;
  - 3. Placenta previa or placenta accreta;
  - 4. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
  - 5. Deep vein thrombosis or pulmonary embolism;
  - 6. Uncontrolled gestational diabetes;
  - 7. Insulin-dependent diabetes;
  - 8. Hypertension;

9. Rh disease with positive titers;
  10. Active:
  11. Preeclampsia or eclampsia persisting after the second trimester;
    - a. Tuberculosis;
    - b. Syphilis;
    - c. Genital herpes at the onset of labor;
    - d. Hepatitis until treated and recovered, following which midwifery services may resume; or
    - e. Gonorrhea until treated and recovered, following which midwifery services may resume;
  12. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
  13. A persistent hemoglobin level below 10 grams or a hematocrit below 30 during the third trimester;
  14. A pelvis that will not safely allow a baby to pass through during labor;
  15. A serious mental illness;
  16. Evidence of substance abuse, including six months prior to pregnancy, to one of the following, evident during an assessment of a client:
    - a. Alcohol,
    - b. Narcotics, or
    - c. Other drugs;
  17. Except as provided in R9-16-108(B)(2), a fetus with an abnormal presentation;
  18. Labor beginning before the beginning of 36 weeks gestation;
  19. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
  20. Gestational age greater than 34 weeks with no prior prenatal care;
  21. A gestation beyond 42 weeks;
  22. Presence of ruptured membranes without onset of labor within 24 hours;
  23. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
  24. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
  25. A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy; or
  26. A non-bleeding placenta retained for more than 60 minutes.
- C. A midwife shall not perform a vaginal delivery after prior Cesarean section for a client who:
1. Had:
    - a. More than one previous Cesarean section;
    - b. A previous Cesarean section:
      - i. With a classical, vertical, or unknown uterine incision;
      - ii. Within 18 months before the expected delivery;
      - iii. With complications, including uterine infection; or
      - iv. Due to failure to progress as a result of cephalopelvic insufficiency; or
    - c. Complications during a previous vaginal delivery after a Cesarean section; or
  2. Has a fetus:
    - a. With fetal anomalies, confirmed by an ultrasound; or
    - b. In a breech presentation.
- D. A midwife shall not perform a vaginal delivery of a fetus in a breech presentation for a client who:
1. Had a previous:

- a. Unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis, or
- b. Cesarean section; or
- 2. Has a fetus:
  - a. With fetal anomalies, confirmed by an ultrasound;
  - b. With an estimated fetal weight less than 2500 grams or more than 3800 grams; or
  - c. In an incomplete breech presentation.
- E. If the client has any of the conditions in subsections (B) through (D), a midwife shall:
  - 1. Document the condition in the client record, and
  - 2. Initiate transfer of care.
- F. A midwife shall not perform any operative procedures except as provided in R9-16-113.
- G. A midwife shall not:
  - 1. Use any artificial, forcible, or mechanical means to assist birth; or
  - 2. Attempt to correct fetal presentations by external or internal movement of the fetus.
- H. A midwife shall not administer drugs or medications except as provided in R9-16-108(I)(5)(f), (K)(1)(g), (K)(2)(c), or R9-16-113.
- I. Except as provided in R9-16-113, a midwife shall:
  - 1. Discontinue midwifery services and transfer care of a newborn in which any of the following conditions are present:
    - a. Birth weight less than 2000 grams;
    - b. Pale, blue, or gray color after 10 minutes;
    - c. Excessive edema;
    - d. Major congenital anomalies; or
    - e. Respiratory distress; and
  - 2. Document the condition in subsection (I)(1) in the newborn record.

***Arizona “Required Consultation”***

- A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:
  - 1. A positive culture for Group B Streptococcus;
  - 2. History of seizure disorder;
  - 3. History of stillbirth, premature labor, or parity greater than 5;
  - 4. Age younger than 16 years;
  - 5. A primigravida older than 40 years of age;
  - 6. Failure to auscultate fetal heart tones by the beginning of 22 weeks gestation;
  - 7. Failure to gain 12 pounds by the beginning of 30 weeks gestation or gaining more than 8 pounds in any two-week period during pregnancy;
  - 8. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits;
  - 9. Excessive vomiting or continued vomiting after the end of 20 weeks gestation;
  - 10. Symptoms of decreased fetal movement;
  - 11. A fever of 100.4° F or 38° C or greater measured twice at 24 hours apart;
  - 12. Tender uterine fundus;
  - 13. Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to the beginning of 36 weeks gestation;
  - 14. Measurements for fetal growth that are not within 2 centimeters of the gestational age;
  - 15. Second degree or greater lacerations of the birth canal;
  - 16. Except as provided in R9-16-111(A)(20), an abnormal progression of labor;

17. An unengaged head at 7 centimeters dilation in active labor;
  18. Failure of the uterus to return to normal size in the current postpartum period;
  19. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful;
  20. Gonorrhea;
  21. Chlamydia;
  22. Syphilis;
  23. Heart disease;
  24. Kidney disease;
  25. Blood disease; or
  26. A positive test result for:
    - a. HIV,
    - b. Hepatitis B, or
    - c. Hepatitis C.
- B. A midwife shall obtain a consultation at the time a newborn demonstrates any of the following conditions:
1. Weight less than 2500 grams or 5 pounds, 8 ounces;
  2. Congenital anomalies;
  3. An Apgar score less than 7 at 5 minutes;
  4. Persistent breathing at a rate of more than 60 breaths per minute;
  5. An irregular heartbeat;
  6. Persistent poor muscle tone;
  7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
  8. Yellowish-colored skin within 48 hours;
  9. Abnormal crying;
  10. Meconium staining of the skin;
  11. Lethargy;
  12. Irritability;
  13. Poor feeding;
  14. Excessively pink coloring over the entire body;
  15. Failure to urinate or pass meconium in the first 24 hours of life;
  16. A hip examination which results in a clicking or incorrect angle;
  17. Skin rashes not commonly seen in the newborn; or
  18. Temperature persistently above 99.0° or below 97.6° F.
- C. The midwife shall inform the client of the consultation required in subsections (A) or (B) and recommendations of the physician or certified nurse midwife.
- D. The midwife shall document the consultation required in subsections (A) or (B) and recommendations received in the client record or newborn record.

***Arizona “emergency measures”***

- A. In an emergency situation in which the health or safety of the client or newborn are determined to be at risk, a midwife:
1. Shall ensure that an emergency medical services provider is called; and
  2. May perform the following procedures as necessary:
    - a. Cardiopulmonary resuscitation of the client or newborn with a bag and mask;

- b. Administration of oxygen at no more than 8 liters per minute via mask for the client and 5 liters per minute for the newborn via neonatal mask;
  - c. Episiotomy to expedite the delivery during fetal distress;
  - d. Suturing of episiotomy or tearing of the perineum to stop active bleeding, following administration of local anesthetic, contingent upon consultation with a physician or certified nurse midwife, or physician's written orders;
  - e. Release of shoulder dystocia by utilizing:
    - i. Hyperflexion of the client's legs to the abdomen,
    - ii. Application of external pressure suprapubically,
    - iii. Rotation of the nonimpacted shoulder until the impacted shoulder is released,
    - iv. Delivery of the posterior shoulder,
    - v. Application of posterior pressure on the anterior shoulder, or
    - vi. Positioning of the client on all fours with the back arched;
  - f. Manual exploration of the uterus for control of severe bleeding; or
  - g. Manual removal of placenta.
- B. A licensed midwife may administer a maximum dose of 20 units of pitocin intramuscularly, in 10-unit dosages each, 30 minutes apart, to a client for the control of postpartum hemorrhage, contingent upon physician or certified nurse midwife consultation and written orders by a physician, and arrangements for immediate transport of the client to a hospital.
- C. A midwife shall document in the client's record any medications taken by a client for the control of postpartum hemorrhage.

***Idaho Statutes Scope of Practice (not nurse midwives)***

- (a) Allow a midwife to obtain and administer, during the practice of midwifery, the following:
  - (i) Oxygen;
  - (ii) Oxytocin and cytotec as postpartum antihemorrhagic agents;
  - (iii) Injectable local anesthetic for the repair of lacerations that are no more extensive than second degree;
  - (iv) Antibiotics to the mother for group b streptococcus prophylaxis consistent with guidelines of the United States centers for disease control and prevention;
  - (v) Epinephrine to the mother administered via a metered dose auto-injector;
  - (vi) Intravenous fluids for stabilization of the woman;
  - (vii) Rho(d)immune globulin;
  - (viii) Vitamin K; and
  - (ix) Eye prophylactics to the baby.
- (b) Prohibit the use of other legend drugs, except those of a similar nature and character as determined by the board to be consistent with the practice of midwifery; provided that, at least one hundred twenty (120) days' advance notice of the proposal to allow the use of such drugs is given to the board of pharmacy and the board of medicine and neither board objects to the addition of such drugs to the midwifery formulary;
- (c) Define a protocol for use by licensed midwives of drugs approved in paragraphs (a) and (b) of this subsection that shall include methods of obtaining, storing and disposing of such drugs and an indication for use, dosage, route of administration and duration of treatment;
- (d) Define a protocol for medical waste disposal; and

(e) Establish scope and practice standards for antepartum, intrapartum, postpartum and newborn care that shall, at a minimum:

(i) Prohibit a licensed midwife from providing care for a client with a history of disorders, diagnoses, conditions or symptoms that include:

1. Placental abnormality;
2. Multiple gestation, except that midwives may provide antepartum care that is supplementary to the medical care of the physician overseeing the pregnancy, so long as it does not interfere with the physician's recommended schedule of care;
3. Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first;
4. Birth under thirty-seven and zero-sevenths ( $37\frac{0}{7}$ ) weeks and beyond forty-two and zero-sevenths ( $42\frac{0}{7}$ ) weeks gestational age;
5. A history of more than one (1) prior cesarean section, a cesarean section within eighteen (18) months of the estimated due date or any cesarean section that was surgically closed with a classical or vertical uterine incision;
6. Platelet sensitization, hematological or coagulation disorders;
7. A body mass index of forty (40.0) or higher at the time of conception;
8. Prior chemotherapy and/or radiation treatment for a malignancy;
9. Previous pre-eclampsia resulting in premature delivery;
10. Cervical insufficiency;
11. HIV positive status; or
12. Opiate use that places the infant at risk of neonatal abstinence syndrome.

(ii) Prohibit a licensed midwife from providing care for a client with a history of the following disorders, diagnoses, conditions or symptoms unless such disorders, diagnoses, conditions or symptoms are being treated, monitored or managed by a licensed health care provider:

1. Diabetes;
2. Thyroid disease;
3. Epilepsy;
4. Hypertension;
5. Cardiac disease;
6. Pulmonary disease;
7. Renal disease;
8. Gastrointestinal disorders;
9. Previous major surgery of the pulmonary system, cardiovascular system, urinary tract or gastrointestinal tract;
10. Abnormal cervical cytology;
11. Sleep apnea;
12. Previous bariatric surgery;
13. Hepatitis;
14. History of illegal drug use or excessive prescription drug use; or
15. Rh or other blood group disorders and a physician determines the pregnancy can safely be attended by a midwife.

(iii) Require a licensed midwife to recommend that a client see a physician licensed under chapter 18, title 54, Idaho Code, or under an equivalent provision of the law of a state bordering Idaho and to document and maintain a record as required by section 54-5511, Idaho Code, if such client has a history of disorders, diagnoses, conditions or symptoms that include:

1. Previous complicated pregnancy;
  2. Previous cesarean section;
  3. Previous pregnancy loss in second or third trimester;
  4. Previous spontaneous premature labor;
  5. Previous pre-term rupture of membranes;
  6. Previous pre-eclampsia;
  7. Previous hypertensive disease of pregnancy;
  8. Parvo;
  9. Toxo;
  10. CMV;
  11. HSV;
  12. Previous maternal/newborn group b streptococcus infection;
  13. A body mass index of at least thirty-five (35.0) but less than forty (40.0) at the time of conception;
  14. Underlying family genetic disorders with potential for transmission; or
  15. Psychosocial situations that may complicate pregnancy.
- (iv) Require that a licensed midwife shall facilitate the immediate transfer to a hospital for emergency care for disorders, diagnoses, conditions or symptoms that include:
1. Maternal fever in labor;
  2. Suggestion of fetal jeopardy such as bleeding or meconium or abnormal fetal heart tones;
  3. Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless imminent delivery is safer than transfer;
  4. Second stage labor after two (2) hours of initiation of pushing when the mother has had a previous cesarean section;
  5. Current spontaneous premature labor;
  6. Current pre-term premature rupture of membranes;
  7. Current pre-eclampsia;
  8. Current hypertensive disease of pregnancy;
  9. Continuous uncontrolled bleeding;
  10. Bleeding which necessitates the administration of more than two (2) doses of oxytocin or other antihemorrhagic agent;
  11. Delivery injuries to the bladder or bowel;
  12. Grand mal seizure;
  13. Uncontrolled vomiting;
  14. Coughing or vomiting of blood;
  15. Severe chest pain; or
  16. Sudden onset of shortness of breath and associated labored breathing.

A transfer of care shall be accompanied by the client's medical record, the licensed midwife's assessment of the client's current condition and a description of the care provided by the licensed midwife prior to transfer;

(v) Establish a written plan for the emergency transfer and transport required in subparagraph (iv) of this paragraph and for notifying the hospital to which a client will be transferred in the case of an emergency. If a client is transferred in an emergency, the licensed midwife shall notify the hospital when the transfer is initiated and accompany the client to the hospital if feasible, or communicate by telephone with the hospital if unable to be present personally, and shall provide the client's medical record. The record shall include the client's name, address, list of diagnosed

medical conditions, list of prescription or over the counter medications regularly taken, history of previous allergic reactions to medications, if feasible the client's current medical condition and description of the care provided by the midwife and next of kin contact information. A midwife who deems it necessary to transfer or terminate care pursuant to this section and any rules promulgated under this section or for any other reason shall transfer or terminate care and shall not be regarded as having abandoned care or wrongfully terminated services. Before nonemergent discontinuing of services, the midwife shall notify the client in writing, provide the client with names of licensed physicians and contact information for the nearest hospital emergency room and offer to provide copies of medical records regardless of whether copying costs have been paid by the client.

(f) Establish and operate a system of peer review for licensed midwives that shall include, but not be limited to, the appropriateness, quality, utilization and the ethical performance of midwifery care.

(2) The rules adopted by the board may not:

(a) Require a licensed midwife to have a nursing degree or diploma;

(b) Except as a condition imposed by disciplinary proceedings by the board, require a licensed midwife to practice midwifery under the supervision of another health care provider;

(c) Except as a condition imposed in disciplinary proceedings by the board, require a licensed midwife to enter into an agreement, written or otherwise, with another health care provider;

(d) Limit the location where a licensed midwife may practice midwifery;

(e) Allow a licensed midwife to use vacuum extraction or forceps as an aid in the delivery of a newborn;

(f) Grant a licensed midwife prescriptive privilege;

(g) Allow a licensed midwife to perform abortions.

### ***Idaho formulary***

01. Midwifery Formulary. A licensed midwife may obtain and administer, during the practice of midwifery, the following: (3-29-10)

a. Oxygen; (3-29-10)

b. Oxytocin and cytotec as postpartum antihemorrhagic agents; (7-1-14)

c. Injectable local anesthetic for the repair of lacerations that are no more extensive than second degree; (3-29-10)

d. Antibiotics to the mother for group b streptococcus prophylaxis consistent with the guidelines set forth in Prevention of Perinatal Group B Streptococcal Disease, published by the Centers for Disease Control and Prevention; (7-1-14)

e. Epinephrine to the mother administered via a metered dose auto-injector; (7-1-14)

f. Intravenous fluids for stabilization of the woman; (3-29-10)

g. Rho (d) immune globulin; (3-29-10)

h. Vitamin K1; and (3-29-10)

i. Eye prophylactics to the baby. (3-29-10)

02. Other Legend Drugs. During the practice of midwifery a licensed midwife may not obtain or administer legend drugs that are not listed in the midwifery formulary. Drugs of a similar nature and character may be used if determined by the Board to be consistent with the practice of midwifery and provided that at least one hundred twenty (120) days' advance notice of the proposal to allow the use of such drugs is given to the Board of Pharmacy and the Board of

Medicine and neither Board objects to the addition of such drugs to the midwifery formulary. (3-29-10)

**Use of Formulary Drugs**

A licensed midwife may use the drugs described in the midwifery formulary according to the following protocol describing the indication for use, dosage, route of administration and duration of treatment:

Drug	Indication	Dose	Route of Administration	Duration of Treatment
Oxygen	Maternal/Fetal Distress	10-12 L/min.10 L/min.	Bag and mask Mask	Until maternal/fetal stabilization is achieved or transfer to hospital is complete
	Neonatal Resuscitation	10-12 L/min.10 L/min.	Bag and mask Mask	Until stabilization is achieved or transfer to a hospital is complete
				1-2 doses
Oxytocin (Pitocin)	Postpartum hemorrhage only	10 Units/ml	Intramuscularly only	Transport to hospital required if more than two doses are administered
Lidocaine HCl 2%	Local anesthetic for use during postpartum repair of lacerations or episiotomy	Maximum 50 ml	Percutaneous infiltration only	Completion of repair
Penicillin G	Group B Strep Prophylaxis	5 million units initial dose, then 2.5 million units every 4 hours until birth	IV in $\geq 100$ ml LR, NS or D <sub>5</sub> LR	Birth of baby
(Recommended)				
Ampicillin Sodium	Group B Strep Prophylaxis	2 grams initial dose, then 1 gram every 4 hours until birth	IV in $\geq 100$ ml NS or LR	Birth of baby
(Alternative)				
Cefazolin Sodium (drug of choice for	Group B Strep Prophylaxis	2 grams initial dose,	IV in $\geq 100$ ml LR, NS or D <sub>5</sub> LR	Birth of baby

penicillin allergy with low risk for anaphylaxis)		then 1 gram every 8 hours		
Clindamycin Phosphate (drug of choice for penicillin allergy with high risk for anaphylaxis)	Group B Strep Prophylaxis	900 mg every 8 hours	IV in $\geq 100$ ml NS (not LR)	Birth of baby
Epinephrine HCl 1:1000	Treatment or post-exposure prevention of severe allergic reactions	0.3 ml pre-metered dose	Subcutaneously or intramuscularly	Every 20 minutes or until emergency medical services arrive
(EpiPen)				Administer first dose then immediately request emergency services
Lactated Ringer's (LR)	To achieve maternal stabilization	I - 2 liter bags	Intravenously with $\geq 18$ gauge catheter	Until maternal stabilization is achieved or transfer to a hospital is complete
5% Dextrose in Lactated Ringer's solution (D <sub>5</sub> LR)		First liter run in at a wide-open rate, the second liter titrated to client's condition		
0.9% Sodium Chloride (NS) Sterile Water	Reconstitution of antibiotic powder	As directed	As directed	Birth of Baby
				1-2 doses
Cytotec (Misoprostol)	Postpartum hemorrhage only	800 mcg	Rectally is the preferred method Orally is allowed	Transport to hospital required if more than one dose is administered
Rho(d) Immune Globulin	Prevention of Rho (d) sensitization in Rho (d) negative women	300 mcg	Intramuscularly	Single dose at any gestation for Rho (d) negative, antibody negative women within 72 hours of

				spontaneous bleeding or abdominal trauma.
				Single dose at 26-28 weeks gestation for Rho (d) negative, antibody negative women
				Single dose for Rho (d) negative, antibody negative women within 72 hours of delivery of Rho (d) positive infant, or infant with unknown blood type
Vitamin K <sub>1</sub>	Prophylaxis for Vitamin K Deficiency Bleeding	1 mg	Intramuscularly	1 dose
0.5% Erythromycin Ophthalmic Ointment	Prophylaxis of Neonatal Ophthalmia	1 cm ribbon in each eye	Topical	1 dose

***Idaho-Midwife may not provide care when***

- a. A current history of any of the following disorders, diagnoses, conditions, or symptoms: (3-29-10)
  - i. Placental abnormality; (3-29-10)
  - ii. Multiple gestation, except that midwives may provide antepartum care that is supplementary to the medical care of the physician overseeing the pregnancy, so long as it does not interfere with the physician's recommended schedule of care; (7-1-14)
  - iii. Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first; (3-29-10)
  - iv. Birth under thirty-seven and zero-sevenths (37 0/7) weeks and beyond forty-two and zero-sevenths (42 0/7) weeks'-gestational age; or (7-1-14)
  - v. A body mass index of forty (40.0) or higher at the time of conception; (3-29-10)
- b. A past history of any of the following disorders, diagnoses, conditions, or symptoms: (3-29-10)
  - i. More than one (1) cesarean section, a cesarean section within eighteen (18) months of the estimated due date or any cesarean section that was surgically closed with a classical or vertical uterine incision; (7-1-14)
  - ii. Platelet sensitization, hematological or coagulation disorders; (7-1-14)
  - iii. Prior chemotherapy or radiation treatment for a malignancy; (3-29-10)
  - iv. Previous pre-eclampsia resulting in premature delivery; (3-29-10)
  - v. Cervical insufficiency; (7-1-14)
  - vi. HIV positive status; or (7-1-14)

vii. Opiate use that places the infant at risk of neonatal abstinence syndrome. (7-1-14)

***Idaho-Patient requires consultation prior to providing care.***

A licensed midwife may not provide care for a client with a history of the disorders, diagnoses, conditions, or symptoms listed here in Subsection 356.03 unless such disorders, diagnoses, conditions or symptoms are being treated, monitored or managed by a licensed health care provider. Before providing care to such a client, the licensed midwife must notify the client in writing that the client must obtain the described physician care as a condition to the client's eligibility to obtain maternity care from the licensed midwife. The licensed midwife must, additionally, obtain the client's signed acknowledgement that the client has received the written notice. The disorders, diagnoses, conditions, and symptoms are: (7-1-14)

- a. Diabetes; (3-29-10)
- b. Thyroid disease; (3-29-10)
- c. Epilepsy; (3-29-10)
- d. Hypertension; (3-29-10)
- e. Cardiac disease; (3-29-10)
- f. Pulmonary disease; (3-29-10)
- g. Renal disease; (3-29-10)
- h. Gastrointestinal disorders; (3-29-10)
- i. Previous major surgery of the pulmonary system, cardiovascular system, urinary tract or gastrointestinal tract; (3-29-10)
- j. Current abnormal cervical cytology; (3-29-10)
- k. Sleep apnea; (3-29-10)
- l. Previous bariatric surgery; (3-29-10)
- m. Hepatitis; (7-1-14)
- n. History of illegal drug use or excessive prescription drug use. For purposes of this Paragraph, "history" means a "current history," and "illegal drug use" means "illegal drug abuse or addiction"; or (7-1-14)
- o. Rh or other blood group disorders and a physician determines the pregnancy can safely be attended by a midwife. (7-1-14)

***Idaho- Midwife must recommend physician involvement***

Before providing care for a client with a history of any of the disorders, diagnoses, conditions or symptoms listed in this Subsection 356.04, a licensed midwife must provide written notice to the client that the client is advised to see a physician licensed under Chapter 18, Title 54, Idaho Code, or under an equivalent provision of the law of a state bordering Idaho, during the client's pregnancy. Additionally, the licensed midwife must obtain the client's signed acknowledgement that the client has received the written notice. The disorders, diagnoses, conditions, and symptoms are: (7-1-14)

- a. Previous complicated pregnancy; (3-29-10)
- b. Previous cesarean section; (3-29-10)
- c. Previous pregnancy loss in second or third trimester; (3-29-10)
- d. Previous spontaneous premature labor; (3-29-10)
- e. Previous pre-term rupture of membranes; (3-29-10)
- f. Previous pre-eclampsia; (3-29-10)
- g. Previous hypertensive disease of pregnancy; (3-29-10)

- h. Parvo; (3-29-10)
- i. Toxo; (3-29-10)
- j. CMV; (3-29-10)
- k. HSV; (3-29-10)
- l. Previous maternal/newborn group b streptococcus infection; (3-29-10)
- m. A body mass index of at least thirty-five (35.0) but less than forty (40.0) at the time of conception; (3-29-10)
- n. Underlying family genetic disorders with potential for transmission; or (3-29-10)
- o. Psychosocial situations that may complicate pregnancy. (3-29-10)

***Idaho-Midwife must transfer mother to hospital***

A licensed midwife must facilitate the immediate transfer of a client to a hospital for emergency care if the client has any of the following disorders, diagnoses, conditions or symptoms: (3-29-10)

- i. Maternal fever in labor of more than 100.4 degrees Fahrenheit, in the absence of environmental factors; (7-1-14)
- ii. Suggestion of fetal jeopardy, such as frank bleeding before delivery, any abnormal bleeding (with or without abdominal pain), evidence of placental abruption, meconium with non-reassuring fetal heart tone patterns where birth is not imminent, or abnormal fetal heart tones with non-reassuring patterns where birth is not imminent; (3-29-10)
- iii. Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless imminent delivery is safer than transfer; (7-1-14)
- iv. Second stage labor after two (2) hours of initiation of pushing when the mother has had a previous cesarean section; (3-29-10)
- v. Current spontaneous premature labor; (3-29-10)
- vi. Current pre-term premature rupture of membranes; (3-29-10)
- vii. Current pre-eclampsia; (3-29-10)
- viii. Current hypertensive disease of pregnancy; (3-29-10)
- ix. Continuous uncontrolled bleeding; (3-29-10)
- x. Bleeding that necessitates the administration of more than two (2) doses of oxytocin or other antihemorrhagic agent; (3-29-10)
- xi. Delivery injuries to the bladder or bowel; (3-29-10)
- xii. Grand mal seizure; (3-29-10)
- xiii. Uncontrolled vomiting; (3-29-10)
- xiv. Coughing or vomiting of blood; (3-29-10)
- xv. Severe chest pain; or (3-29-10)
- xvi. Sudden onset of shortness of breath and associated labored breathing. (3-29-10)
- b. Plan for Emergency Transfer and Transport. When facilitating a transfer under Subsection 356.05, the licensed midwife must notify the hospital when the transfer is initiated, accompany the client to the hospital, if feasible, or communicate by telephone with the hospital if the licensed midwife is unable to be present personally. The licensed midwife must also ensure that the transfer of care is accompanied by the client's medical record, which must include: (3-29-10)
  - i. The client's name, address, and next of kin contact information; (3-29-10)
  - ii. A list of diagnosed medical conditions; (3-29-10)
  - iii. A list of prescription or over the counter medications regularly taken; (3-29-10)
  - iv. A history of previous allergic reactions to medications; and (3-29-10)

- v. If feasible, the licensed midwife's assessment of the client's current medical condition and description of the care provided by the licensed midwife before transfer. (3-29-10)
- c. Transfer or Termination of Care. A midwife who deems it necessary to transfer or terminate care pursuant to the laws and rules of the Board or for any other reason shall transfer or terminate care and shall not be regarded as having abandoned care or wrongfully terminated services. Before nonemergent discontinuing of services, the midwife shall notify the client in writing, provide the client with names of licensed physicians and contact information for the nearest hospital emergency room and offer to provide copies of medical records regardless of whether copying costs have been paid by the client. (7-1-14)

***Idaho- Newborn conditions requiring transfer or consultation***

Conditions for which a licensed midwife must facilitate the immediate transfer of a newborn to a hospital for emergency care: (4-11-15)

- a. Respiratory distress defined as respiratory rate greater than eighty (80) or grunting, flaring, or retracting for more than one (1) hour. (4-11-15)
- b. Any respiratory distress following delivery with meconium stained fluid. (4-11-15)
- c. Central cyanosis or pallor for more than ten (10) minutes. (4-11-15)
- d. Apgar score of six (6) or less at five (5) minutes of age. (4-11-15)
- e. Abnormal bleeding. (4-11-15)
- f. Any condition requiring more than eight (8) hours of continuous postpartum evaluation. (4-11-15)
- g. Any vesicular skin lesions. (4-11-15)
- h. Seizure-like activity. (4-11-15)
- i. Any green emesis. (4-11-15)
- j. Poor feeding effort due to lethargy or disinterest in nursing for more than two (2) hours immediately following birth. (4-11-15)

02. Newborn Consultation Required. Conditions for which a licensed midwife must consult a Pediatric Provider (Neonatologist, Pediatrician, Family Practice Physician, Advanced Practice Registered Nurse, or Physician Assistant): (4-11-15)

- a. Temperature instability, defined as a temperature less than ninety-six point eight (96.8) degrees Fahrenheit or greater than one hundred point four (100.4) degrees Fahrenheit documented two (2) times more than fifteen (15) minutes apart. (4-11-15)
- b. Murmur lasting more than twenty-four (24) hours immediately following birth. (4-11-15)
- c. Cardiac arrhythmia. (4-11-15)
- d. Congenital anomalies. (4-11-15)
- e. Birth injury. (4-11-15)
- f. Clinical evidence of prematurity, including but not limited to, low birth weight of less than two thousand five hundred (2,500) grams, smooth soles of feet, or immature genitalia. (4-11-15)
- g. Any jaundice in the first twenty-four (24) hours after birth or significant jaundice at any time. (4-11-15)
- h. No stool for more than twenty-four (24) hours immediately following birth. (4-11-15)
- i. No urine output for more than twenty-four (24) hours. (4-11-15)
- j. Development of persistent poor feeding effort at any time. (4-11-15)

***Texas***

"Newborn" means an infant from birth through the first six weeks of life.

"Normal" means, as applied to pregnancy, labor, delivery, the postpartum period, and the newborn period, and as defined by commission rule, circumstances under which a midwife has determined that a client is at a low risk of developing complications.

"Postpartum period" means the first six weeks after a woman has given birth.

"Normal childbirth" The labor and vaginal delivery at or close to term (37 up to 42 weeks) of a pregnant woman whose assessment reveals no abnormality or signs or symptoms of complications.

"Postpartum care"--The care of a woman for the first six weeks after the woman has given birth.

"Consultation" is the process by which a midwife, who maintains primary management responsibility for the woman's care, seeks the advice of another health care professional or member of the health care team.

"Collaboration" is the process in which a midwife and a health care practitioner of a different profession jointly manage the care of a woman or newborn who needs joint care, such as one who has become medically complicated. The scope of collaboration may encompass the physical care of the client, including delivery, by the midwife, according to a mutually agreed-upon plan of care. If a physician must assume a dominant role in the care of the client due to increased risk status, the midwife may continue to participate in physical care, counseling, guidance, teaching, and support. Effective communication between the midwife and the health care professional is essential to ongoing collaborative management.

### ***Connecticut-Scope of Practice***

Nurse-midwives shall practice within a health care system and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. Nurse-midwifery care shall be consistent with the standards of care established by the American College of Nurse-Midwives. Each nurse-midwife shall provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the midwife's scope of practice. Each nurse-midwife shall sign the birth certificate of each infant delivered by the nurse-midwife. If an infant is born alive and then dies within the twenty-four-hour period after birth, the nurse-midwife may make the actual determination and pronouncement of death provided: (1) The death is an anticipated death; (2) the nurse-midwife attests to such pronouncement on the certificate of death; and (3) the nurse-midwife or a physician licensed pursuant to chapter 370<sup>1</sup> certifies the certificate of death not later than twenty-four hours after such pronouncement. In a case of fetal death, as described in section 7-60, the nurse-midwife who delivered the fetus may make the actual determination of fetal death and certify the date of delivery and that the fetus was born dead.

### ***New Mexico-prescriptive authority***

A. Certified nurse-midwives who have fulfilled requirements for prescriptive authority may prescribe in accordance with rules, regulations, guidelines and formularies for individual certified nurse-midwives promulgated by the department of health.

B. As used in this section, "prescriptive authority" means the ability of the certified nurse-midwife to practice independently, serve as a primary care provider and as necessary collaborate with licensed medical doctors or osteopathic physicians. Certified nurse-midwives who have fulfilled requirements for prescribing drugs may prescribe, distribute and administer to their patients dangerous drugs, including controlled substances included in Schedules II through V of

the Controlled Substances Act,<sup>1</sup> that have been prepared, packaged or fabricated by a licensed pharmacist or doses of drugs that have been prepackaged by a pharmaceutical manufacturer in accordance with the Pharmacy Act<sup>2</sup> and New Mexico Drug, Device and Cosmetic Act.

### ***New Mexico Regs***

Scope of practice: Practice by CNMs encompasses independently providing a full range of primary health care services for women from adolescence to beyond menopause. These services include primary care, gynecologic and family planning services, pre-conception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; independently prescribe, distribute and administer dangerous drugs, devices and contraceptive methods, and controlled substances in Schedules II-V of the Controlled Substances Act (NMSA 1978, Section 30-31-1); admit, manage and discharge patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. These services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers. A CNM practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. A CNM practices in accordance with the ACNM “standards for the practice of midwifery”. A CNM who expands beyond the ACNM “core competencies” to incorporate new procedures that improve care for women and their families shall comply with the guidelines set out in the ACNM “standards for the practice of midwifery”, standard VIII. Practice guidelines for home births should be informed by the “ACNM home birth practice handbook”.

#### **B. Prescriptive authority.**

(1) Dangerous drugs: A CNM who prescribes distributes or administers a dangerous drug or device shall do so in accordance with the New Mexico Drug, Device and Cosmetic Act (NMSA 1978, Section 26-1).

(2) Controlled substances.

(a) A CNM shall not prescribe nor distribute controlled substances in Schedule I of the Controlled Substances Act (NMSA 1978, Section 26-1).

(b) A CNM shall not prescribe, distribute or administer controlled substances in Schedules II-V of the Controlled Substances Act unless she is registered with the New Mexico board of pharmacy and the United States drug enforcement administration to prescribe, distribute and administer controlled substances.

(c) A CNM who prescribes, distributes or administers a controlled substance in Schedules II-V of the Controlled Substances Act shall do so in accordance with the Controlled Substances Act (NMSA 1978, Section 26-1).

(d) An individual employed as a CNM by the United States military, the United States veterans administration or the United States public health service and operating in the official capacity of that employment who is prescribing, distributing or administering controlled substances under that facility's United States drug enforcement administration registration is exempt from the Subparagraphs (a), (b) and (c) of Paragraph (2) of this subsection.

(3) Prescription pads: a CNM may prescribe by telephone, by written prescription or by e-mail. A CNM prescription shall have the CNM's name, office address and telephone number printed

on it. In the event that a CNM is writing a prescription printed with the names of more than one CNM, the name of the CNM writing the individual prescription shall be indicated. The name and address of the client, the date of the prescription, the name and quantity of the drug prescribed, and directions for use shall be included on a prescription.

(4) Labeling: when distributing a drug, a CNM shall label it with the client's name, the date, instructions for use, and the CNM's name, address and telephone number.

(5) Except in emergencies, CNMs shall not prescribe controlled substances for themselves, members of their households or immediate family members.

C. Guidelines for management of chronic pain with controlled substances. The treatment of chronic pain with various modalities, including controlled substances such as opiates and opioids, is a legitimate practice when done in the usual course of CNM practice. The goal when treating chronic pain is to reduce or eliminate pain and also to avoid development of or contribution to addiction, drug abuse and overdosing. Effective dosages should be prescribed, with both under- and over-prescribing to be avoided, using patient protection as a guiding principle. The CNM should provide control of the patient's pain for its duration, while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. A CNM may treat patients with addiction, physical dependence or tolerance who have legitimate pain, however such patients require very close monitoring and precise documentation.

(1) If, in a CNM's professional opinion, a patient is seeking pain medication for reasons that are not medically justified, the CNM is not required to prescribe controlled substances for the patient.

(2) When prescribing, dispensing or administering controlled substances for management of chronic pain, a CNM shall:

(a) obtain a PMP report for the patient covering the preceding 12 months from the New Mexico board of pharmacy, or another state's report where applicable and available;

(b) complete a history and physical examination and include an evaluation of the patient's psychological and pain status, any previous history of significant pain, past history of alternate treatments for pain, potential for substance abuse, coexisting disease or medical conditions, and the presence of medical indications or contra-indications related to controlled substances;

(c) be familiar with and employ screening tools, as well as the spectrum of available modalities for therapeutic purposes, in the evaluation and management of pain, and consider an integrative approach to pain management in collaboration with other care providers, including but not limited to acupuncturists, chiropractors, doctors of oriental medicine, exercise physiologists, massage therapists, pharmacists, physical therapists, psychiatrists or psychologists;

(d) develop a written individual treatment plan taking age, gender and culture into consideration, with stated objectives by which treatment can be evaluated, such as degree of pain relief, improved physical and psychological function, or other accepted measures, and including any need for further testing, consultation, referral or use of other treatment modalities as appropriate;

(e) discuss the risks and benefits of using controlled substances with the patient or legal guardian and document this discussion in the record;

(f) make a written agreement with the patient or legal guardian outlining patient responsibilities, including that the chronic pain patient will receive all chronic pain management prescriptions from one practitioner and one pharmacy whenever possible;

- (g) maintain complete and accurate records of care provided and drugs prescribed, including the indications for use, the name of the drug, quantity, prescribed dosage and number of refills authorized;
- (h) when indicated by the patient's condition, consult with health care professionals who are experienced in the area of the chronic pain, though not necessarily specialists in pain control, both early in the course of long-term treatment and at least every six months;
- (i) when treating patients with drug addiction or physical dependence, use drug screening prior to and during the course of treatment to identify actual drugs being consumed and to compare with patients' self reports (this should be included in the written agreement, see Subparagraph (f) above);
- (j) note the following possible indications of drug abuse by a patient and take appropriate steps to further investigate and to avoid contributing to drug abuse; such steps may include termination of treatment; some of this information may be available only through PMP reports;
  - (i) receiving controlled substances from multiple prescribers;
  - (ii) receiving controlled substances for more than 12 consecutive weeks;
  - (iii) receiving more than one controlled substance analgesic;
  - (iv) receiving a new prescription for any long-acting controlled substance analgesic formulation, including oral or transdermal dosage forms or methadone;
  - (v) overutilization, early refills;
  - (vi) appearing overly sedated or intoxicated upon presentation; or
  - (vii) an unfamiliar patient requesting a controlled substance by specific name, street name, color, or identifying marks.

### ***North Carolina***

- (1) "Interconceptional care" includes but is not limited to:
  - a. Family planning;
  - b. Screening for cancer of the breast and reproductive tract; and
  - c. Screening for and management of minor infections of the reproductive organs;
- (2) "Intrapartum care" includes but is not limited to:
  - a. Attending women in uncomplicated labor;
  - b. Assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation;
  - c. Performing amniotomy;
  - d. Administering local anesthesia;
  - e. Performing episiotomy and repair; and
  - f. Repairing lacerations associated with childbirth.
- (3) "Midwifery" means the act of providing prenatal, intrapartum, postpartum, newborn and interconceptional care. The term does not include the practice of medicine by a physician licensed to practice medicine when engaged in the practice of medicine as defined by law, the performance of medical acts by a physician assistant or nurse practitioner when performed in accordance with the rules of the North Carolina Medical Board, the practice of nursing by a registered nurse engaged in the practice of nursing as defined by law, or the rendering of childbirth assistance in an emergency situation.
- (4) "Newborn care" includes but is not limited to:
  - a. Routine assistance to the newborn to establish respiration and maintain thermal stability;
  - b. Routine physical assessment including APGAR scoring;

- c. Vitamin K administration; and
- d. Eye prophylaxis for ophthalmia neonatorum.
- (5) “Postpartum care” includes but is not limited to:
  - a. Management of the normal third stage of labor;
  - b. Administration of pitocin and methergine after delivery of the infant when indicated; and
  - c. Six weeks postpartum evaluation exam and initiation of family planning.
- (6) “Prenatal care” includes but is not limited to:
  - a. Historical and physical assessment;
  - b. Obtaining and assessing the results of routine laboratory tests; and
  - c. Supervising the use of prenatal vitamins, folic acid, iron, and nonprescription medicines.

### ***Utah***

- (3) “Consultation and Referral Plan” means a written plan jointly developed by a certified nurse midwife, as defined in Subsection (7), and a consulting physician that permits the certified nurse midwife to prescribe schedule II-III controlled substances in consultation with the consulting physician.
- (4) “Consulting physician” means a physician and surgeon or osteopathic physician:
  - (a) with an unrestricted license as a physician;
  - (b) qualified by education, training, and current practice in obstetrics, gynecology, or both to act as a consulting physician to a nurse midwife practicing under this chapter and providing intrapartum care or prescribing Schedule II-III controlled substances; and
  - (c) who is available to consult with a nurse midwife, which does not include the consulting physician being present at the time or place the nurse midwife is engaged in practice.
- (5) “Individual” means a natural person.
- (6) “Intrapartum referral plan”:
  - (a) means a written plan prepared by a nurse midwife describing the guidelines under which the nurse midwife will consult with a consulting physician, collaborate with a consulting physician, and refer patients to a consulting physician; and
  - (b) does not require the nurse midwife to obtain the signature of a physician on the intrapartum referral plan.
- (7) “Nurse midwife” means a person licensed under this chapter to engage in practice as a certified nurse midwife.
- (8) “Physician” means a physician and surgeon or osteopathic surgeon licensed under Chapter 67, Utah Medical Practice Act or Chapter 68, Utah Osteopathic Medical Practice Act.
- (9) “Practice as a certified nurse midwife” means:
  - (a) practice as a registered nurse as defined in [Section 58-31b-102](#), and as consistent with the education, training, experience, and current competency of the licensee;
  - (b) practice of nursing within the generally recognized scope and standards of nurse midwifery as defined by rule and consistent with professionally recognized preparations and educational standards of a certified nurse midwife by a person licensed under this chapter, which practice includes:
    - (i) having a safe mechanism for obtaining medical consultation, collaboration, and referral with one or more consulting physicians who have agreed to consult, collaborate, and receive referrals, but who are not required to sign a written document regarding the agreement;

- (ii) providing a patient with information regarding other health care providers and health care services and referral to other health care providers and health care services when requested or when care is not within the scope of practice of a certified nurse midwife; and
- (iii) maintaining written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed; and
- (c) the authority to:
  - (i) elicit and record a patient's complete health information, including physical examination, history, and laboratory findings commonly used in providing obstetrical, gynecological, and well infant services to a patient;
  - (ii) assess findings and upon abnormal findings from the history, physical examination, or laboratory findings, manage the treatment of the patient, collaborate with the consulting physician or another qualified physician, or refer the patient to the consulting physician or to another qualified physician as appropriate;
  - (iii) diagnose, plan, and implement appropriate patient care, including the administration and prescribing of:
    - (A) prescription drugs;
    - (B) schedule IV-V controlled substances; and
    - (C) schedule II-III controlled substances in accordance with a consultation and referral plan;
  - (iv) evaluate the results of patient care;
  - (v) consult as is appropriate regarding patient care and the results of patient care;
  - (vi) manage the intrapartum period according to accepted standards of nurse midwifery practice and a written intrapartum referral plan, including performance of routine episiotomy and repairs, and administration of anesthesia, including local, pudendal, or paracervical block anesthesia, but not including general anesthesia and major conduction anesthesia;
  - (vii) manage the postpartum period;
  - (viii) provide gynecological services;
  - (ix) provide noncomplicated newborn and infant care to the age of one year; and
  - (x) represent or hold oneself out as a certified nurse midwife, or nurse midwife, or use the title certified nurse midwife, nurse midwife, or the initials C.N.M., N.M., or R.N.



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# OBSTETRIC CARE CONSENSUS

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*This document has been endorsed by the following organizations:*

*American Association of Birth Centers*

*American College of Nurse-Midwives*

*Association of Women's Health, Obstetric and Neonatal Nurses*

*Commission for the Accreditation of Birth Centers*

*The American Academy of Pediatrics leadership, the American Society of Anesthesiologists leadership, and the Society for Obstetric Anesthesia and Perinatology leadership have reviewed the opinion and are supportive of the Levels of Maternal Care.*

[PDF Format](#)

## Levels of Maternal Care

**Abstract:** In the 1970s, studies demonstrated that timely access to risk-appropriate neonatal and obstetric care could reduce perinatal mortality. Since the publication of the *Toward Improving the Outcome of Pregnancy* report, more than three decades ago, the conceptual framework of regionalization of care of the woman and the newborn has been gradually separated with recent focus almost entirely on the newborn. In this current document, maternal care refers to all aspects of antepartum, intrapartum, and postpartum care of the pregnant woman. The proposed classification system for levels of maternal care pertains to birth centers, basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV). The goal of regionalized maternal care is for pregnant women at high risk to receive care in facilities that are prepared to provide the required level of specialized care, thereby reducing maternal morbidity and mortality in the United States.

### Objectives

Quality and Safety in Women's Health Care	<ul style="list-style-type: none"> <li>• To introduce uniform designations for levels of maternal care that are complementary but distinct from levels of neonatal care and that address maternal health needs, thereby reducing maternal morbidity and mortality in the United States</li> <li>• To develop standardized definitions and nomenclature for facilities that provide each level of maternal care</li> </ul>
Special Issues in Women's Health	<ul style="list-style-type: none"> <li>• To provide consistent guidelines according to level of maternal care for use in quality improvement and health promotion</li> <li>• To foster the development and equitable geographic distribution of full-service maternal care facilities and systems that promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum services</li> </ul>

## Statements of Policy

## Background

## ACOG-Supported Documents

In the 1970s, studies demonstrated that timely access to risk-appropriate neonatal and obstetric care could reduce perinatal mortality. In 1976, the March of Dimes and its partners first articulated the concept of an integrated system for regionalized perinatal care in a report titled *Toward Improving the Outcome of Pregnancy* (1). This report included criteria that stratified maternal and neonatal care into three levels of complexity, and recommended referral of high-risk patients to higher-level centers with the appropriate resources and personnel needed to address their increased complexity of care.

## Task Force and Work Group Reports

## Technology Assessments

After the publication of the March of Dimes report, most states developed coordinated regional systems for perinatal care. The designated regional or tertiary care centers provided the highest levels of obstetric and neonatal care, while serving smaller facilities' needs through education and transport services. Numerous studies have validated the concept that improved neonatal outcomes were achieved through application of risk-appropriate maternal transport systems (2, 3). A comprehensive meta-analysis has shown increased odds of neonatal mortality for very low birth weight (very LBW, also commonly known as VLBW) infants (less than 1,500 g) born outside of a level III hospital (38% versus 23%; adjusted odds ratio, 1.62; 95% confidence interval, 1.44–1.83) (4). Data indicate higher neonatal mortality for very LBW infants born in hospitals that are staffed by neonatologists in the absence of a more complete multidisciplinary team (level II), compared with those born in level III centers (5).

## The Ob-Gyn Workforce

## Your Pregnancy and Childbirth: Month to Month, Sixth Edition

Since the March of Dimes report was published, the conceptual framework of regionalization of care of the woman and the newborn has changed to focus almost entirely on the newborn (6, 7). The American College of Obstetricians and Gynecologists (the College) and the American Academy of Pediatrics (AAP) outline the capabilities of health care providers in hospitals delivering basic, specialty, subspecialty, and regional obstetric care in *Guidelines for Perinatal Care*, Seventh Edition (6). With 39% of hospital births in the United States occurring at hospitals that deliver less than 500 newborns each year and an additional 20% occurring at hospitals that deliver between 501 newborns and 1,000 newborns each year (8), it likely is that the majority of maternal care in the United States is provided at basic-care and specialty-care hospitals. However, a recent commentary noted the need to readdress "perinatal levels of care" to focus specifically on maternal health conditions that warrant designation as high risk, and to define specific clinical and systems criteria to manage such conditions (9). This document is a call for an integrated, regionalized framework to identify when transfer of care may be necessary to provide risk-appropriate maternal care.

Although maternal mortality in high resource countries improved substantially during the 20th century, maternal mortality rates in the United States have worsened in the past 14 years (10). Currently, the United States is ranked 60th in the world for maternal mortality (11). According to a Centers for Disease Control and Prevention study, the leading causes of maternal mortality are associated with chronic conditions that affect women of reproductive age, and common obstetric complications such as hemorrhage (12). Moreover, maternal mortality in the United States represents a small component of the larger emerging problem of maternal severe morbidities and near-miss mortality that increased by 75% between 1998–99 and 2008–09 (13). National increases in obesity, hypertensive disorders, and diabetes among women of reproductive age increase the risk of maternal morbidity and mortality, as does the increasing cesarean delivery rate (14, 15). Although specific modifications in the clinical management of these conditions have been instituted (eg, the use of thromboembolism prophylaxis and bariatric beds in obstetrics), more can be done to improve the system of care for high-risk women at facility and population levels.

Although there is strong evidence of more favorable neonatal outcomes with regionalized perinatal care, evidence of a beneficial effect on maternal outcome is limited. Maternal mortality is an uncommon event, and methods for tracking severe morbidity only have been proposed recently (13). Data indicate that obstetric complications are significantly more frequent in hospitals with low delivery volume (16), and that obstetric providers with the lowest patient volume have significantly increased rates of obstetric complications compared with high-volume providers (17). Hospital clinical volume likely is a proxy measure for institutional and individual experience that may not be available at hospitals with lower volumes (18). Also, data indicate that outcomes are better if certain conditions, such as placenta previa or placenta accreta, are managed in a high-volume hospital (19, 20). It also has been noted that maternal mortality is inversely related to the population density of maternal-fetal medicine subspecialists at the state level (21), although other factors, such as the presence of obstetrician-gynecologists, nurses, and anesthesiologists who have experience in high-risk maternity care, also may contribute to this trend. Although these findings provide support for an association between availability of resources and favorable maternal outcomes, they do not prove a direct cause and effect relationship between levels of care and outcomes.

A number of states have incorporated maternal care criteria into perinatal guidelines. Indiana, Arizona, and Maryland emphasize the need for stratification of facilities based on levels of maternal care that are distinct from neonatal needs, but use inconsistent definitions and nomenclature: the Indiana Perinatal Networks guideline is modeled after the March of Dimes report and uses levels I, II, and III (22); the Arizona system defines levels I, II, IIE, and III of maternal care (23); and the Maryland Perinatal System uses levels I, II, III, and IV (24). Despite their differences, an essential component of each of these guidelines is the concept of an integrated system in which, just as with neonatal care, level III and level IV maternal centers serve level I and level II centers by providing educational resources, consultation services, and streamlined systems for maternal and neonatal transport when necessary.

This document has four objectives: 1) introduce uniform designations for levels of maternal care that are complementary but distinct from levels of neonatal care and that address maternal health needs, thereby preventing further increases in maternal morbidity and mortality in the United States; 2) develop standardized definitions and nomenclature for facilities that provide each level of maternal care, including birth centers; 3) provide consistent guidelines of service according to level of maternal care for use in quality improvement and health promotion; and 4) foster the development and equitable

geographic distribution of full-service maternal care facilities and systems that promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum services. This document focuses on maternal care and does not include an in-depth discussion about high-risk neonatal care capability based on gestational age or birth weight. Nevertheless, optimal perinatal care requires synergy in institutional capabilities for the woman and the fetus or neonate.

### Definitions of Levels of Maternal Care

In this document, maternal care refers to all aspects of antepartum, intrapartum, and postpartum care of the pregnant woman. In order to standardize a complete and integrated system of perinatal regionalization and risk-appropriate maternal care, a classification system should be established for levels of maternal care that pertain to birth centers (as defined in the Birth Centers section of this document), basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV) (see [Table 1](#) and [Table 2](#)). This system is in concert with the College and AAP Guidelines for Perinatal Care, Seventh Edition (6). Although data on which to base these distinctions in resources and capacity for maternal care are limited, the definitions were created from the characteristics of successful regionalized perinatal systems in a number of states (see Background). In this context, regionalized perinatal systems represent a combination of maternal and neonatal services. Establishing clear, uniform criteria for designation of maternal centers that are integrated with emergency response systems will help ensure that the appropriate personnel, physical space, equipment, and technology are available to achieve optimal outcomes, as well as to facilitate subsequent data collection regarding risk-appropriate care. Trauma is not integrated into the levels of maternal care because trauma levels are already established. Pregnant women should receive the same level of trauma care as nonpregnant patients. This document addresses the care provided at birth centers and hospitals, but home birth is not included.

Birth Center	
Definition	Peripartum care of low-risk women with uncomplicated singleton term pregnancies with a vertex presentation who are expected to have an uncomplicated birth
Capabilities	<ul style="list-style-type: none"> <li>• Capability and equipment to provide low-risk maternal care and a readiness at all times to initiate emergency procedures to meet unexpected needs of the woman and newborn within the center, and to facilitate transport to an acute care setting when necessary.</li> <li>• An established agreement with a receiving hospital with policies and procedures for timely transport.</li> <li>• Data collection, storage, and retrieval.</li> <li>• Ability to initiate quality improvement programs that include efforts to maximize patient safety.</li> <li>• Medical consultation available at all times.</li> </ul>
Types of health care providers	Every birth attended by at least two professionals: <ul style="list-style-type: none"> <li>• Primary maternal care providers. This includes CNMs, CMs, CPMs, and licensed midwives who are legally recognized to practice within the jurisdiction of the birth center; family physicians; and ob-gyns.</li> <li>• Availability of adequate numbers of qualified professionals with competence in level I care criteria and ability to stabilize and transfer high-risk women and newborns.</li> </ul>
Examples of appropriate patients (not requirements)	<ul style="list-style-type: none"> <li>• Term, singleton, vertex presentation</li> </ul>
Level I (Basic Care)	
Definition	Care of uncomplicated pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until patient can be transferred to a facility at which specialty maternal care is available
Capabilities	Birth center capabilities plus <ul style="list-style-type: none"> <li>• ability to begin emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.</li> <li>• available support services, including access to obstetric ultrasonography, laboratory testing, and blood bank supplies at all times.</li> <li>• protocols and capabilities for massive transfusion, emergency release of blood products, and management of multiple component therapy.</li> <li>• ability to establish formal transfer plans in partnership with a higher-level receiving facility.</li> <li>• ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so.</li> </ul>
Types of health care providers	Birth center providers plus <ul style="list-style-type: none"> <li>• continuous availability of adequate number of RNs with competence in level I care criteria and ability to stabilize and transfer high-risk women and newborns.</li> <li>• nursing leadership has expertise in perinatal nursing care.</li> <li>• obstetric provider with privileges to perform emergency cesarean available to attend all deliveries.</li> <li>• anesthesia services available to provide labor analgesia and surgical anesthesia.</li> </ul>
Examples of appropriate patients (not requirements)	Any patient appropriate for a birth center, plus capable of managing higher-risk conditions such as

	<ul style="list-style-type: none"> <li>• term twin gestation</li> <li>• trial of labor after cesarean delivery</li> <li>• uncomplicated cesarean delivery</li> <li>• preeclampsia without severe features at term</li> </ul>
<b>Level II (Specialty Care)</b>	
<b>Definition</b>	<b>Level I facility plus care of appropriate high-risk antepartum, intrapartum, or postpartum conditions, both directly admitted and transferred from another facility</b>
<b>Capabilities</b>	<p>Level I facility capabilities plus</p> <ul style="list-style-type: none"> <li>• computed tomography scan and ideally magnetic resonance imaging with interpretation available.</li> <li>• basic ultrasonographic imaging services for maternal and fetal assessment.</li> <li>• special equipment needed to accommodate the care and services needed for obese women.</li> </ul>
<b>Types of health care providers</b>	<p>Level I facility health care providers plus</p> <ul style="list-style-type: none"> <li>• continuous availability of adequate numbers of RNs with competence in level II care criteria and ability to stabilize and transfer high-risk women and newborns who exceed level II care criteria.</li> <li>• nursing leadership and staff have formal training and experience in the provision of perinatal nursing care and should coordinate with respective neonatal care services.</li> <li>• ob-gyn available at all times.</li> <li>• director of obstetric service is a board-certified ob-gyn with special interest and experience in obstetric care.</li> <li>• MFM available for consultation onsite, by phone, or by telemedicine, as needed.</li> <li>• anesthesia services available at all times to provide labor analgesia and surgical anesthesia.</li> <li>• board-certified anesthesiologist with special training or experience in obstetric anesthesia available for consultation.</li> <li>• medical and surgical consultants available to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities.</li> </ul>
<b>Examples of appropriate patients (not requirements)</b>	<p>Any patient appropriate for level I care, plus higher-risk conditions such as</p> <ul style="list-style-type: none"> <li>• severe preeclampsia</li> <li>• placenta previa with no prior uterine surgery</li> </ul>
<b>Level III (Subspecialty Care)</b>	
<b>Definition</b>	<b>Level II facility plus care of more complex maternal medical conditions, obstetric complications, and fetal conditions</b>
<b>Capabilities</b>	<p>Level II facility capabilities plus</p> <ul style="list-style-type: none"> <li>• advanced imaging services available at all times.</li> <li>• ability to assist level I and level II centers with quality improvement and safety programs.</li> <li>• provide perinatal system leadership if acting as a regional center in areas where level IV facilities are not available (see level IV).</li> <li>• medical and surgical ICUs accept pregnant women and have critical care providers onsite to actively collaborate with MFMs at all times.</li> <li>• appropriate equipment and personnel available onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.</li> </ul>
<b>Types of health care providers</b>	<p>Level II health care providers plus</p> <ul style="list-style-type: none"> <li>• continuous availability of adequate numbers of nursing leaders and RNs with competence in level III care criteria and ability to transfer and stabilize high-risk women and newborns who exceed level III care criteria, and with special training and experience in the management of women with complex maternal illnesses and obstetric complications.</li> <li>• ob-gyn available onsite at all times.</li> <li>• MFM with inpatient privileges available at all times, either onsite, by phone, or by telemedicine.</li> <li>• director of MFM service is a board-certified MFM.</li> <li>• director of obstetric service is a board-certified ob-gyn with special interest and experience in obstetric care.</li> <li>• anesthesia services available at all times onsite.</li> <li>• board-certified anesthesiologist with special training or experience in obstetric anesthesia in charge of obstetric anesthesia services.</li> <li>• full complement of subspecialists available for inpatient consultations.</li> </ul>
<b>Examples of appropriate patients (not requirements)</b>	<p>Any patient appropriate for level II care, plus higher-risk conditions such as</p> <ul style="list-style-type: none"> <li>• suspected placenta accreta or placenta previa with prior uterine surgery</li> <li>• suspected placenta percreta</li> <li>• adult respiratory syndrome</li> <li>• expectant management of early severe preeclampsia at less than 34 weeks of gestation</li> </ul>
<b>Level IV (Regional Perinatal Health Care Centers)</b>	

Definition	Level III facility plus on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care
Capabilities	Level III facility capabilities plus <ul style="list-style-type: none"> <li>on-site ICU care for obstetric patients.</li> <li>on-site medical and surgical care of complex maternal conditions with the availability of critical care unit or ICU beds.</li> <li>Perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region, and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.</li> </ul>
Types of health care providers	Level III health care providers plus <ul style="list-style-type: none"> <li>MFM care team with expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. This includes comanagement of ICU-admitted obstetric patients. An MFM team member with full privileges is available at all times for on-site consultation and management. The team is led by a board-certified MFM with expertise in critical care obstetrics.</li> <li>physician and nursing leaders with expertise in maternal critical care.</li> <li>continuous availability of adequate numbers of RNs who have experience in the care of women with complex medical illnesses and obstetric complications; this includes competence in level IV care criteria.</li> <li>director of obstetric service is a board-certified MFM, or board-certified ob-gyn with expertise in critical care obstetrics.</li> <li>anesthesia services are available at all times onsite.</li> <li>board-certified anesthesiologist with special training or experience in obstetric anesthesia in charge of obstetric anesthesia services.</li> <li>adult medical and surgical specialty and subspecialty consultants available onsite at all times to collaborate with MFM care team.</li> </ul>
Examples of appropriate patients (not requirements)	Any patient appropriate for level III care, plus higher-risk conditions such as <ul style="list-style-type: none"> <li>severe maternal cardiac conditions</li> <li>severe pulmonary hypertension or liver failure</li> <li>pregnant women requiring neurosurgery or cardiac surgery</li> <li>pregnant women in unstable condition and in need of an organ transplant</li> </ul>
<p>Abbreviations: CMs, certified midwives; CNMs, certified nurse-midwives; CPMs, certified professional midwives; ICU, intensive care unit; MFM, maternal-fetal medicine subspecialists; ob-gyns, obstetrician-gynecologists; RNs, registered nurses;.</p> <p>*These guidelines are limited to the maternal needs. Consideration of perinatal needs and the appropriate level of care should occur following existing guidelines. In fact, levels of maternal care and levels of neonatal care may not match within facilities. Additionally, these are guidelines, and local issues will affect systems of implementation for regionalized maternal care, perinatal care, or both. Data from Levels of Neonatal Care. American Academy of Pediatrics Committee on Fetus and Newborn. Pediatrics 2012;130:587-97.</p>	

Table 2. Levels of Maternal Care by Services ⇐

Required Service	Level of Maternal Care				
	Birth Centers	Level I	Level II	Level III	Level IV
Nursing	Adequate numbers of qualified professionals with competence in level I care criteria	Continuously available RNs with competence in level I care criteria  Nursing leadership has expertise in perinatal nursing care	Continuously available RNs with competence in level II care criteria  Nursing leadership has formal training and experience in perinatal nursing care and coordinates with respective neonatal care services	Continuously available nursing leaders and RNs with competence in level III care criteria and have special training and experience in the management of women with complex maternal illnesses and obstetric complications	Continuously available RNs with competence in level IV care criteria  Nursing leadership has expertise in maternal intensive and critical care
Minimum primary delivery provider to be available	CNMs, CMs, CPMs, and licensed midwives	Obstetric provider with privileges to perform emergency cesarean delivery	Ob-gyns or MFMs	Ob-gyns or MFMs	Ob-gyns or MFMs
Obstetrics surgeon		Available for emergency cesarean delivery	Ob-gyn available at all times	Ob-gyn onsite at all times	Ob-gyn onsite at all times
MFMs			Available for consultation onsite, by phone, or by	Available for at all times onsite, by phone, or by	Available at all times for on-site consultation and management

			telemedicine, as needed	telemedicine with inpatient privileges	
Director of obstetric services			Board-certified ob-gyn with experience and interest in obstetrics	Board-certified ob-gyn with experience and interest in obstetrics	Board-certified MFM or board-certified ob-gyn with expertise in critical care obstetrics
Anesthesia		Anesthesia services available	Anesthesia services available at all times Board-certified anesthesiologist with special training or experience in obstetrics, available for consultation	Anesthesia services available at all times Board-certified anesthesiologist with special training or experience in obstetrics is in charge of obstetric anesthesia services	Anesthesia services available at all times Board-certified anesthesiologist with special training or experience in obstetrics is in charge of obstetric anesthesia services
Consultants	Established agreement with a receiving hospital for timely transport, including determination of conditions necessitating consultation and referral	Established agreement with a higher-level receiving hospital for timely transport, including determination of conditions necessitating consultation and referral	Medical and surgical consultants available to stabilize	Full complement of subspecialists available for inpatient consultation, including critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, and neonatology	Adult medical and surgical specialty and subspecialty consultants available onsite at all times, including those indicated in level III and advanced neurosurgery, transplant, or cardiac surgery
ICU				Appropriate equipment and personnel available onsite to ventilate and monitor women in labor and delivery until safely transferred to ICU Accepts pregnant women	Collaborates actively with the MFM care team in the management of all pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions Comanages ICU-admitted obstetric patients with MFM team

Abbreviations: CMs, certified midwives; CNMs, certified nurse-midwives; CPMs, certified professional midwives; ICU, intensive care unit; MFMs, maternal-fetal medicine specialists; ob-gyns, obstetrician-gynecologists; RNs, registered nurses.

Once levels of maternal care are established, analysis of data collected from all facilities and regional systems will inform future updates to the levels of maternal care. Consistent with the levels of neonatal care published by the AAP (7), each level reflects required minimal capabilities, physical facilities, and medical and support personnel. Note that each higher level of care includes and builds on the capabilities of the lower levels. As with the AAP-defined levels of neonatal care, the system will be modified as analysis is completed.

The goal of regionalized maternal care is for pregnant women at high risk to receive care in facilities that are prepared to provide the required level of specialized care. Each facility should have a clear understanding of its capability to handle increasingly complex levels of maternal care, and should have a well-defined threshold for transferring women to health care facilities that offer a higher level of care. These proposed categories of maternal care are meant to facilitate this process. These guidelines also are intended to foster the development of equitably distributed resources throughout the country. These are guidelines, not mandates, and geographic and local issues will affect systems of implementation for regionalized perinatal care. In fact, levels of maternal and neonatal care may not match within facilities. However, a pregnant woman should be cared for at the facility that best meets her needs as well as her neonate's needs. Because all facilities cannot maintain the breadth of resources available at subspecialty centers, interfacility transport of pregnant women or women in the postpartum period is an essential component of a regionalized perinatal health care system. To ensure optimal care of all pregnant women, all birth centers, hospitals, and higher-level facilities should collaborate to develop and maintain maternal and neonatal transport plans and cooperative agreements capable of managing the health care needs of women who develop complications; receiving hospitals should openly accept transfers. The appropriate care level for patients should be driven by their medical need for that care and not limited by financial constraint. Because of the importance of accurate data for the assessment of outcomes, all facilities should have requirements for data collection, storage, and retrieval.

An important goal of regionalized maternal care is for higher-level facilities to provide training for quality improvement initiatives, educational support, and severe morbidity and mortality case review for lower-level hospitals. In those regions that do not have a facility that qualifies as a level IV center, any level III facilities in the region should provide the educational and consultation function (see Table 3).

*Birth Centers*

In 1995, the American Association of Birth Centers ([www.birthcenters.org](http://www.birthcenters.org)) defined *birth centers* as “a homelike facility existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers provide family-centered care for healthy women before, during and after normal pregnancy, labor and birth.” This common definition is used in this document and includes birth centers regardless of their location. Birth centers provide peripartum care to low-risk women with uncomplicated singleton term pregnancies with a vertex presentation who are expected to have an uncomplicated birth. Cesarean delivery or operative vaginal delivery are not offered at birth centers.

In a freestanding birth center, every birth should be attended by at least two professionals. The primary maternity care provider that attends each birth is educated and licensed to provide birthing services. Primary maternity care providers include certified nurse-midwives (CNMs), certified midwives, certified professional midwives, and licensed midwives who are legally recognized to practice within the jurisdiction of the birth center; family physicians; and obstetrician-gynecologists. In addition, there should be adequate numbers of qualified professionals available who have completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with level I care criteria and are able to stabilize and transfer high-risk women and newborns. Medical consultation should be available at all times. These facilities should be ready to initiate emergency procedures (including cardiopulmonary and newborn resuscitation and stabilization) at all times (7), to meet unexpected needs of the woman and newborn within the center, and to facilitate transport to an acute care setting when necessary. To ensure optimal care of all women, a birth center should have a clear understanding of its capability to provide maternal and neonatal care and the threshold at which it should transfer women to a facility with a higher level of care. A birth center should have an established agreement with a receiving hospital and have policies and procedures in place for timely transport. These transfer plans should include risk identification; determination of conditions necessitating consultation; referral and transfer; and a reliable, accurate, and comprehensive communication system between participating facilities and transport teams. All facilities should have quality improvement programs that include efforts to maximize patient safety.

Birth center facility licenses currently are available in more than 80% of states in the United States and state requirements for accreditation for birth centers vary. Three national agencies (Accreditation Association for Ambulatory Health Care [[www.aaahc.org](http://www.aaahc.org)], The Joint Commission [[www.jointcommission.org](http://www.jointcommission.org)], and The Commission for the Accreditation of Birth Centers [[www.birthcenteraccreditation.org](http://www.birthcenteraccreditation.org)]) provide accreditation of birth centers. The Commission for the Accreditation of Birth Centers is the only accrediting agency that chooses to use the national American Association of Birth Centers Standards for Birth Centers in its accreditation process.

Summary and Recommendations	Grade of Recommendations
In order to standardize a complete and integrated system of perinatal regionalization and risk-appropriate maternal care, a classification system should be established for levels of maternal care that pertain to birth centers (as defined in the Birth Centers section of this document), basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV).	1C Strong recommendation, low quality evidence
Introduce uniform designations for levels of maternal care that are complementary but distinct from levels of neonatal care.	1C Strong recommendation, low quality evidence
Establishing clear, uniform criteria for designation of maternal centers that are integrated with emergency response systems will help ensure that the appropriate personnel, physical space, equipment, and technology are available to achieve optimal outcomes, as well as to facilitate subsequent data collection regarding risk-appropriate care.	1C Strong recommendation, low quality evidence
Each facility should have a clear understanding of its capability to handle increasingly complex levels of maternal care, and should have a well-defined threshold for transferring women to health care facilities that offer a higher level of care. To ensure optimal care of all pregnant women, all birth centers, hospitals, and higher-level facilities should collaborate to develop and maintain maternal and neonatal transport plans and cooperative agreements capable of managing the health care needs of women who develop complications; receiving hospitals should openly accept transfers.	1C Strong recommendation, low quality evidence
Higher-level facilities should provide training for quality improvement initiatives, educational support, and severe morbidity and mortality case review for lower-level hospitals. In those regions that do not have a facility that qualifies as a level IV center, any level III facilities in the region should provide the educational and consultation function.	1C Strong recommendation, low quality evidence
Facilities and regional systems should develop methods to track severe maternal morbidity and mortality to assess the efficacy of utilizing maternal levels of care.	1C Strong recommendation, low quality evidence
Analysis of data collected from all facilities and regional systems will inform future updates to the levels of maternal care.	1C Strong recommendation, low quality evidence
Follow-up interdisciplinary work groups are needed to further explore the implementation needs to adopt the proposed classification system for levels of maternal care in all facilities that provide maternal care.	1C Strong recommendation, low quality evidence

#### *Level I Facilities (Basic Care)*

Level I facilities (basic care) provide care to women who are low risk and are expected to have an uncomplicated birth (Table 1). Level I facilities have the capability to perform routine intrapartum and postpartum care that is anticipated to be uncomplicated (6). As in birth centers, maternity care providers, midwives, family physicians, or obstetrician-gynecologists

should be available to attend all births. Adequate numbers of registered nurses (RNs) are available who have completed orientation, demonstrated competence in the care of obstetric patients (women and fetuses) consistent with level I care criteria, and are able to stabilize and transfer high-risk women and newborns. Nursing leadership should have expertise in perinatal nursing care. An obstetric provider with privileges to perform an emergency cesarean delivery should be available to attend deliveries. Anesthesia services should be available to provide labor analgesia and surgical anesthesia. Level I facilities have the capability to begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care (6, 25). Support services include access to obstetric ultrasonography, laboratory testing, and blood bank supplies at all times. All hospitals with obstetric services should have protocols and capabilities in place for massive transfusion, emergency release of blood products (before full compatibility testing is complete), and for management of multiple component therapy. These facilities and health care providers can appropriately detect, stabilize, and initiate management of unanticipated maternal, fetal, or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available. To ensure optimal care of all pregnant women, formal transfer plans should be established in partnership with a higher-level receiving facility. These plans should include risk identification; determination of conditions necessitating consultation; referral and transfer; and a reliable, accurate, and comprehensive communication system between participating hospitals and transport teams (6). All facilities should have education and quality improvement programs to maximize patient safety, provide such programs through collaboration with facilities with higher levels of care that receive transfers, or both. Examples of women who need at least level I care include women with term twin gestation; women attempting trial of labor after cesarean delivery; women expecting an uncomplicated cesarean delivery; and women with preeclampsia without severe features at term.

#### *Level II Facilities (Specialty Care)*

Level II facilities (specialty care) provide care to appropriate high-risk pregnant women, both admitted and transferred to the facility. In addition to the capabilities of a level I (basic care) facility, level II facilities should have the infrastructure for continuous availability of adequate numbers of RNs who have demonstrated competence in the care of obstetric patients (women and fetuses). Orientation and demonstrated competence should be consistent with level II care criteria and include stabilization and transfer of high-risk women and newborns who exceed level II care criteria. The nursing leaders and staff at a level II facility should have formal training and experience in the provision of perinatal nursing care and should coordinate with respective neonatal care services. Although midwives and family physicians may practice in level II facilities, an attending obstetrician-gynecologist should be available at all times. A board-certified obstetrician-gynecologist with special interest and experience in obstetric care should be the director of obstetric services. Access to a maternal-fetal medicine subspecialist for consultation should be available onsite, by phone, or by telemedicine as needed. Anesthesia services should be available at all times to provide labor analgesia and surgical anesthesia. A board-certified anesthesiologist with special training or experience in obstetric anesthesia should be available for consultation. Support services include level I capabilities plus computed tomography scan and, ideally, magnetic resonance imaging with interpretation available; basic ultrasonographic imaging services for maternal and fetal assessment; and special equipment needed to accommodate the care and services needed for obese women (6). Medical and surgical consultants should be available to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities. Examples of women who need at least level II care include women with severe preeclampsia and women with placenta previa with no prior uterine surgery.

#### *Level III Facilities (Subspecialty Care)*

Level III facilities (subspecialty care) provide all level I (basic care) and level II (specialty care) services, and have subspecialists available onsite, by phone, or by telemedicine to assist in providing care for more complex maternal and fetal conditions. Level III facilities will function as the regional perinatal health care centers for some areas of the United States if there are no level IV facilities available. In these areas, the level III facilities will be responsible for the leadership, facilitation of transport and referral, educational outreach, and data collection and analysis outlined in the Regionalization section discussed later in this document.

Designation of level III should be based on the demonstrated experience and capability of the facility to provide comprehensive management of severe maternal and fetal complications. An obstetrician-gynecologist is available onsite at all times and a maternal-fetal medicine subspecialist is available at all times, either onsite, by phone, or by telemedicine, and should have inpatient privileges. The director of the maternal-fetal medicine service should be a board-certified maternal-fetal medicine subspecialist. A board-certified obstetrician-gynecologist with special interest and experience in obstetric care should direct obstetric services. Anesthesia services should be available at all times onsite. A board-certified anesthesiologist with special training or experience in obstetric anesthesia should be in charge of obstetric anesthesia services. A full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, and neonatology should be available for inpatient consultations. An on-site intensive care unit (ICU) should accept pregnant women and have critical care providers onsite to actively collaborate with maternal-fetal specialists at all times. Equipment and personnel with expertise must be available onsite to ventilate and monitor women in the labor and delivery unit until they can be safely transferred to the ICU.

Level III facilities have nursing leaders and adequate numbers of RNs who have completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with level III care criteria, including transfer of high-risk women and newborns who exceed level III care criteria, and who have special training and experience in the management of women with complex maternal illnesses and obstetric complications. These nursing personnel continuously are available. Level III facilities should be able to provide imaging services including basic interventional radiology, maternal echocardiography, computed tomography, magnetic resonance imaging, and nuclear medicine imaging with interpretation should be available at all times. Level III facilities should have the ability to perform detailed obstetric ultrasonography and fetal assessment, including Doppler studies. These facilities also should provide evaluation of new technologies and therapies. Examples of women who need at least level III care include those women with extreme risk of massive hemorrhage at delivery, such as those with suspected placenta accreta or placenta previa with prior uterine surgery; women with suspected placenta percreta; women with adult respiratory distress syndrome; and women with rapidly evolving disease, such as planned expectant management of severe preeclampsia at less than 34 weeks of gestation.

#### *Level IV Facilities (Regional Perinatal Health Care Centers)*

Level IV facilities (regional perinatal health care centers) include the capabilities of level I, level II, and level III facilities with additional capabilities and considerable experience in the care of the most complex and critically ill pregnant women throughout antepartum, intrapartum, and postpartum care. Although level III and level IV may seem to overlap, a level IV facility is distinct from a level III facility in the approach to the care of pregnant women and women in the postpartum period with complex and critical illnesses. In addition to having ICU care onsite for obstetric patients, a level IV facility must have evidence of a maternal-fetal medicine care team that has the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. The maternal-fetal medicine team collaborates actively in the comanagement of all obstetric patients who require critical care and ICU services. This includes comanagement of ICU-admitted obstetric patients. A maternal-fetal medicine team member with full privileges is available at all times for on-site consultation and management. The team should be led by a board-certified maternal-fetal medicine subspecialist with expertise in critical care obstetrics. The maternal-fetal medicine team must have expertise in critical care at the physician level, nursing level, and ancillary services level. A key principle of caring for critically ill pregnant and peripartum women is the facility's recognition of the need for seamless communication between maternal-fetal medicine subspecialists and other subspecialists in the planning and facilitation of care for women with the most high-risk complications of pregnancy. There should be institutional support for the routine involvement of a maternal-fetal medicine care team with the critical care units and specialists. There also should be a commitment to having physician and nursing leaders with expertise in maternal intensive and critical care, as well as adequate numbers of available RNs in level IV facilities who have experience in the care of women with complex medical illnesses and obstetric complications; this includes completed orientation, demonstrated competence in the care of obstetric patients (women and fetuses) consistent with level IV care criteria. The director of obstetric services is a board-certified maternal-fetal medicine subspecialist or a board-certified obstetrician-gynecologist with expertise in critical care obstetrics. As in level III facilities, anesthesia services are available onsite at all times. A board-certified anesthesiologist with special training or experience in obstetric anesthesia should be in charge of obstetric anesthesia services. Level IV facilities should include the capability for on-site medical and surgical care of complex maternal conditions (eg, congenital maternal cardiac lesions, vascular injuries, neurosurgical emergencies, and transplants) with the availability of critical (or intensive) care unit beds. There should be adult medical and surgical specialty and subspecialty consultants (a minimum of those listed in level III) available onsite at all times to collaborate with the maternal-fetal medicine care team. The designation of level IV also may pertain only to a particular specialty in that advanced neurosurgery, transplant, and cardiovascular capabilities may not all be available in the same regional facility. Examples of women who would need level IV care (at least at the time of delivery) include pregnant women with severe maternal cardiac conditions, severe pulmonary hypertension, or liver failure; pregnant women in need of neurosurgery or cardiac surgery; or pregnant women in unstable condition and in need of an organ transplant.

#### **Regionalization**

Regional centers, which include any level III facility that functions in this capacity and all level IV facilities, should coordinate regional perinatal health care services; provide outreach education to facilities and health care providers in their region; and provide analysis and evaluation of regional data, including perinatal complications and outcomes, as part of collaboration with lower-level care facilities in the region. Community outreach and data analysis and evaluation will require additional resources in personnel and equipment within these facilities.

Although specific supporting data are not currently available in maternal health, it is believed that concentrating the care of women with the most complex pregnancies at designated regional perinatal health care centers will allow these centers to maintain the expertise needed to achieve optimal outcomes. Regionalization of maternal health care services requires that there be available and coordinated specialized services, professional continuing education to maintain competency, facilitation of opportunities for transport and back-transport, and collection of data on long-term outcomes to evaluate the effectiveness of delivery of perinatal health care services and the safety and efficacy of new therapies. Because the health statuses of women and fetuses may differ, referral should be organized to meet the needs of both. In some cases with specific care needs, optimal coordination of care will not be delineated by geographic area, but rather by availability of specific expertise (eg, transplant services or fetal surgery).

#### *Measurement and Evaluation of Regionalized Maternal Care*

Implicit in the effort to establish levels of maternal care is the goal to provide the best possible maternal outcomes, as well as ongoing quality improvement. If levels of maternal care improve care, then ensuring that appropriate transfer of women occurs should be associated with a decrease in preventable maternal severe morbidities and mortality. There also should be a shift toward less severe morbidity in lower-level care facilities. Therefore, facilities and regional systems should develop methods to track severe maternal morbidity and mortality to assess the efficacy of utilizing maternal levels of care.

Operational definitions are needed to compare data and outcomes between levels of maternal care. However, waiting for the precise measure before establishing tiered levels of care invites unnecessary delay. Therefore, two constructs to implement with the utilization of levels of maternal care are proposed: 1) identify women at extreme risk of morbidity and 2) identify severe morbidity outcomes that may improve with appropriate use of maternal levels of care. Some women at extreme risk of severe morbidities, such as stroke, cardiopulmonary failure, or massive hemorrhage, can be identified during the antepartum period and should give birth in the appropriate level hospital. Examples of such women include those with suspected placenta accreta or placenta percreta; prior cesarean birth and current anterior previa; severe heart disease such as complex cardiac malformations and pulmonary hypertension, coronary artery disease, or cardiomyopathy; severe preeclampsia with uncontrollable hypertension; and preterm HELLP syndrome.

Outcome morbidities that may improve with appropriate use of levels of maternal care include stroke, returns to the operating room, massive transfusions, severe maternal morbidity, and potential ICU admissions. The incidence of these outcomes could decrease or be shifted from lower-level to higher-level hospitals. For example, known placenta accreta has the potential for massive blood loss and need for advanced surgical services, which are best available at facilities with a high designated level of care. Expectant management of severe early preeclampsia, septic shock, and pulmonary hypertension are

other examples of conditions that require considerable resources likely best available at facilities with a high designated level of care. Although the development of comprehensive lists of what conditions comprise extreme morbidity risks and what outcomes ought to be measured currently is an evolving process, prospective measurement with continuous monitoring and evaluation of any regionalized maternal care system is critical to improvement in care processes and outcomes.

#### *Determination and Implementation of Levels of Maternal Care*

Many barriers to the implementation of levels of maternal care may need to be overcome. The development of the classification system is the first step; the next step, is the implementation of this concept in all facilities that provide maternal care. The questions of whether to have state-level or national-level accrediting bodies establish and set these proposed levels of maternal care, as well as how to provide the financing needed to run them, are unanswered. Follow-up interdisciplinary work groups are needed to further explore the implementation needs to adopt the proposed classification system for levels of maternal care in all facilities that provide maternal care.

The determination of the appropriate level of care to be provided by a given facility should be guided by local and state health care regulations, national accreditation and professional organization guidelines, and identified regional perinatal health care service needs (6). State and regional authorities should work together with the multiple institutions within a region to determine the appropriate coordinated system of care.

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Society for Maternal–Fetal Medicine Grading System: Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Recommendations			
Obstetric Care Consensus documents will use Society for Maternal–Fetal Medicine's grading approach: <a href="http://www.ajog.org/article/S0002-9378(2013)2900744-8/fulltext">http://www.ajog.org/article/S0002-9378(2013)2900744-8/fulltext</a> . Recommendations are classified as either strong (Grade 1) or weak (Grade 2), and quality of evidence is classified as high (Grade A), moderate (Grade B), and low (Grade C)*. Thus, the recommendations can be 1 of the following 6 possibilities: 1A, 1B, 1C, 2A, 2B, 2C.			
Grade of Recommendation	Clarity of Risk and Benefit	Quality of Supporting Evidence	Implications
1A. Strong recommendation, high quality evidence	Benefits clearly outweigh risk and burdens, or vice versa.	Consistent evidence from well performed randomized controlled trials or overwhelming evidence of some other form. Further research is unlikely to change confidence in the estimate of benefit and risk.	Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1B. Strong recommendation, moderate quality evidence	Benefits clearly outweigh risk and burdens, or vice versa.	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.	Strong recommendation, and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C. Strong recommendation, low quality evidence	Benefits appear to outweigh risk and burdens, or vice versa.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious flaws. Any estimate of effect is uncertain.	Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
2A. Weak recommendation, high quality evidence	Benefits closely balanced with risks and burdens.	Consistent evidence from well-performed randomized controlled trials or overwhelming evidence of some other form. Further research is unlikely to change confidence in the estimate of benefit and risk.	Weak recommendation, best action may differ depending on circumstances or patients or societal values.
2B. Weak recommendation, moderate quality evidence	Benefits closely balanced with risks and burdens; some uncertainty in the estimates of benefits, risks, and burdens.	Evidence from randomized controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an effect on confidence in the estimate of benefit and risk and may change the estimate.	Weak recommendation, alternative approaches likely to be better for some patients under some circumstances.
2C. Weak recommendation, low quality evidence	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens.	Evidence from observational studies, unsystematic clinical experience, or from randomized controlled trials with serious	Very weak recommendation, other alternatives may be equally reasonable

	flaws. Any estimate of effect is uncertain.
Best practice	Recommendation in which either (i) there is enormous amount of indirect evidence that clearly justifies strong recommendation (direct evidence would be challenging, and inefficient use of time and resources, to bring together and carefully summarize), or (ii) recommendation to contrary would be unethical.
Modified from Grading guide. In: UpToDate, Basow, DS (Ed), UpToDate, Waltham, MA, 2013. Available at: <a href="http://www.uptodate.com/home/grading-guide">http://www.uptodate.com/home/grading-guide</a> . Retrieved October 9, 2013.	
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