

# Midwifery Program Training III: **Rules Effective July 2014**

Bureau of Special Licensing  
June 20, 2014



*Health and Wellness for all Arizonans*

**BUREAU OF SPECIAL LICENSING  
MIDWIFE TRAINING**

June 20, 2014

**AGENDA**

- |                    |   |   |
|--------------------|---|---|
| <b>1:00 – 1:15</b> | <b>Welcome &amp; iLinc Logistics</b>  | <b>Pragathi Tummala, MPH<br/>Bureau Chief , Special Licensing</b>   |
| <b>1:15 – 2:00</b> | <b>Rules Going into Effect July 2014</b> <ul style="list-style-type: none"><li>• Overview</li><li>• Common Errors</li></ul> | <b>Don Gibson, MPA, Team Lead &amp;<br/>Pat Glass, RN, Surveyor</b> |
| <b>2:00 – 2:40</b> | <b>Frequently Asked Questions<br/>Regulation Process</b>  | <b>Pragathi Tummala, MPH</b>  |
| <b>2:40 – 3:00</b> | <b>Open for Questions</b>   |   |



## A Little i-Linc Housekeeping



PLEASE.....

- Do **not** put your phone on hold during the webinar.
- Keep your phones **muted** by pressing \*6.

### For questions:

- You may raise your hand for the presenters to take live questions throughout their presentations.
- You may also type your questions in the chat text box on the lower left screen at any time.

**Thank you for attending!**

# Rules Effective July 1, 2014

## **R9-16-108 (M) Responsibilities of a Midwife; Scope of Practice**

**M.)** Subsections (B), (C)(1)(b), (C)(1)(d) and (J)(2) and (4) are effective July 1, 2014.

## R9-16-108 (B)

B.) Except as provided in R9-16-111(C) or (D) [**Prohibited Practice; Transfer of Care**], 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.

# R9-16-111 (C) Prohibited Practice; Transfer of Care

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.

## R9-16-111(D) Prohibited Practice; Transfer of Care

**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.

## R9-16-108 (C)(1)(b)

C.) Before providing services to a client, a midwife ***shall***:

1. Inform a client, both orally and in writing, of:

b. If applicable to the client's condition, the midwife's experience with:

1. Vaginal birth after prior Cesarean section delivery, or
2. Delivery of a fetus in a complete breech or frank breech presentation;

## R9-16-108 (C)(1)(d)

- c.)** Before providing services to a client, a midwife ***shall***:
- 1.** Inform a client, both orally and in writing, of:
    - d.** The requirement for tests specified in subsections (I) [Prenatal required testing] and (K)(4)(c) [Postpartum newborn screening], 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;

## R9-16-108 (I)(1)(3)

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;
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;

# Arizona Revised Statutes (A.R.S.) § 36-693(B)

## **36-693** Blood tests required; pregnant women; umbilical cord at delivery; definition

A.) A physician shall at the time of the first prenatal examination, after a diagnosis of pregnancy, take or cause to be taken a sample of the blood of the woman and submit it to an approved laboratory for a standard serological test for syphilis. If the woman has not had a serological test prior to delivery, a sample of blood from the umbilical cord shall be taken at delivery for examination.

**B.)** Any other person permitted by law to attend pregnant women but not permitted to take blood samples shall cause a sample of the blood of each pregnant woman attended by him to be taken under the direction of a duly licensed physician of medicine and surgery as required by subsection A. The physician shall have the sample submitted to an approved laboratory for a standard serological test for syphilis.

## R9-16-108 (I)(2)(4) (cont.)

I.) During the prenatal period, the midwife shall:

- ~~2.~~ Until October 1, 2013, ~~schedule or arrange 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;
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;

## R9-16-108 (I)(5)

I.) During the prenatal period, the midwife shall:

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;

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## R9-16-108 (I)(5) continued....

I.) During the prenatal period, the midwife shall:

5.) Conduct a prenatal visit ... that includes:

- 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;

## R9-16-108 (I) (6)(7)(8)(9)

- I.) During the prenatal period, the midwife shall:
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).

## R9-16-108 (J)(2)

- J.) During the intrapartum period, a midwife shall:
2. Contact the hospital identified in subsection (D)(1)(a) [Emergency Care Plan] according to the policies and procedures established by the hospital regarding communication with midwives when the client begins labor and ends labor;

## R9-16-108(D)(1)(a)

**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

## R9-16-108 (J)(4)

J.) During the intrapartum period, a midwife shall:

4. For deliveries described in subsection (B) [allowable VBAC and Breech], 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;

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# FREQUENTLY ASKED QUESTIONS:



*Health and Wellness for all Arizonans*

# Frequently Asked Questions:

**Q#1.** Does the informed Consent for Midwifery Services indicate that we must read the 30 pages of Midwifery Rules to our clients? This is impossible.

*Answer: You must cover the basic information listed in R9-16-108(C), and make available to them, anything that covers midwifery licensing and scope in Article 1, if they have any questions.*

*The informed consent form was developed by the Licensed Midwife Advisory Committee in October 2013.*

## Frequently Asked Questions:

**Q#2.** If a midwife activates Emergency Care Plan for a complication, and the client refuses EMS care, can the midwife continue care?

*Answer: The LM implements the Emergency Care Plan for a condition that threatens the life of the client or the client's child R9-16-108 (F), so the LM cannot continue to provide services.*

## Frequently Asked Questions:

**Q#3.** Can midwives provide breastfeeding support, maternal wellbeing, parenting support, etc. after the 6 week postpartum period?

*Answer: As per R9-16-101 "Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery or postpartum care. "Postpartum" means the six-week period following delivery of a newborn and placenta.*

*A midwife must end services at the end of the 6 week period that is defined as postpartum.*

## Frequently Asked Questions:

**Q#4.** If a client is out of town during the latter part of the 6 week postpartum period, should it be said their care was terminated at their 2, 3 or 4 week visit? Will the state say that care was terminated too soon?

*Answer: A LM is not required to see the client the full six weeks of postpartum care. They cannot exceed 6 weeks but can end care any time before that period. If a client cancels a 6 week appointment, contact them via phone and document your last postpartum contact with the client as the last day of care.*

## Frequently Asked Questions:

**Q#5.** Should the termination of care always be exactly 6 weeks after the delivery date no matter when the last appointment was conducted since the midwife is available to them up to 6 weeks? Is the end of postpartum care during the 6th week or must it end at exactly 6 weeks and 0 days?

*Answer: Per definition in R9-16-101 "Postpartum" means the six-week period following delivery of a newborn and placenta. The postpartum period is calculated to end at 42 days after the birth.*

## Frequently Asked Questions:

**Q#6.** If a transfer of care occurs, can postpartum appointments be done by the midwife after mom and baby are stable? Some hospitals with residents do not offer follow up care. Some doctors say to follow up with the midwife on discharge.

*Answer: Sometimes, this is allowable. (i.e., TOC for epidural) However, if the transfer of care is part of a prohibited practice, the LM cannot provide postpartum for the client. Check with us if you need technical assistance.*

## Frequently Asked Questions:

**Q#7.** If a newborn screen is done by the pediatrician instead of the midwife, is a refusal required or can it be documented as completed by that pediatrician in the client's chart?

*Answer: If the test was done by a pediatrician, it can just be documented in the client's chart by the LM. No refusal form is required.*

## Frequently Asked Questions:

**Q#8.** Can you please clarify the definition of urinalysis? Is this a urine exam at each prenatal visit for protein, glucose, ketones, and nitrites or a complete laboratory urinalysis study?

*Answer: Up to 28 weeks, the urinalysis can be declined R9-16-108 (I)(1)(3)(b). After this time, every prenatal visit must include all the tests listed in rule R9-16-108 (I)(5).*

R9-16-108 (I)(1)(3)(b) During the prenatal period, the midwife *shall*:

(3) As of October 1, 2013, except as provided in R9-16-110 [Assertion to Decline Required Tests], ensure that the following tests in subsection (I)(1) are completed

1)b. **urinalysis**

R9-16-108 (I)(5)(a) Conduct a prenatal visit at least once every 4 weeks beginning 28 weeks....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;

## Frequently Asked Questions:

**Q#9.** If a patient with serious mental illness is stable, and the doctor releases them to a midwife to provide midwifery, is that allowed if the midwife has a letter from the physician?

*Answer: No one, including a physician can waive or override the rules. R9-16-111 (B)(15) [Prohibited practice; Transfer of Care]*

B) A midwife shall not accept for midwifery services..... for a client who has or develops any of the following:

15. A serious mental illness

## Frequently Asked Questions:

**Q#10.** Is the state willing to pay for the extra cost of the required tests? Some clients don't qualify for or choose AHCCCS care, and cannot afford the cost of these tests. Is there a resource the state could refer us to for these tests?

*Answer: No, the state will not pay for required tests. While ADHS cannot endorse any facilities, every month Maricopa County provides free STD testing at various sites.*

*[www.maricopa.gov/publichealth/services/std/outreach.aspx](http://www.maricopa.gov/publichealth/services/std/outreach.aspx)*

*There are also other websites or resources that you can google to find free testing within the state. [www.yourstdhelp.com/arizona.html](http://www.yourstdhelp.com/arizona.html)*

## Frequently Asked Questions:

**Q#11.** Does the EMS provider have to be named in the emergency action plan? Can the plan be to call 911 and take whichever EMS provider arrives. There are different EMS providers in each city, and their contracts with the cities change. The midwife maybe unaware of these changes.

*Answer: An EMS provider does not have to be named; stating 911 will suffice. At the time of the prenatal visit of the birthing location before 35 weeks R9-16-108 (I)(9), you must confirm that communication is available to the hospital and EMS provider identified in the ECP.*

## Frequently Asked Questions:

**Q#12.** Non-emergency transfers may occur during labor which do not necessitate activating the Emergency Care Plan. In this situation a client may choose to go to a provider not listed on the Plan. Is that ok?

*Answer: Yes, the emergency care plan is activated only during an emergency, and lists the closest hospital and the EMS provider. All other transfers or consults can seek out any qualified provider type named in the rules definition for "transfer of care." R-16-101*

## Frequently Asked Questions:

**Q#13.** Which definition of Large for Gestational Age does the department use? The range for LGA is 4000 grams to 4500 grams. Midwives generally feel that 4500 grams should be used.

*Answer: There is nothing in the rules that defines Large for Gestational Age. LM should assess the infant and make a determination for the reporting.*

*The Merck Manual defines "a newborn, whether delivered preterm, term, or post-term, whose weight is above that of 90% of newborns of the same gestational age at birth (above the 90th percentile) is considered large for gestational age."*

# Frequently Asked Questions:

**Q#14.** R9-16-111 (H) states that a midwife shall not administer drugs or medications except as provided in R9-16-108(l)(5)(f), (K)(1)(g), (K)(2)(c), or R9-16-113. The exceptions are for Rhogam and newborn Vitamin K. Exceptions are not given for Emergency Measures and Newborn Eye Medication. What do we do?

*Answer: During routine care, the above medications can be administered under a physician's written orders; also other medications can be administered as needed with a script. R9-16-108(K)(2)(d) Document the administration of any medications or vitamins to the newborn....according to the physician's orders.*

*Medications allowed during emergency measures are spelled out in R9-16-113(A)(2)(b) [oxygen], R9-16-113(A)(2)(d) [anesthetic for suturing] R9-16-113 (B) [pitocin] and R9-16-113 (C) [meds needed to control postpartum hemorrhage documentation]*

## Frequently Asked Questions:

**Q#15.** Does a LM have to fill out information about the Emergency Action Plan( EAP) on the Survey Monkey even if there is no emergency or do we just make something up?

*Answer: The LM would only provide this information on the Survey Monkey if the EAP is activated; otherwise you leave it blank.*

*Providing false data to the department R9-16-116 (3)[Denial, Suspension, or Revocation of a License; Civil penalties; Procedures] could result in enforcement action for Falsification of records.*

## Frequently Asked Questions:

**Q#16.** The Decline assertion forms are not in the same font or format as the Informed Consent Document. They also lack the Department of Health logo. Can you please fix this?

*Answer: All forms have been updated to include the logos and have been posted on our website.*

# Frequently Asked Questions:

**Q#17:** Does the monitoring of active labor require forced vaginal checks? Can a client decline?

Answer: As per R9-16-108 (J)(3)

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;

# REGULATION PROCESS

# Licensing and Compliance

- Rules and Statutes must be followed.
- Assurance of health and safety is done through regulation and licensing.
- A violation of the rules or statutes may result in enforcement actions.
- Technical assistance is available through the program.
- Trainings and guides have been created and posted on our website for all aspects of midwifery services and requirements.
- Our goal is compliance.

# Enforcement Process:

**Rules not followed**

## **Citation and SOD**

- Statement of Deficiency issued
- Needs plan of correction submitted by LM or
- Goes to Enforcement

## **Enforcement:**

- Civil \$ penalty and/or
- Legal action -----
- If the LM does not agree with the citation then can IDR: Informal Dispute Resolution (LM submits additional data)
  - Citation reversed
  - Citation upheld

## **Citation Upheld or no IDR:**

- LM submits the signed enforcement agreement and pays fine, or
- LM requests a Formal Hearing with ALJ and/or Informal Settlement Conference with ADHS

## **OAH (Office of Administrative Hearings)**

- Legal actions (notice to deny, suspend, or revoke)
- Any actions that are unable to be resolved with the Informal Settlement Conference

# Questions??

# Midwifery Program Training III: Rules Effective July 2014

Bureau of Special Licensing  
June 20, 2014

**LOCATED IN 1740 W. ADAMS  
ROOM 411**

**1:00-3:00 pm**

