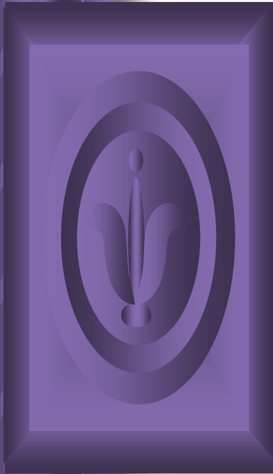

Advisory Board on Midwifery

Virginia Board of Medicine

September 29, 2017

10:00 a.m.

Advisory Board of Midwifery
Board of Medicine
Friday, September 29, 2017, 10:00 a.m.
9960 Mayland Drive, Suite 201
Henrico, VA

Call to Order – Kim Pekin, CPM, –Chair	
Emergency Egress Procedures – Alan Heaberlin	i
Roll Call – Beulah Archer	
Approval of Minutes of June 9, 2017	1-3
Adoption of the Agenda	
Public Comment on Agenda Items	
New Business	

1. NARM 2016 Job Analysis Survey - Kim Pekin, CPM 4-56
2. New DMAS Rules Affecting Licensed Midwives- Kim Pekin, CPM
3. Electronic Submission of Birth Certificates – Elaine Yeatts
4. Discussion of Student Exemption and License Applicant Status – Dr. Harp
5. Approval of 2018 Calendar – Dr. Harp
6. Election of Officers – Kim Pekin

Announcements

Next Meeting Date: TBD

Adjournment

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

Training Room 2

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the doors, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

ADVISORY BOARD ON MIDWIFERY
Minutes
October 7, 2016

The Advisory Board on Midwifery met on Friday, October 7, 2016 at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT: Kim Pekin, CPM, Chair
Maya Hawthorn, CPM
Mayanne Zielinski, CPM
Ami Keatts, MD

MEMBERS ABSENT: The Citizen Member seat is vacant.

STAFF PRESENT: Alan Heaberlin, Deputy Executive Director
Colanthia Morton, Operations Manager
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: None

CALL TO ORDER

Kim Pekin, CPM, called the meeting to order at 10:05 a.m.

ROLL CALL –Beulah Baptist Archer

Roll was called and a quorum declared.

APPROVAL OF THE October 9, 2015 MEETING MINUTES

Maya Hawthorn moved to approve the minutes. The motion was seconded and carried.

ADOPTION OF THE AGENDA

Maya Hawthorn moved to adopt the agenda. The motion was seconded and carried.

000 01

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment.

NEW BUSINESS

Mayanne Zielinski nominated Kim Pekin as Chair and herself as vice-chair. The motion was seconded and carried.

ANNOUNCEMENTS

Colanthia Morton announced that there were currently 87 midwives licensed by the Virginia Board of Medicine.

NEXT MEETING DATE

February 3, 2017.

ADJOURNMENT

Kim Pekin adjourned the meeting at 10:25.

____
Kim Pekin, CPM, Chair

____
William L. Harp, MD
Executive Director

____
Beulah Baptist Archer, Licensing Specialist

ADVISORY BOARD ON MIDWIFERY
Minutes
June 9, 2017

The Advisory Board on Midwifery met on Friday, June 9, 2017, at 10:00 a.m., at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia 23233.

MEMBERS PRESENT:	Kim Pekin, CPM Maya Hawthorn, CPM Natasha Jones, MSC Ami Keatts, M.D. Mayanne Zielinski, CPM
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, M.D. Executive Director Alan Heaberlin, Deputy Director, Licensing Colanthia Morton, Operations Manager Beulah Baptist Archer, Licensing Specialist
GUESTS PRESENT:	Ralston King, Medical Society of VA Becky Bowers-Lanier, VMA Nicole Pugar, ACOG-NA Degra Nofsinger, CPM, VA Midwives Alliance, President

CALL TO ORDER

Kim Pekin called the meeting to order at 10:10 a.m.

EMERGENCY EGRESS PROCEDURES

Alan Heaberlin announced how to exit the building in the event of an emergency or drill.

ROLL CALL

Beulah Baptist Archer called the roll, and a quorum was declared.

APPROVAL OF THE FEBRUARY 3, 2017 MEETING MINUTES

Mayanne Zielinski moved to approve the minutes. The motion was seconded and carried.

ADOPTION OF THE AGENDA

Mayanne Zielinski moved to adopt the agenda. The motion was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

No public comment on agenda items.

NEW BUSINESS

1. NARM 2016 Job Analysis Survey –Kim Pekin, CPM

Elaine suggested to the Advisory Board that the members review the NARM Job Analysis Survey, their three Guidance Documents, and the regulations that Govern the Practice of Midwifery to see if any inconsistencies exist. Mayanne Zielinski moved to table the topic until the next meeting. The motion was seconded and carried. The guidance documents and regulations were provided to the members, along with the packet that contained the NARM Job Analysis Survey.

2. CPM's Ordering Ultrasounds and Lab Tests – Kim Pekin , CPM

Kim Pekin addressed the Advisory Board regarding the increased resistance licensed midwives are encountering when ordering standard obstetrical ultrasounds, biophysical profiles, and lab tests. Clint Bowen, from INOVA Hospital requested a statement from DHP stating that ordering ultrasounds is listed in the scope of practice for midwives.

Dr. Harp and Elaine Yeatts confirmed that if a statement is provided, it would need to come from the Board of Medicine. Ms. Yeatts suggested that counsel be consulted to determine if the Board could further interpret the scope of practice that appears to include the ordering of ultrasounds and other tests.

Maya Hawthorn moved to ask the Board of Medicine to review the midwifery scope of practice that includes ordering ultrasounds, non-stress tests, biophysical profiles, and lab tests and consider approving a guidance document. The motion was seconded and carried.

ANNOUNCEMENTS – Alan Heaberlin

Alan provided the totals for licensed midwives in Virginia as of June 9, 2017.

Licensed Midwives	85
Virginia addresses	63
Out-of-state addresses	22

Kim Pekin announced that UPS is now delivering newborn metabolic screenings, via next day air, to the Division of Consolidated Laboratory Services.

NEXT MEETING DATE

TBD

ADJOURNMENT

Kim Pekin adjourned the meeting.

Kim Pekin, CPM, Chair

William L. Harp, MD
Executive Director

Beulah Baptist Archer, Licensing Specialist

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54.1-3408 which says a nurse, pursuant to the order of a prescribing practitioner, can administer medications. The nursing license must be current and active.

5. 2016 NARM Job Analysis Survey Comprehensive Report

Kim Pekin requested a review of the job analysis survey to clarify the function of a Licensed Midwife. She asked that a statement reaffirming the scope of practice in accordance with NARM 2016 be drafted to include the ordering of medical tests, conducting Well-Woman care, and prenatal screenings. This statement would be useful for midwives to send to other entities with whom they interact.

Dr. Harp advised that this request would be presented to the Executive Committee in April.

ANNOUNCEMENTS – Alan Heaberlin

Alan provided the totals for licensed midwives in Virginia as of February 3, 2017.

Licensed Midwives	91
Current Active	66
In-State Current Active	24
Out-of- state Current Active	1

NEXT MEETING DATE

June 9, 2017.

ADJOURNMENT

A motion to adjourn was made, seconded and passed.

____
Kim Pekin, CPM
Chair

____
William L. Harp, MD
Executive Director

____
Beulah Baptist Archer
Licensing Specialist

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2016 NARM Job Analysis Survey Comprehensive Report

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Acknowledgements

This study was completed through the work of many individuals at Inteleos, who worked together to construct the survey, facilitate survey administration, and analyze the data. The NARM Job Analysis Committee reviewed and updated the job task statements (work activities) and demographic questions from the 2008 NARM job analysis before and after the survey was administered, and an experienced group of Certified Professional Midwives served as the pilot survey group in reviewing the survey. It was much appreciated that more than 700 CPMs across the U.S. and Canada took the time to participate in the survey by describing their experience in the field and providing their opinion on entry-level practice in midwifery.

ABOUT THE REPORT

The North American Registry of Midwives (NARM) contracted with Inteleos Psychometric Services (IPS) to conduct a job analysis survey for the primary purpose of updating the contents of the NARM Written Examination for the Certified Professional Midwives (CPMs). The job analysis survey was created by the NARM Board of Directors and a group of subject-matter experts who were all CPMs.

The job analysis identified the essential and current competencies necessary for safe and competent practice of midwifery in the U.S. and Canada. The results from the survey were used in the development of the test content outline that will guide the content distribution of the NARM Written Examination. This report details the methodology, data collection, analyses, and survey results. It also includes the test content outline that resulted from the job analysis.

METHODOLOGY

Job Analysis Committee

A job analysis committee consisting of 15 members was formed in March 2016. The committee consisted of seven (7) NARM board members and eight (8) subject-matter experts who were all CPMs. See Appendix A for a list of the committee members and their credentials.

Survey Questionnaire Development

The job tasks (work activities) from the 2008 NARM job analysis survey and the MANA Core Competencies served as the springboards for the development of the 2016 NARM job analysis survey questionnaire. The committee met on April 21, 2016 at the William F. Bolger Center, in Potomac, MD. The meeting was facilitated by Dr. David Paulson from IPS and Ida Darragh from NARM. The committee spent most of the day reviewing and revising the job tasks from the 2008 survey and adding new job tasks. The committee completed the review of the job tasks and developed demographic questions through additional webinars. The committee reached a consensus on an initial list of 733 tasks to be used on the survey.

These tasks were divided into seven domains: (1) Professional Issues, Knowledge and Skills; (2) General Healthcare Skills; (3) Maternal Health Assessment; (4) Prenatal Care; (5) Labor, Birth and Immediate Postpartum; (6) Postpartum; and (7) Well-care Baby (up to six weeks).

Two rating scales were developed to rate the 700+ job tasks: Frequency and Importance. The Frequency and Importance rating scales were scored 1-5. The response options for the Frequency scale were Never (1), Rarely (2), Occasionally (3), Often (4), and Frequently (5). The response options for the Importance scale were Not Important (1), Somewhat Important (2), Moderately Important (3), Very Important (4), and Critically Important (5).

The survey questionnaire was pilot-tested with a group of 30 CPMs. The purpose of the pilot-testing was to obtain input on the demographic questions, job tasks missing from the survey, or job tasks they would like to revise or delete. The information received from the pilot-test was used in refining the survey instrument. The final survey, consisting of 26 demographic questions and 670 job tasks along with the two rating scales, was reviewed and approved by the NARM Board of Directors in May 2016.

Survey Administration

The survey was made available to participants as a web-based survey through the survey platform Qualtrics®. An invitation to participate in the study was sent via email to the 2,168 CPMs in the U.S. and Canada (see Appendix B for the full email text). The 2,168 CPMs represented all the CPMs who hold current CPM credential.

The survey was made available to the participants for approximately three weeks between September 16, 2016 and October 9, 2016. The participants responded anonymously and all responses were kept confidential. Of the 2,168 email invitations sent out, 6 emails failed to send due to an incorrect mail server address, and 54 emails bounced due to an incorrect username address.

Among the 2,108 CPMs that received the survey invitation, 1,126 opened the survey link, and 950 began the survey.

A total of 706 (approximately 33% of those sampled) CPMs completed at least 50% to the survey, and 627 of those CPMs completed the entire survey. Those who responded to at least 50% of the survey questions were deemed to have 'completed' the survey and were included in all subsequent analyses. The data analysis was based on the responses from the 706 CPMs.

Data Analysis

Respondents were asked the following questions for each task: 'How frequently do you perform the task in your practice?' and' How important is the task in affecting clinical decisions and patient outcomes?' The frequency and importance rating scales were scored 1-5.

The survey data from Qualtrics® platform was downloaded into Excel and data analysis was performed using SPSS and Excel.

The frequency and importance rating scales were combined into a single measure of overall Criticality (ranging from 0-16), as shown in Table 1, using a hierarchical method where a particular value on the importance scale would outweigh or outrank all values on the frequency scale except 'never.' Higher criticality values indicate the more critical tasks. The tasks were ranked by Criticality within each content domain. In addition, the Criticality values were summed across all tasks within each domain to yield the initial percentages of examination items in each domain.

The tasks in each domain were color-coded to represent 'buckets' of Criticality. The original intention was for the NARM Committee to evaluate only the tasks in the Yellow bucket. Green tasks were to be included based on clear indication of their criticality by the survey respondents. Red were to be excluded for having been seen as non-critical by respondents. However, many of the Red tasks were considered by the Committee for possible inclusion.

Table 1. NARM Job Analysis 2016- Criticality Distribution

Response Scales		Overall Criticality Score
Importance	**Frequency**	
Critically Important (5)	Frequently (5)	16
	Often (4)	15
	Occasionally (3)	14
	Rarely (2)	13
Very Important (4)	Frequently (5)	12
	Often (4)	11
	Occasionally (3)	10
	Rarely (2)	9
Moderately Important (3)	Frequently (5)	8
	Often (4)	7
	Occasionally (3)	6

SURVEY RESULTS

The results from the survey were presented to the NARM Job Analysis Committee on October 17, 2016 by Dr. Ellen Julian of IPS. The 670 tasks were grouped into three buckets:

1. Green bucket - tasks with overall criticality ratings of 10-16 (478 tasks in this bucket),
2. Yellow bucket – tasks with overall criticality rating of 6-9 (165 tasks in this bucket)
3. Red bucket – tasks with overall criticality rating of 0-5 (27 tasks in this bucket)

The main purpose of the online meeting with the Committee was to review the 165 tasks (borderline tasks) in the yellow bucket and 27 tasks (trivial tasks) in the red bucket and decide whether they should be kept as part of the exam content outline. Based on the review of these tasks, the committee decided to keep 157 of 165 yellow tasks and 15 out of the 27 red tasks. Thus, including the 478 green tasks, the committee kept a total of 650 tasks out the 670 tasks surveyed as part of the exam content outline. The resulting exam content outline is shown in Table 2.

The percent of Total Criticality shown under the cell "Before Culling" displays the percent distribution of the exam content outline based only on the survey results. The column titled "% of Total Criticality" under the cell "After Culling" shows the exam content outline breakdown after the committee review of the yellow and red tasks. At the end, the committee reviewed the content outline and made some slight changes to the distribution based on their professional expertise in midwifery. The committee's final recommended exam content outline is shown in the far-right column.

Table 2. Exam Content Outline Breakdown by Domain Before and After Committee Culling of Tasks

Domain #	Domain	Before Culling # Tasks	Before Culling % of Total Criticality	Acceptable Range	After Culling # Tasks	After Culling % of Total Criticality	Job Analysis Committee Recommended Distribution
1	Professional Issues, Knowledge, and Skills	26	4%	4%-4%	24	4%	4%
2	General Healthcare Skills	80	11%	10%-12%	79	12%	10%
3	Maternal Health Assessment	56	8%	6%-8%	46	7%	7%
4	Prenatal Care	139	21%	19%-23%	134	21%	23%
5	Labor, Birth and Immediate Postpartum	262	40%	37%-45%	261	40%	40%
6	Postpartum	60	9%	9%-11%	60	9%	10%
7	Well-Baby Care	47	7%	7%-8%	46	7%	6%
	Total	670	100%		650	100%	100%

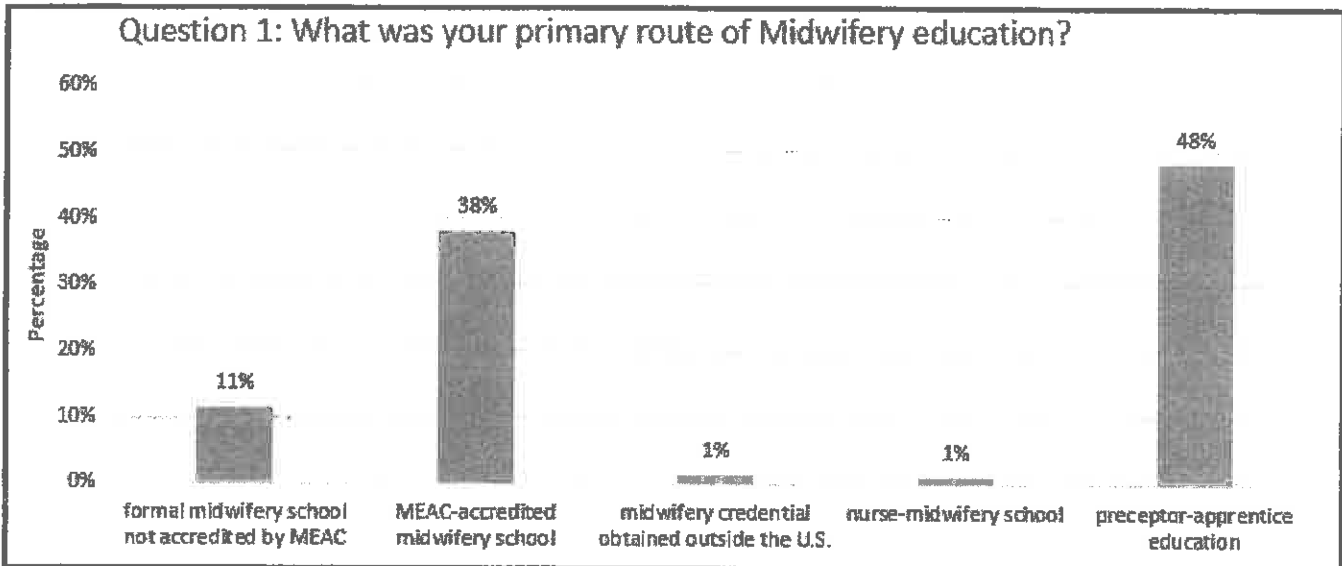
Exam Content Outline and Task Descriptions

See Appendix C for the new exam content outline and list of tasks. The tasks culled by the NARM Job Analysis Committee can be found in Appendix D. For the full survey results, with frequency, importance, and criticality scores, as well as the "bucket" placement for each task and committee decision on whether to keep or remove the task, see Appendix E.

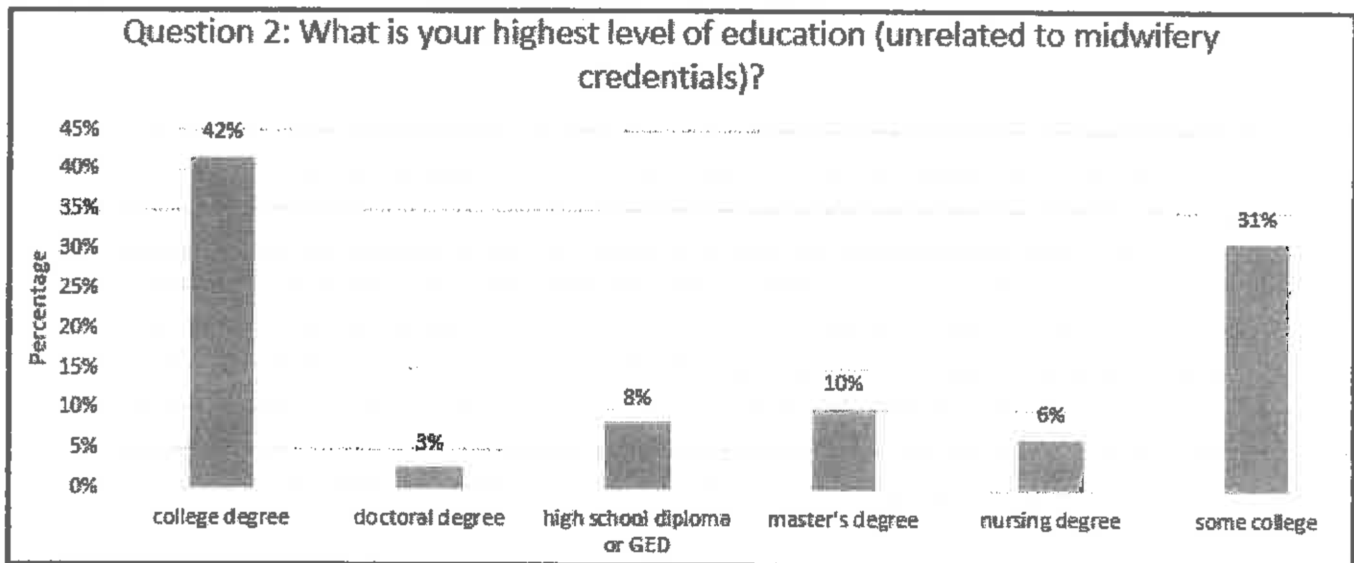
Demographics and Backgrounds of Participants

Education

Approximately 48% of the respondents received education through a preceptor-apprentice program (Question 1).

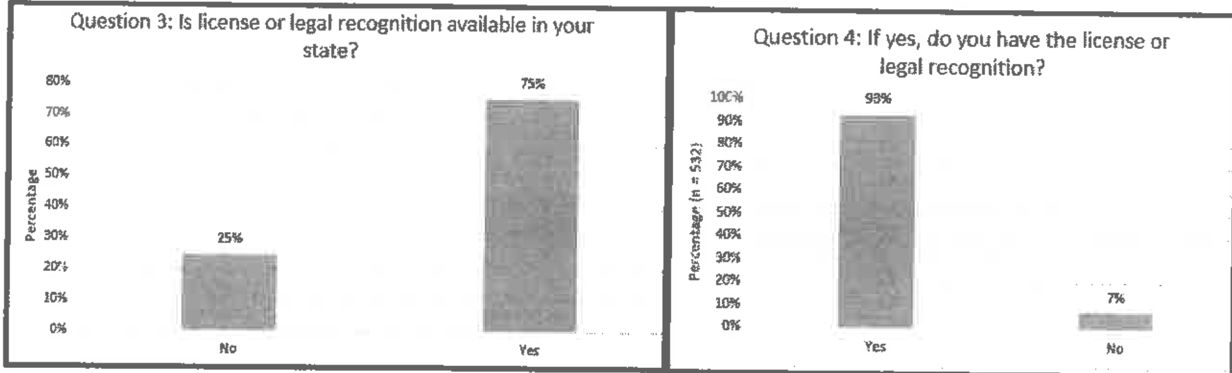


Additionally, most respondents had a higher education degree, with 42% holding a college degree, 6% holding a nursing degree, 10% holding a master's degree, and 3% holding a doctoral degree (Question 2).

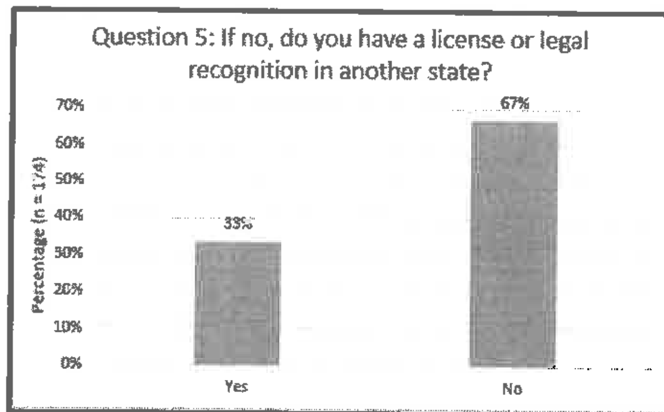


Licensure

In regards to licensure, most (75%) of the respondents practiced in a state that has licensure or legal recognition available (Question 3). Almost all of the 532 respondents who had licensure or legal recognition available were licensed or legally recognized (Question 4).

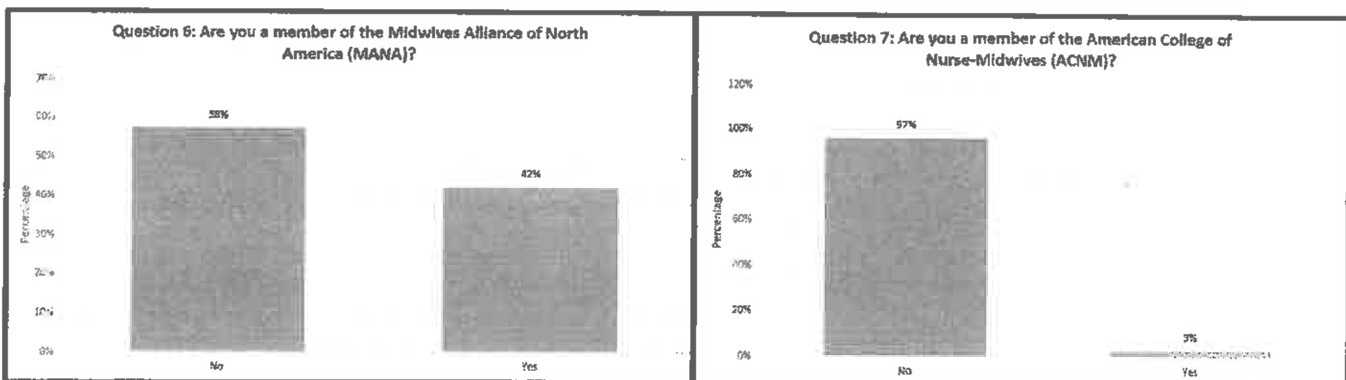


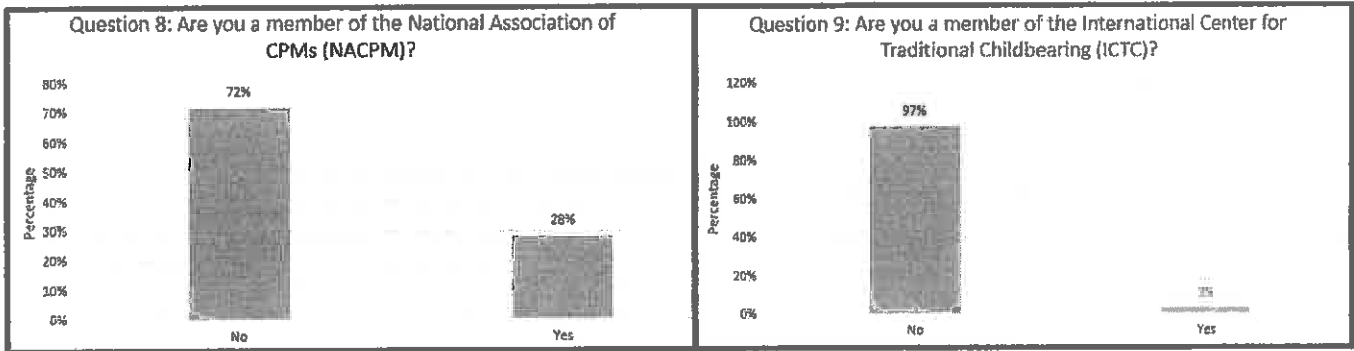
Among the 174 respondents who practiced in states without licensure, 33% had licensure or legal recognition in another state (Question 5).

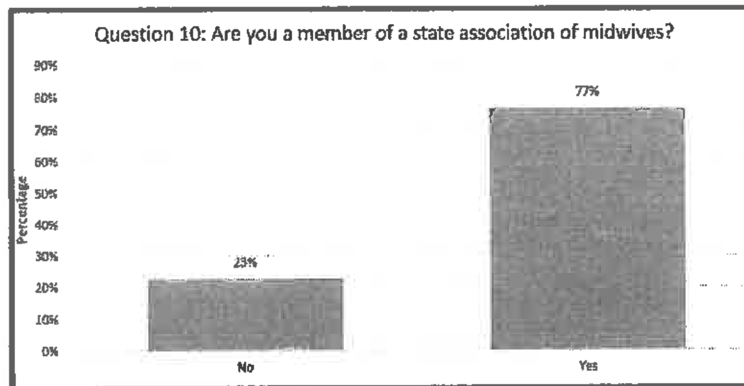


Group Membership

Among respondents, 42% were members of the Midwives Alliance of North America (Question 6) and only 3% were members of the American College of Nurse-Midwives (Question 7). Twenty eight (28) percent of respondents were members of the National Association of CPMs (Question 8) and 3% were members of the International Center for Traditional Childbearing (Question 9). Regardless of national group membership, most respondents (77%) were part of a state association of midwives (Question 10).

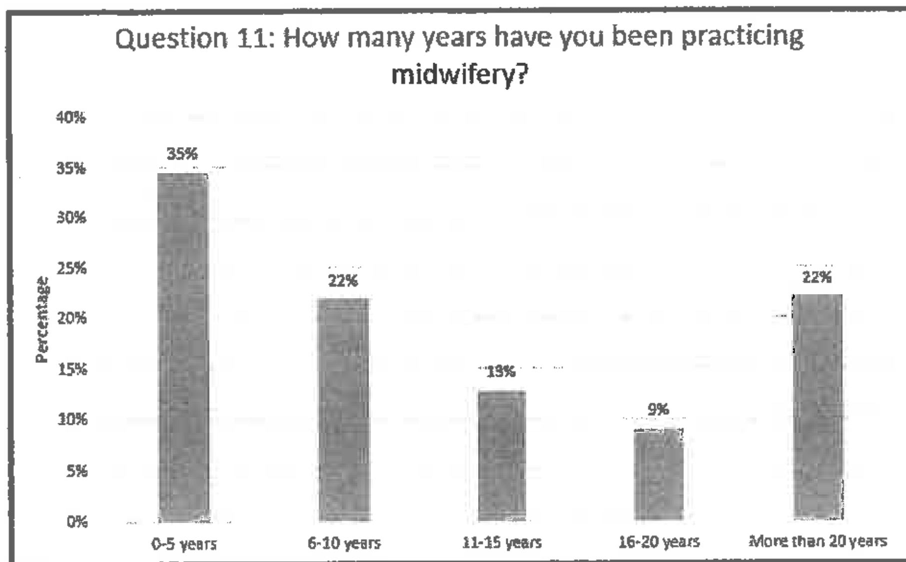






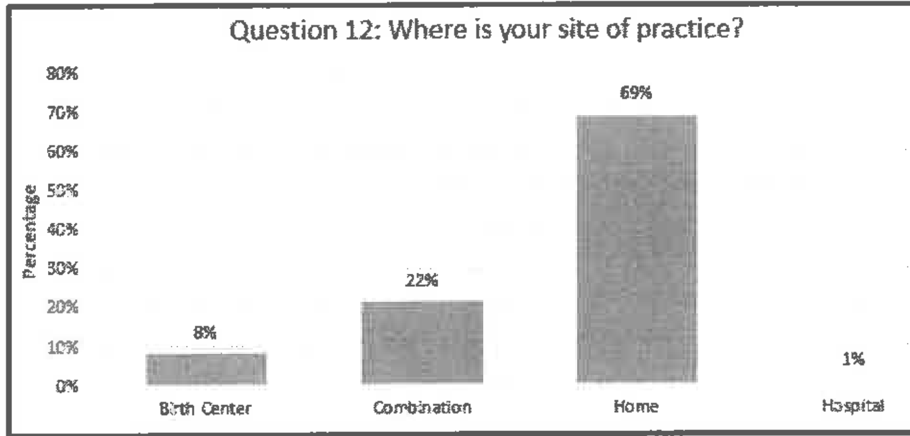
Length of Practice

Thirty five percent (35%) of the respondents had been practicing for 5 years or less, while 22% had been practicing for more than 20 years (Question 11).



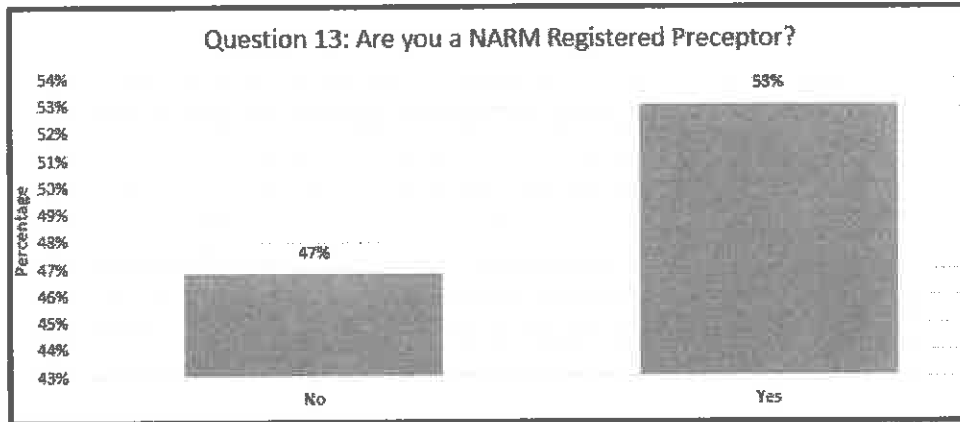
Work Setting

Most respondents (69%) practiced exclusively out of their home, while 8% practiced at a birth center and only 1% practiced exclusively at a hospital, however 22% practiced out of some combination of the three (Question 12).



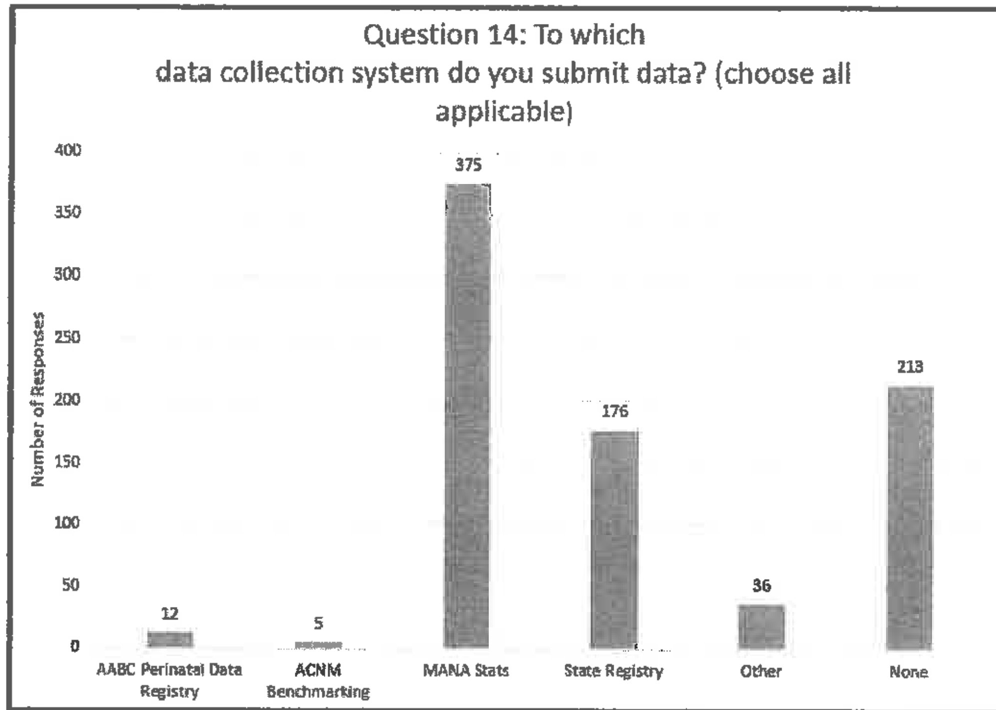
NARM Registration

A slight majority of respondents, 53%, were NARM Registered Preceptors (Question 13).

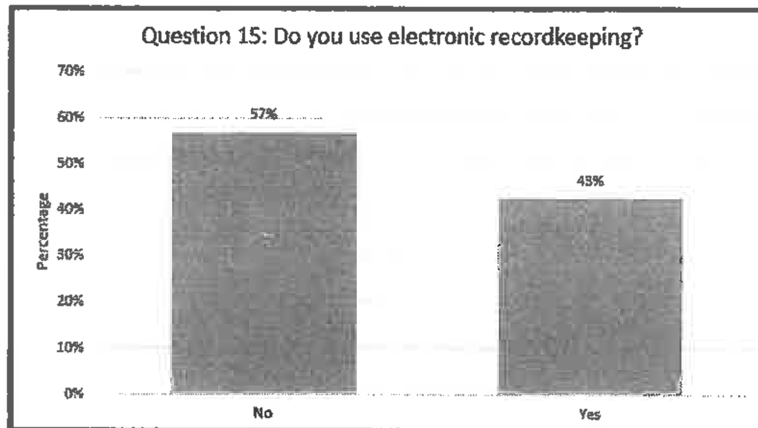


Data Collection and Records

Out of the 706 respondents, 375 regularly submitted data to MANA Stats (approximately 53%) and 176 regularly submitted data to a state registry (approximately 25%), while 213 (approximately 30%) did not submit data to any collection system (Question 14). Many of the respondents submitted data to multiple collection systems.

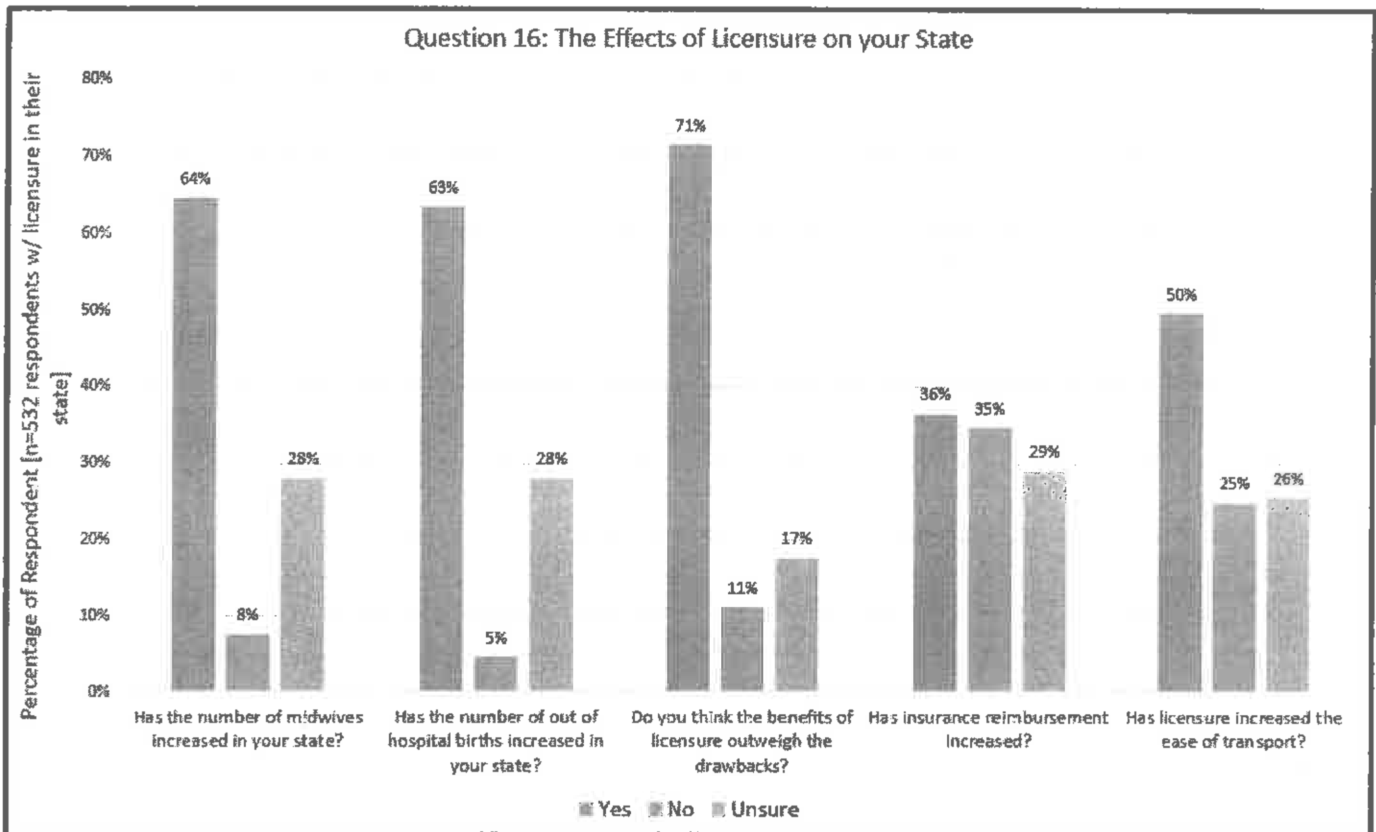


Most respondents (57%) did not keep electronic records (Question 15).



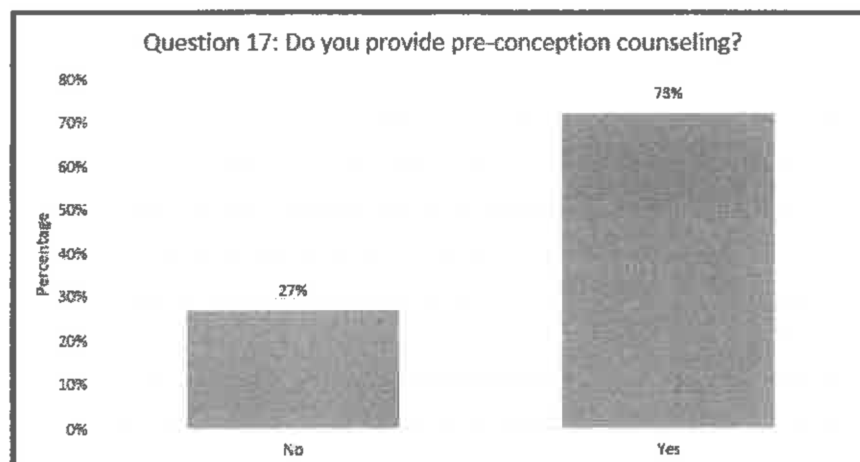
Effects of Licensure

When asked about the effects of licensure, most respondents believed that licensure had a positive effect on their state, with 71% agreeing that "the benefits of licensure outweigh the drawbacks" (Question 16).

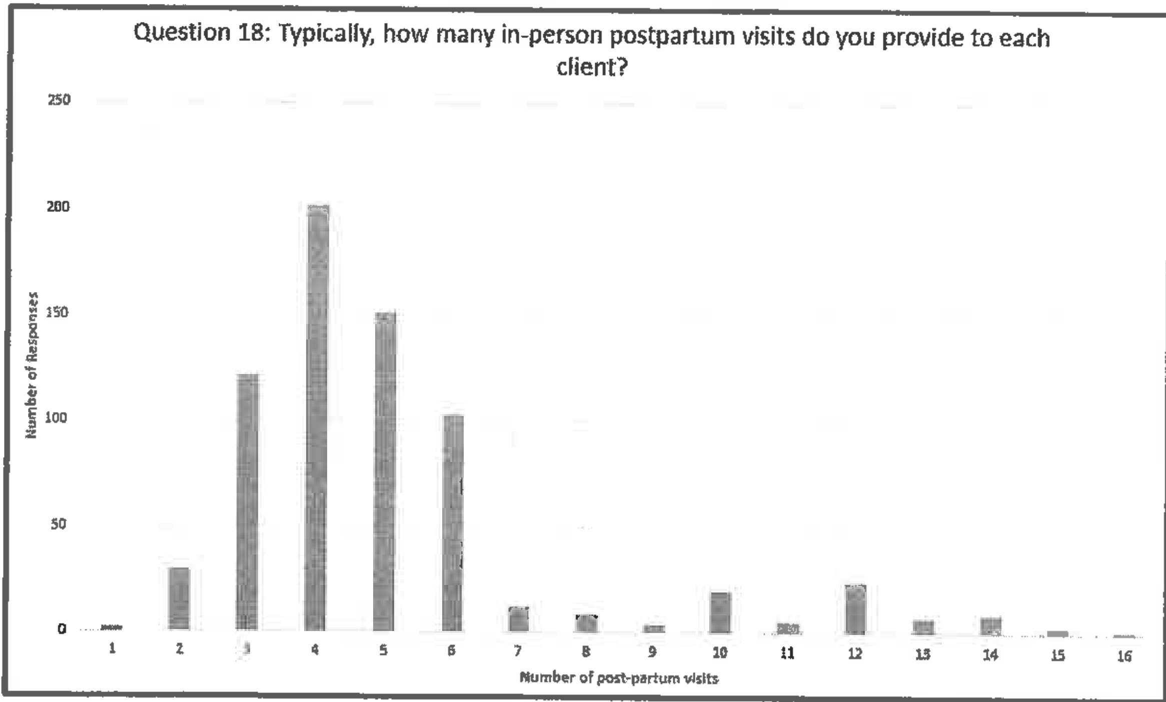


Breadth of Provided Services

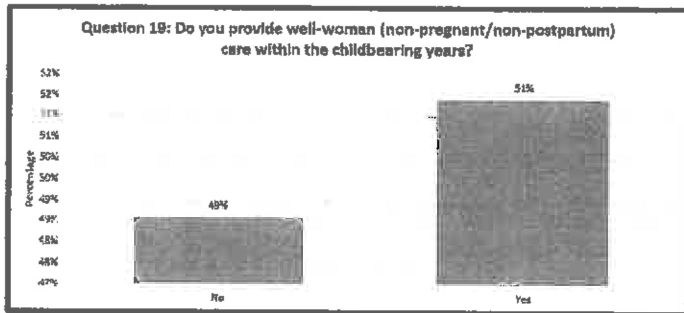
Most (73%) of respondents provided pre-conception counseling to their clients (Question 17).

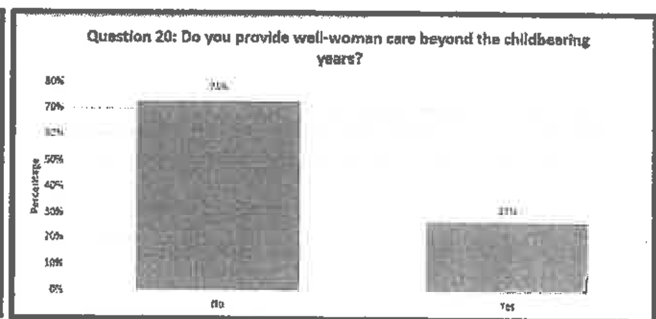


The most common number of post-partum visits that a respondent provided to a client is 4, with most respondents typically providing between 3 and 6 post-partum visits (Question 18).



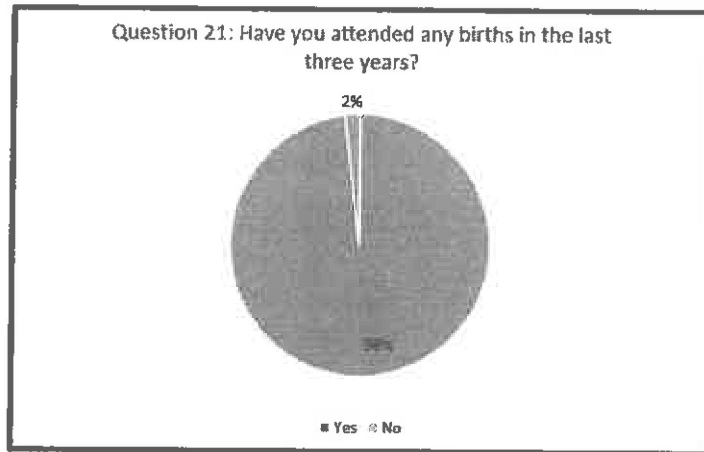
A slight majority (51%) of respondents provided well-woman care within the child-bearing years (Question 19), but most (73%) did not provide well-woman care beyond the child-bearing years (Question 20).





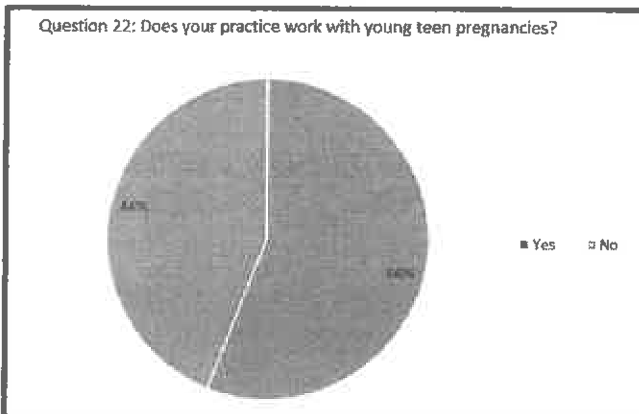
Activity

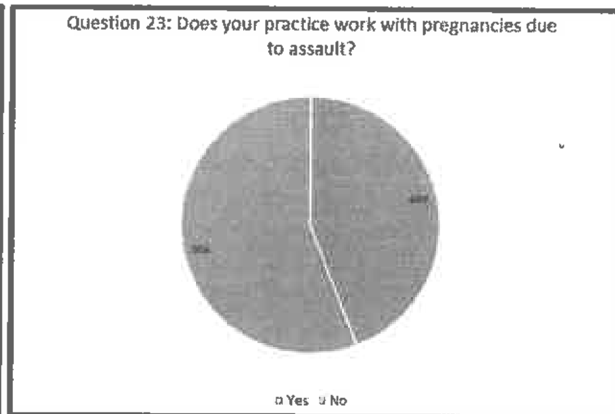
Almost all respondents (98%) had attended a birth in the last three years at the time of the survey (Question 21).



Social Issues

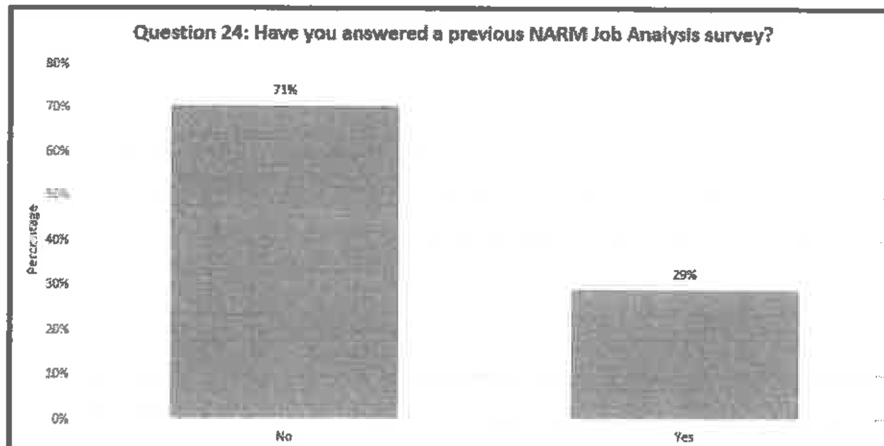
Slightly more than half (56%) of respondents' practices have worked with young teen pregnancies (Question 22), while slightly less than half (44%) of respondent's practices have worked with pregnancies due to assault (Question 23).





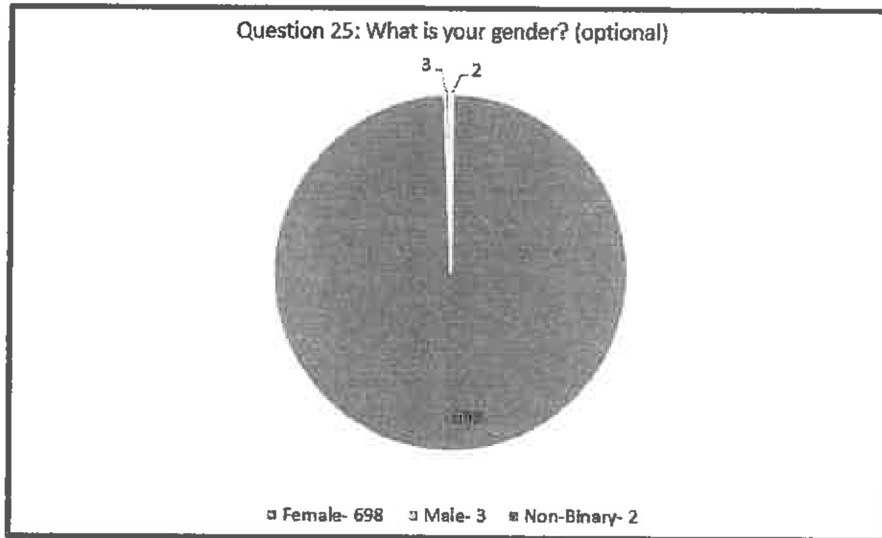
Previous Participation

For most respondents (71%), this was the first NARM Job Analysis survey they had participated in (Question 24).

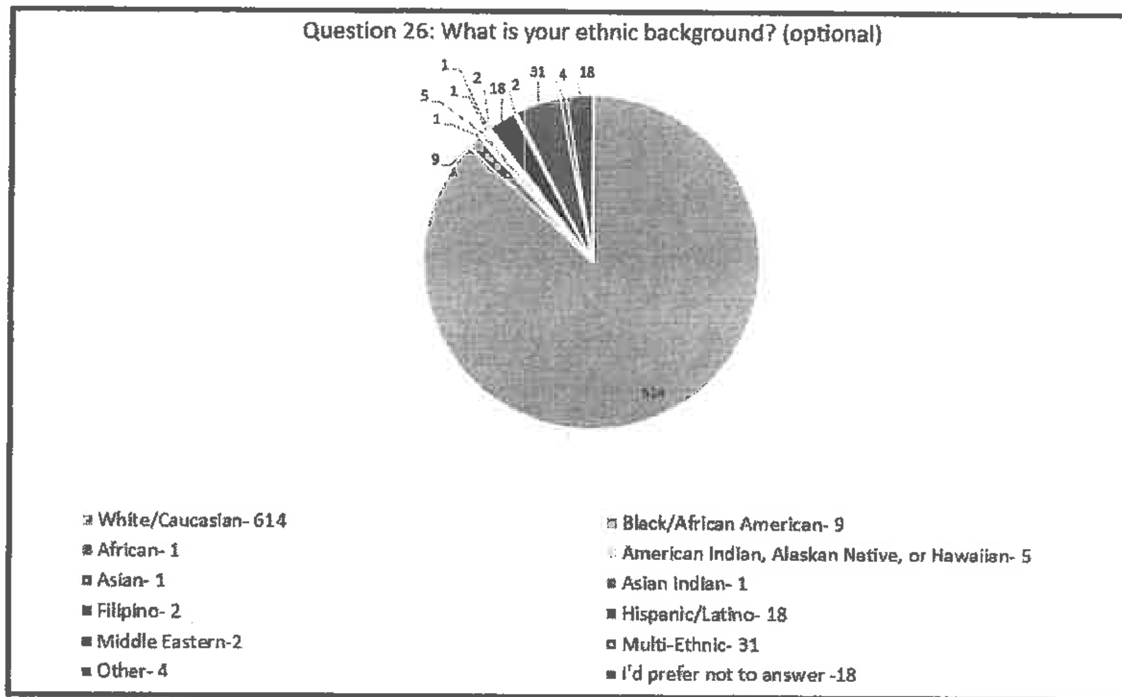


Gender and Ethnicity

Almost all (698 out of 706, nearly 99%) of survey respondents identified themselves as female, while 3 identified themselves as male and 2 identified themselves as non-binary (Question 25).



In addition, 614 of the 706 respondents (approximately 87%) identified themselves as white or Caucasian (Question 26). Of the remaining 13%, 31 respondents identified themselves as multi-ethnic, and 18 respondents identified themselves as Hispanic and/or Latino. This was an optional question, so 18 respondents declined to identify their ethnicity.



Appendix A
Job Analysis Committee Members

Lisa Clark, BS
Huntsville, Alabama

Debbie Pulley, CPM
Lilburn, Georgia

Kelly Jenkins, CPM, LM
Bluemont, Virginia

Karen S. Webster, CPM
Elkton, Maryland

Shanna Mastrangelo, CPM, LM, EMT
Shepherdstown, West Virginia

May Anne Zielinski, CPM
Chantilly, Virginia

Carol Nelson, CPM, LM
Summertown, Tennessee

Elizabeth Reiner, CPM, LM
Myersville, Maryland

Claudia Booker, CPM
Washington, District of Columbia

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Appendix B

Dear ${m://FirstName}:

The North American Registry of Midwives (NARM) in collaboration with the Inteleos Psychometric Services is in the process of updating the contents of the NARM Written Examination through a national job analysis survey among the 1000+ Certified Professional Midwives (CPMs). The job analysis would identify the essential competencies necessary for safe and competent practice of midwifery. The survey was created by the NARM Board of Directors and a group of subject matter experts.
We invite you to participate in the survey. This survey is critically important to the mission of NARM. It helps us to remain sensitive to advances and changes in your profession so the NARM Written Examination remains current and valid. **Please complete the survey by no later than October 9th, 2016.**
We recommend that you use a computer (a desktop or laptop) rather than a smartphone in responding to the survey. To complete the survey, please click the link provided at the end of this email. You will be sent to the survey, which is taken through your internet browser. Please review the instructions on the first page explaining how the survey works before continuing to the survey questions.

If you are interrupted while taking the survey, you may return to complete it at a later time. The survey automatically saves your data every time you advance to a new page. You may return to the survey as many times as you want. If you have questions or problems, please email our vendor at survey@inteleos.org with the subject "NARM Job Analysis Survey." Please include your full name in your correspondence.

Thank you in advance for helping NARM to remain on the cutting edge of your profession.

Follow this link to the Survey:
${l://SurveyLink?d=Take the survey}

Sincerely,
Ida Darragh, LM, CPM
Executive Director
North American Registry of Midwives

Appendix C

NEW Exam Content Outline for the NARM Written Examination recommended by the NARM Job Analysis Committee and approved by the NARM Board of Directors.

Summary of the new exam content outline, as approved by the NARM Job Analysis Committee:

Domain #	Domain Name	# Tasks	% Distribution
1	Professional Issues, Knowledge, and Skills	24	4%
2	General Healthcare Skills	79	10%
3	Maternal Health Assessment	46	7%
4	Prenatal Care	134	23%
5	Labor, Birth and Immediate Postpartum	261	40%
6	Postpartum	60	10%
7	Well-Baby Care (up to six weeks)	46	6%
	Total	650	100%

Detailed new exam content outline, in order of appearance on the survey:

[illegible]
Applies understanding of social determinants of health such as income, literacy, education, sanitation, housing, environmental hazards, food security, and common threats to health in the local community.
Applies understanding of direct and indirect causes of maternal and neonatal mortality and morbidity in the local community.
Understands principles of research, evidence-based practice, critical interpretation of professional literature, and interpretation of vital statistics and research findings.
Provides information on national and local health services such as health and social services, WIC, breastfeeding, substance abuse, mental health, and bereavement.
Educates about resources for health care and social services during civil emergencies.
Educates regarding legal and regulatory framework governing reproductive health for women, including laws, policies, protocols, and professional guidelines.
Applies understanding of human rights and their effects on the health of individuals on situations such as female genital cutting, cultural effect of religious beliefs, gender roles and human sexuality, and domestic partner violence.
Facilitates mother's decision of where to give birth by discussing items such as advantages and risks of different birth sites, requirements of the birth site, and how to prepare and equip the birth site.
Provides interactive support and counseling and/or referral for the possibility of less-than-optimal pregnancy and birth outcomes.
Is responsible and accountable for clinical decisions and actions.
Acts in accordance with professional ethics, values, and human rights.
Acts consistently in accordance with standards of practice.
Maintains/updates knowledge and skills.
Behaves in a courteous, non-judgmental, non-discriminatory, and culturally appropriate manner with all clients.
Is respectful of individuals and of their culture and customs.
Maintains confidentiality of all information shared by the client and communicates essential information to other healthcare providers or family members only with permission and with compelling need including:
protected Health Information (PHI) and personal information
records retention issues such as storage, disposal, accessibility
responsible use of social media
privacy and security of financial information

[illegible]
Applies shared decision making with clients and supports them in making decisions including need for referral or transfer of care.
Shares and explains protocols of practice including regulatory requirements and client's right to refuse testing or intervention.
Uses appropriate communication and listening skills with clients and support team.
/ Accurately and completely records all relevant information in the client's chart and explains results to client.
Is able to comply with all local requirements for reporting births and deaths.
[illegible]
Demonstrates the application of the following Universal Precautions: , and disposal of medical waste.
handwashing, gloving and ungloving, sterile technique
cleaning and sterilizing instruments, work surfaces, and equipment
cleaning and/or disposing of medical waste
Educates on the benefits and contraindications of alternative healthcare practices such as herbs, hydrotherapy, chiropractic, homeopathic, and acupuncture.
Understands the benefits and risks and recommends the appropriate use of vitamin and mineral supplements such as prenatal multi-vitamins, Vitamin C, Vitamin E, Folate, B-complex, B-6, B-12, iron, calcium, magnesium, probiotics, and Vitamin D.
Demonstrates knowledge of the benefits and risks and appropriate administration of the following pharmacological (prescriptive) agents:
local anesthetic for suturing
medical oxygen
Methergine® (methylergonovine maleate)
prescriptive ophthalmic ointment
Pitocin® for postpartum hemorrhage
RhoGam®
vitamin K (oral or IM)
antibiotics for Group B Strep
IV fluids
Cytotec (misoprostol)
epinephrine
Demonstrates knowledge of benefits/risks of ultrasounds for indications such as pregnancy dating, anatomy scan, AFI, fetal wellbeing and growth, position, placental position, and determination of multiples.
Demonstrates knowledge of benefits/risks of biophysical profile including counseling and referral.
Demonstrates knowledge of how and when to use instruments and equipment, including:
Amnihook® or Amnicot®
bag and mask resuscitator
bulb syringe
Delee® tube-mouth suction device
hemostats
lancets
nitrazine paper
scissors (all kinds)
suturing equipment
Straight, in and out catheter
vacutainer /blood collection tube
gestational wheel or calendar
newborn and adult scale
thermometer
urinalysis strips

[illegible]
cord clamps
doppler
fetoscope
stethoscope
gaginal speculum
blood pressure cuff
oxygen tank, flow meter, cannula, and face mask
pulse oximeter
laryngeal mask airway (LMA)
Demonstrate proper use of injection equipment including syringe, single and multi-dose vial/ampules, and sharps container.
Obtains or refers for urine culture.
Obtains or refers for vaginal culture
Obtains or refers for blood screening tests.
Evaluates laboratory and medical records with appropriate education and counseling of client including:
hematocrit/hemoglobin
blood sugar (glucose)
HIV
Hepatitis B
Hepatitis C
Rubella
Syphilis (VDRL or RPR)
Group B Strep
gonorrhea culture
Complete Blood Count
bBlood type and Rh factor
Rh antibodies
chlamydia
PAP test
vitamin D
thyroid panel
HbA1C
benetic screening
blood albumin
complete metabolic panel
progesterone
HCG
[illegible]
Obtain and maintain records of health, reproductive and family medical history, and possible implications to current pregnancy, including:
personal information/demographics
personal history including religion, occupation, education, marital status, economic status
personal history including changes in health or behavior, and client's evaluation of their health and nutrition
Increased risk for less-than-optimal outcomes due to allostatic stress from racism and resource scarcity.
potential exposure to environmental toxins

- medical conditions
- surgical history
- reproductive history, including
  - menstrual history
  - gynecologic history
  - sexual history
  - childbearing history
  - contraceptive practice
  - history of sexually transmitted infections
  - History of behavioral risk factors for sexually transmitted infections
  - history of risk of exposure to blood borne pathogens
  - Rh type and plan of care if negative
- family medical history
- psychosocial history
- history of abuse
- mental health
- mother's medical history:
  - genetics
  - alcohol use
  - drug use
  - tobacco use
  - allergies (environmental and medical)
  - history of vasovagal response or fainting
  - Foreign travel history
  - Vaccination history/status
- biologic father's medical history:
  - genetics
  - alcohol use
  - drug use
  - tobacco use

Perform a physical examination, including assessment of:

- general appearance/skin condition
- baseline weight and height
- vital signs
- HEENT (Head, Eyes, Ears, Nose, and Throat), including
  - thyroid by palpation
- lymph glands of neck, chest, and under arms
- breasts
  - Evaluates mother's knowledge of self-breast examination techniques, and instructs if needed.
- torso, extremities for bruising, abrasions, moles, and unusual growths
- baseline reflexes
- heart and lungs
- abdomen by palpation and observation for scars

C00024

[illegible]
kidney pain (CVAT)
deep tendon reflexes of the knee
condition of the vulva, vagina, cervix, perineum, and anus
vascular system (edema, varicosities, thrombophlebitis)
[illegible]
Provides appropriate prenatal care and educates the family of significance.
Understands and educates about the anatomy and physiology of pregnancy and birth.
Provide education for parents in providing preparation for siblings at birth and adjustment to the new baby.
Understands normal and abnormal changes during pregnancy.
Assess results of routine prenatal exams including ongoing assessment of:
maternal psycho-social and emotional health and well-being; signs of abuse
social support system
vaginal discharge including signs and symptoms of infection
maternal health by tracking variations and changes in:
blood pressure
weight
color of mucus membranes
general reflexes
elimination/urination patterns
sleep patterns
energy levels
nutritional patterns, pica
hemoglobin/hematocrit
glucose levels
breast conditions/implications for breastfeeding
Assess urine for:
appearance: color, density, odor, and clarity
protein
glucose
ketones
Ph
leukocytes
nitrites
blood
specific gravity
Estimates due date based on standard methods.
Assessment of fetal growth and wellbeing including:
fetal heart rate/tones auscultated with feta scope or Doppler
correlation of weeks gestation to fundal height
fetal activity and responsiveness to stimulation
Fetal palpation for:
fetal weight
fetal size

fetal lie
degree of fetal head flexion
clonus
vital signs
respiratory assessment
edema
Provides prenatal education, counseling, and recommendations for:
nutritional and non-allopathic dietary supplement support
normal body changes in pregnancy
exercise and movement
weight gain in pregnancy
common complaints of pregnancy:
sleep difficulties
nausea/vomiting
fatigue
inflammation of sciatic nerve
breast tenderness
skin itchiness
vaginal yeast infection
bacterial vaginosis
symptoms of anemia
indigestion/heartburn
constipation
hemorrhoids
carpal tunnel syndrome
round ligament pain
headache
leg cramps
backache
varicose veins
sexual changes
emotional changes
fluid retention/swelling, edema
vision changes
Recognizes and responds to potential prenatal complications/variations by identifying, assessing, recommending treatment, or referring for:
antepartum bleeding (first, second, or third trimester)
pregnancy inducted hypertension
preeclampsia
gestational diabetes
urinary tract infection
fetus small for gestational age
fetus large for gestational age
intrauterine growth retardation

- thrombophlebitis
- oligohydramnios
- polyhydramnios
- breech presentation
  - identifying breech presentation
  - turning breech presentation with
    - alternative positions (tilt board, exercises, etc.)
    - referral for external version
    - non-allopathic methods (moxibustion, homeopathic)
  - management strategies for unexpected breech delivery
- multiple gestation
  - identifying multiple gestation
  - management strategies for unexpected multiple births
- occupit posterior position
  - identification
  - prevention
  - techniques to encourage rotation
- vaginal birth after cesarean (VBAC)
  - identifying previous cesarean through history and physical examination
  - indications/contraindications for out of hospital births
  - Identify risk factors for uterine rupture such as type of uterine suturing method, uterine incision (classical or low transverse), uterine scar thickness, interdelivery interval, number of previous cesareans, previous vaginal births, and implantation site of the placenta.
  - management strategies for VBAC
- Recognizes signs and symptoms of uterine rupture and knows emergency treatment.
- Preventing Pre-Term Birth:
  - Risk Assessment for pre-term birth:
    - smoking
    - vaginal infections; urinary tract infection
    - periodontal health
    - prior pre-term birth
    - Review other factors that may contribute to pre-term birth such as stress and emotional health.
  - Educate and counsel a mother who requests early induction of labor.
  - Educate for signs of pre-term labor.
- Identify and respond to pre-term labor with:
  - referral
  - consults for pre-term labor
  - treat pre-term labor with standard measures
- Assess and evaluate a post-date pregnancy by monitoring/assessing:
  - fetal movement, growth, and heart tone variability
  - estimated due date calculations
  - previous birth patterns
  - amniotic fluid volume
  - maternal tracking of fetal movement
  - Consult or refer for:

[illegible]
ultrasound
hon-stress test
biophysical profile
Standard measures for treating a post-date pregnancy
Cholestasis
Conditions from previous pregnancies, such as diastasis, prolapse, cyctocele, rectocele
Identifying and referring for:
tubal, molar, or ectopic pregnancy
placental abruption
placenta previa
Identifying premature rupture of membranes.
Managing premature rupture of membranes in a FULL-TERM pregnancy:
monitor fetal heart tones and movement
minimize internal vaginal examinations
reinforce appropriate hygiene techniques
monitor vital signs for infection
encourage increased fluid intake
support nutritional/non-allopathic treatment
stimulate labor
consult for prolonged rupture of membranes
review Group B.Strep status and inform of options
Consult and refer for premature rupture of membranes in a PRE-TERM pregnancy.
Establishes and follows emergency contingency plans for mother/baby.
Educates on options for hospital transport including augmentation, pharmacological pain relief, and/or instrument assisted delivery.
Cesarean birth:
knows local options for cesarean birth
educates on procedures for cesarean birth
provides support before, during, and after (as permitted) the cesarean process
follow-up for cesarean birth including:
physical healing
emotional healing
breastfeeding and infant care challenges after cesarean birth
[illegible]
Understands and supports the normal physiological process of labor and birth.
Understands the relationship of maternal and fetal anatomy in relation to labor and birth.
Facilitates maternal relaxation and provides comfort measures throughout labor.
Communicates in a calming voice, using kind and encouraging words.
Applies knowledge of emotional and psychological aspects of labor to provide support.
Applies knowledge of physical support in labor such as counter pressure, position changes, massage, and water.
Waterbirth:
educates on benefits and risks
equipping the birth site for a water birth
Discuss specific management of complications during waterbirth

[illegible]

- **Recognizes and counsels on signs of early labor and appropriate activities.**
- Assesses maternal and infant status based on:
  - vital signs
  - food and fluid intake
  - status of membranes
  - uterine contractions such as frequency, duration, and intensity
  - fetal heart tones
  - fetal lie, presentation, position, and descent
  - cervical effacement and dilation
- Assesses and supports normal progress of labor.
- Recognizes and responds appropriately to conditions that slow or stall labor such as:
  - anterior/swollen lip
  - posterior or asynclitic fetal position
  - pendulous belly inhibiting descent
  - maternal exhaustion
  - maternal fears and emotions
  - abnormal labor patterns
  - deep transverse arrest
  - obstructed labor
- Advises on non-allopathic remedies for slow or stalled labor such as nipple stimulation, herbs, positions, and movement.
- Recognizes, prevents, or treats maternal dehydration.
- Recognizes and responds to labor and birth complications such as:
  - abnormal fetal heart tones and patterns
  - cord prolapse
  - Recognizes and responds to variations in presentations such as:
    - breech
      - Understands mechanism of descent and rotation for complete, frank, or footling breech presentation.
      - cord management strategies specific to breech deliveries
      - techniques for release of nuchal arms with breech
      - Practice techniques for maintaining head flexion
    - nuchal hand/arm
      - apply counter pressure to hand or arm and perineum
      - sweep arm out
    - nuchal cord
      - loop finger under cord, sliding over heard or shoulder
      - clamp and cut cord
      - press baby's head into perineum and somersault the baby out
      - prepare for possible resuscitation
    - face and brow
      - mechanism of delivery for face or brow presentation
      - determine position of chin
      - management strategies for face or brow presentation
      - prepare for resuscitation or treatment of bruising/swelling/eye injury

    - multiple birth and delivery
      - identifies multiple gestation
      - consults or transports according to plan
      - prepares for attention to more than one
    - shoulder dystocia
      - apply gentle traction while encouraging pushing
      - reposition the mother to:
        - hands and knees (Gaskin maneuver)
        - exaggerated lithotomy (McRobert's position)
        - end of bed
        - squat
      - reposition shoulders to oblique diameter
      - Shift pelvic angle with lunge or runner's pose
      - extract posterior arm
      - flex shoulders of newborn, then corkscrew
      - apply supra-pubic pressure
      - sweep arm across newborn's face
      - fracture baby's clavicle
    - indications for performing an episiotomy
  - management of meconium stained fluids:
    - recognize and assess degree of meconium
    - follow standard resuscitation procedures for meconium
  - management of maternal exhaustion:
    - hydration and nutrition
    - rest/bath/removal of distractions
    - monitor maternal and fetal vital signs including urine ketones
    - evaluate for consultation or referral
  - Recognize/consult/transport for signs of:
    - uterine rupture
    - uterine inversion
    - amniotic fluid embolism
    - stillbirth
- Evaluate and support during second stage:
  - recognizes and assess progress in second stage
  - supports maternal instincts in pushing techniques and positions
  - recommends/suggests pushing techniques and positions when needed
  - monitors vital signs; understands normal and abnormal changes
  - facilitates supportive environment and family involvement
  - prepares necessary equipment for immediate access
  - uses appropriate hand techniques for perineal support and birth of baby
- Assess condition and provide immediate care of newborn.
  - Understands, recognizes, and supports normal newborn adjustment at birth.
    - Keep mother and baby warm and together for initial assessment.

000030

Determine APGAR score at one minute, five minutes, and if needed, at ten minutes.
Monitor respiratory and cardiac function by assessing:
symmetry of chest
sound and rate of heart tones and respirations
nasal flaring
grunting
chest retractions
circumoral cyanosis
central cyanosis
Stimulate newborn respiration according to AAP/NRP recommendations.
Encourage parental touch and speech while keeping baby warm.
Respond to need for newborn resuscitation according to AAP/NRP recommendations.
Recognize and consult or transport for apparent birth defects.
Recognizes signs and symptoms of Meconium Aspiration Syndrome and consults or transports.
Provides appropriate care of the umbilical cord.
Clamps and cuts cord after pulsing stops.
Evaluates the cord, including number of vessels.
Collects cord blood sample if needed.
Assesses gestational age.
Assesses for central nervous system disorder.
Recognizes and responds to normal third stage including physiological and active management strategies.
Determines signs of placental separation such as:
separation gush
contractions
lengthening of cord
urge to push
rise in fundus
Facilitates delivery of the placenta by:
breast feeding/nipple stimulation
changing maternal position
perform guarded cord traction
emptying the bladder
administering non-allopathic treatments
encouraging maternal awareness
manual removal
transport for removal
Assess condition of placenta and membranes, and recognize normal and abnormal characteristics.
Estimate and monitor ongoing blood loss.
Responds to a trickle bleed by:
assess origin
assess fundal height and uterine size
fundal massage
assess vital signs

[illegible]
empty bladder
breastfeeding or nipple stimulation
express clots
non-allopathic treatments
Responds to postpartum hemorrhage with:
fundal massage
external bimanual compression
internal bimanual compression
manual removal of clots
administer medications
non-allopathic treatments
increasing maternal focus and participation
administer or refer for IV fluids
consult and/or transfer; activate emergency back up plan
treat for hypovolemic shock according to standard recommendations or protocols
perform external aortic compression
Assess general condition of mother:
Assess for bladder distension:
encourage urination
perform catheterization if needed
Assess condition of vagina, cervix, and perineum for:
cystocele
rectocele
hematoma
hemorrhoids
bruising
prolapsed cervix or uterus
tears, lacerations
assess blood color and volume; identify source
apply direct pressure on tear
clamp vessel; if identified
suture 1st or 2nd degree or labial tears
administer local anesthetic
performs suturing according to standard procedures and protocols
provides alternative repair methods (non-suturing)
Provides instructions on care and treatment of perineum.
Monitors maternal vital signs after birth.
Promote timely food and drink
Facilitates breastfeeding by assisting and teaching about:
colostrum
positions for mother and baby
skin to skin contact
latching on

C00032

maternal hydration and nutrition
maternal rest
feeding patterns
maternal comfort measures for engorgement
letdown reflex
milk expression
normal newborn urine and stool output
Perform a newborn exam by assessing for normal and abnormal.
The head for:
sze/circumference
molding
hematoma
caput
suture lines
fontanels
The eyes for:
jaundice
pupil condition
tracking
spacing
clarity
hemorrhage
discharge
red eye reflex
The ears for:
positioning
response to sound
patency
cartilage
The mouth for:
appearance and feel of palate
lip and mouth color
tongue
lip cleft
signs of dehydration
tongue and lip tie
The nose for:
patency
flaring nostrils
The neck for:
enlarged glands, thyroid, and lymph
trachea placement
soft tissue swelling

[illegible]
unusual range of motion
The clavicle for:
integrity
symmetry
The chest for:
symmetry
nipples
breast enlargement or discharge
measurement (chest circumference)
heart sounds (rate and irregularities)
ascultate the lungs, front and back, for:
breath sounds
equal bilateral expansion
The abdomen for:
enlarged organs
masses
hernias
bowel sounds
rigidity
The groin for:
femoral pulses
swollen glands
The genitalia for:
appearance
position of urethral opening
testicles for:
descent
rugae
herniation
The labia for:
patency
maturity of clitoris and labia
The rectum for:
patency
meconium
Abduct hips for dislocation.
The legs for:
symmetry of creases in the back of legs
equal length
foot/ankle abnormality
The feet for:
abnormalities
digits: number, webbing

[illegible]
creases
The arms for symmetry in:
structure
movement
The hands for:
digits: number, webbing
palm creases
length of nails
The backside of the baby for:
temperature
symmetry of hips, range of motion
condition of the spine:
dimpling
holes
straightness
flexion of extremities and muscle tone
reflexes:
sucking
moro
babinski
plantar/palmar
stepping
grasping
rooting
blinking
Skin condition for:
color
lesions
birthmarks
milia
vernix
lanugo
peeling
rashes
bruising
mongolian spots
length of baby
weight of baby
Perform a newborn exam by assessing for normal and abnormal characteristics
Assess for central nervous system disorder
Assess gestational age of the baby
Administer eye prophylaxis with informed consent of parents
Administer Vitamin K with informed consent of parents

000035

Review Group B Strep status and signs or symptoms.
Do you use a pulse oximeter for:
maternal assessment
newborn assessment
Assess gestational age of the baby.
Administer eye prophylaxis with informed consent of parents.
Administer Vitamin K with informed consent of parents.
Review Group B Strep status and signs or symptoms.
[illegible]
Physical and emotional changes following childbirth, including normal process of involution.
Assesses and evaluates normal or abnormal conditions of mother and baby at:
day one to day two
day three to day four
one to two weeks
three to four weeks
five to six weeks
Assesses and provides counseling and education for:
postpartum subjective history
lochia vs. abnormal bleeding
return of menses
vital signs, digestion, elimination patterns
muscle prolapse of vagina and rectum (cystocele, rectocele)
condition and strength of pelvic floor
condition of uterus (size and involution), ovaries, and cervix
condition of vulva, vagina, perineum, and anus
facilitates psycho-social adjustment
Screens, recognizes, and responds to mild postpartum depression.
Counsels for appropriate support from family and friends.
Increases home or phone visits as needed.
Screens, recognizes, and responds to increased severity of postpartum depression or psychosis; initiates emergency intervention.
Counsels client and family on resources for depression; increases follow-up.
Knows signs and symptoms, differential diagnosis, and appropriate midwifery management or referral for:
uterine infection
urinary tract infection
infection of vaginal tear or incision
last postpartum bleeding/hemorrhage
thrombophlebitis
separation of abdominal muscles
separation of symphysis pubis
postpartum preeclampsia
Consult or refer for jaundice in the first 24 hours after birth.
Provide direction for care of circumcised penis.
Provide direction for care of intact (uncircumcised) penis.

[illegible]
Provide breastfeeding care and counseling.
Educates regarding adverse factors affecting breastfeeding or breastmilk including:
environmental
biological
occupational
pharmacological
Evaluating conditions of breasts and nipples including:
Treat sore nipples
Evaluate baby's sucking method, position of lips and tongue including:
exposure to air
alternate nursing positions
apply topical agents
apply expressed breastmilk
Flange of lips
Latch on
Tongue tie
Sucking
Swallowing
Treat thrush on nipples by:
dry nipples after nursing
non-allopathic remedies
allopathic treatments
Treat mastitis by:
providing immune support including:
nutrition/hydration
non-allopathic remedies
encourage multiple nursing positions
apply herbal/non-allopathic compresses
apply warmth, soaking in tub or by shower
encourage adequate rest/relaxation
assess for signs and symptoms of infection
teach mother to empty breasts at each feeding
provide or teach gentle massage of sore spots
Consult or refer to breastfeeding support groups, lactation counselor, or other healthcare providers.
Provides contraceptive and family planning education, counseling, and referrals.
Provides opportunity for verbal and written feedback from client.

[illegible]
Instructs the family on newborn care including:
principles of newborn adaptation to extrauterine life including physiologic changes in pulmonary and cardiac systems
basic needs of newborn including breathing, warmth, nutrition, and bonding
normal/abnormal newborn activity, responses, vital signs, appearance, and behavior
normal growth and development of the newborn and infant
Assess the current health and appearance of baby including:

- temperature
- heart rate, rhythm, and regularity
- respirations
- appropriate weight gain
- length
- measurement of circumference of head
- neuro-muscular response
- level of alertness
- wake/sleep cycles
- feeding patterns
- urination and stool for frequency, quality, and color
- appearance of skin
- condition of cord

Understands, respects, and counsels on traditional or cultural practices related to the newborn.

Advises mother in care of:

- diaper rash
- cradle cap
- heat rash
- colic
- cord care

Recognizes signs/symptoms and differential diagnosis of:

- infections
- cardio-respiratory abnormalities
- glucose disorders
- birth defects
- failure to thrive
- newborn hemorrhagic disease (early and late onset)
- polycythemia
- non-accidental injuries
- dehydration

Evaluate, counsel, and monitor for physiological jaundice after 24 hours:

- Encourage mother to breastfeed every two hours.
- Expose front and back of newborn to sunlight through window glass.
- Assess and monitor newborn lethargy and hydration.
- Consult or refer for additional screening and/or treatment.

Provide information for referral for continued well-baby care.

- Educate about options for pediatrician or family practitioner.
- Educate about health care providers for immunizations or non-immunizations.
- Perform or refer for newborn metabolic screening.
- Perform or refer for newborn hearing screening.
- Perform or refer for pulse oximetry newborn screening for critical congenital heart disease (CCHD).
- Educate about referral for integrative/complimentary/alternative practitioners

Support and educate parents during grieving process for loss of pregnancy, stillbirth, congenital birth defects, or neonatal death.

Support and educate parents of newborns transferred to hospital or with special needs.

Support integration of baby into family.

000038

Appendix D

Below are the 20 tasks considered not critical by survey respondents and removed from the task list by the Job Analysis Committee, in the order of appearance on the survey:

[illegible]
Maintain/update knowledge of state requirements regarding mandatory reporting (STI's, infectious disease, child abuse)
Performs and understands administrative and business functions such as third party billing, OSHA/Workplace safety and insurance, employer responsibilities, business entity formation, and tax filing.
[illegible]
Demonstrates knowledge of how and when to use instruments and equipment, including:
Indwelling catheter
[illegible]
Obtain and maintain records of health, reproductive and family medical history, and possible implications to current pregnancy, including:
Provides care to families who have conceived through assisted reproductive technologies (ART) such as in vitro fertilization, assisted insemination, donor egg, and donor sperm.
Provides care for a client who plans to relinquish their baby for adoption or who carries a surrogate pregnancy.
Perform a physical examination, including assessment of:
HEENT (Head, Eyes, Ears, Nose, and Throat), including:
eyes, pupils, whites, and conjunctiva
mouth, teeth, mucus membrane, and tongue
hair and scalp
breasts:
Performs breast examination.
musco-skeletal system including spine straightness and symmetry and posture
cervix by speculum exam
size of uterus and ovaries by bimanual exam
internal pelvic landmarks
[illegible]
Referral for those at risk for pre-term birth for:
ultrasound for cervical length
Fetal fibronectin (fFN) test
cerclage
hormonal testing
Methylene Tetrahydrofolate Reductase (MTHFR) testing
[illegible]
Perform a newborn exam by assessing for normal and abnormal.
The hands for:
finger taper
[illegible]
Recognizes signs/symptoms and differential diagnosis of:
congenital syphilis

Appendix E

The complete task list after committee review, ordered by domain and criticality, highest to lowest.

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
Professional Issues, Knowledge, and Skills	4.27	4.20	12.05		
1_11 - Act in accordance with professional ethics, values, and human rights.	4.94	4.80	15.15	+	Yes
1_10 - Take responsibility and accountability for clinical decisions and actions.	4.87	4.75	14.88	+	Yes
1_15 - Behave in a courteous, non-judgmental, non-discriminatory, and culturally a...	4.92	4.70	14.73	+	Yes
1+_1 - Apply shared decision making with clients and support them in making decisi...	4.77	4.69	14.54	+	Yes
1_16 - Stay respectful of individuals and of their culture and customs.	4.86	4.66	14.51	+	Yes
1+_3 - Use appropriate communication and listening skills with clients and support...	4.87	4.65	14.49	+	Yes
1_13 - Maintain/update knowledge and skills.	4.64	4.64	14.19	+	Yes
1+_2 - Share and explain protocols of practice including regulatory requirements a...	4.77	4.54	13.89	+	Yes
1+_4 - Accurately and completely record all relevant information in the client's c...	4.76	4.52	13.84	+	Yes
1_12 - Act consistently in accordance with standards of practice.	4.77	4.43	13.51	+	Yes
1P_1 - Protected Health Information (PHI) and personal information.	4.80	4.38	13.29	+	Yes
1+_5 - Comply with all local requirements for reporting births and deaths.	4.83	4.32	13.07	+	Yes
1P_4 - Privacy and security of financial information.	4.73	4.33	13.03	+	Yes
1_8 - Facilitate mother's decision of where to give birth by discussing items suc...	4.63	4.33	12.97	+	Yes
1_3 - Understand principles of research, evidence-based practice, critical interp...	4.33	4.17	12.02	+	Yes
1P_3 - Responsible use of social media.	4.39	4.20	11.90	+	Yes
1_9 - Provide interactive support and counseling and/or referral for the possibil...	3.54	4.31	11.74	+	Yes
1P_2 - Records retention issues such as storage, disposal, accessibility.	4.44	4.06	11.64	+	Yes
1_1 - Apply understanding of social determinants of health such as income, litera...	4.06	3.91	10.72	+	Yes
1_2 - Apply understanding of direct and indirect causes of maternal and neonatal...	3.76	3.92	10.42	+	Yes
1_4 - Provide information on national and local health services such as health an...	3.70	3.87	10.18	+	Yes
1_14 - Maintain/update knowledge of state requirements regarding mandatory reporti...	3.6	3.7	9.5	±	No
1_7 - Apply understanding of human rights and their effects on the health of indi...	3.3	3.8	9.4	±	Yes
1+_6 - Perform and understand administrative and business functions such as third...	3.7	3.6	9.0	±	No
1_6 - Educate regarding legal and regulatory framework governing reproductive hea...	3.2	3.2	7.2	±	Yes
1_5 - Educate about resources for health care and social services during civil em...	1.92	2.78	3.58		Yes
Healthcare Skills	3.58	3.86	9.84		
2A_2 - Cleaning and sterilizing instruments, work surfaces, and equipment	4.86	4.80	15.03	+	Yes
2A_1 - Handwashing, gloving and ungloving, sterile technique	4.89	4.73	14.80	+	Yes
2G_21 - Blood pressure cuff	4.95	4.69	14.69	+	Yes
2K_10 - Blood type and Rh factor	4.85	4.68	14.50	+	Yes
Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
2G_19 - Stethoscope	4.87	4.57	14.13	+	Yes

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2G_17 - Doppler	4.79	4.55	13.99	+	Yes
2K_1 - Hematocrit/hemoglobin	4.82	4.50	13.82	+	Yes
2K_11 - Rh antibodies	4.57	4.59	13.80	+	Yes
2A_3 - Cleaning and/or disposing of medical waste	4.68	4.46	13.51	+	Yes
2++_3 - Obtain or refer for blood screening tests.	4.53	4.42	13.15	+	Yes
2K_9 - Complete Blood Count	4.70	4.36	13.09	+	Yes
2G_14 - Thermometer	4.63	4.25	12.65	+	Yes
2G_13 - Newborn and adult scale	4.88	4.17	12.57	+	Yes
2++_1 - Demonstrate proper use of injection equipment including syringe, single and...	3.87	4.39	12.32	+	Yes
2G_16 - Cord clamps	4.67	4.15	12.28	+	Yes
2K_6 - Syphilis (VDRL or RPR)	4.45	4.22	12.15	+	Yes
2C_12 - Iron	4.58	4.13	12.12	+	Yes
2K_4 - Hepatitis B	4.38	4.21	12.09	+	Yes
2D_5 - Pitocin® for postpartum hemorrhage	3.21	4.48	11.90	+	Yes
2G_2 - Bag and mask resuscitator	2.43	4.69	11.89	+	Yes
2B_2 - Educate on the benefits and contraindications of alternative healthcare pra...	4.63	4.05	11.82	+	Yes
2G_12 - Gestational wheel or calendar	4.64	4.03	11.76	+	Yes
2K_2 - Blood sugar (glucose)	4.28	4.12	11.72	+	Yes
2G_18 - Fetoscope	4.14	4.14	11.71	+	Yes
2C_7 - Folate	4.45	4.06	11.69	+	Yes
2G_8 - Scissors (all kinds)	4.44	4.06	11.67	+	Yes
2K_3 - HIV	3.80	4.22	11.47	+	Yes
2D_6 - RhoGam®	3.09	4.40	11.33	+	Yes
2K_5 - Rubella	4.48	3.97	11.21	+	Yes
2G_15 - Urinalysis strips	4.54	3.89	11.14	+	Yes
2+_1 - Demonstrate knowledge of benefits/risks of ultrasounds for indications such...	4.32	3.96	11.10	+	Yes
2C_8 - Probiotics	4.49	3.82	10.80	+	Yes
2G_9 - Suturing equipment	3.03	4.23	10.79	+	Yes
2C_2 - Prenatal multivitamins	4.66	3.77	10.79	+	Yes
2K_7 - Group B Strep	4.29	3.89	10.77	+	Yes
2G_5 - Hemostats	4.06	3.87	10.55	+	Yes
2G_22 - Oxygen tank, flow meter, cannula, and face mask	2.73	4.23	10.50	+	Yes
2++_2 - Obtain or refer for urine culture.	3.44	4.00	10.35	+	Yes
2G_11 - Vacutainer /blood collection tube	3.90	3.89	10.34	+	Yes
2D_1 - Local anesthetic for suturing	3.25	4.05	10.29	+	Yes
2C_14 - Magnesium	4.32	3.73	10.24	+	Yes
2+_2 - Demonstrate knowledge of benefits/risks of biophysical profile including co...	3.51	3.91	10.10	+	Yes
2C_13 - Calcium	4.2	3.7	10.0	±	Yes
2K_12 - Chlamydia	3.4	4.0	9.9	±	Yes
2++_4 - Obtain or refer for vaginal culture.	3.3	3.9	9.9	±	Yes
2K_8 - Gonorrhea culture	3.4	4.0	9.9	±	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
2C_5 - Vitamin D	4.2	3.7	9.9	±	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
2G_6 - Lancets	4.0	3.7	9.8	±	Yes
2D_7 - Vitamin K (oral or IM)	3.7	3.7	9.4	±	Yes
2D_2 - Medical oxygen	2.7	3.9	9.1	±	Yes
2G_23 - Pulse oximeter	3.4	3.7	8.8	±	Yes
2C_4 - Vitamin C	4.0	3.4	8.7	±	Yes
2C_9 - B-complex	3.8	3.4	8.6	±	Yes
2K_15 - Thyroid panel	3.0	3.7	8.5	±	Yes
2K_13 - PAP test	3.2	3.6	8.4	±	Yes
2K_20 - Hepatitis C	2.9	3.7	8.3	±	Yes
2C_11 - B-12	3.7	3.4	8.2	±	Yes
2K_19 - Complete metabolic panel	2.7	3.7	8.2	±	Yes
2G_10 - Straight, in and out catheter	2.3	3.8	8.1	±	Yes
2G_20 - Vaginal speculum	3.0	3.5	8.0	±	Yes
2D_10 - Cytotec (misoprostol)	2.3	3.8	7.9	±	Yes
2C_10 - B-6	3.6	3.3	7.8	±	Yes
2K_16 - HbA1C	2.8	3.4	7.4	±	Yes
2D_3 - Methergine® (methylergonovine maleate)	2.2	3.7	7.4	±	Yes
2K_14 - Vitamin D	2.9	3.4	7.3	±	Yes
2K_22 - HCG	2.6	3.4	7.2	±	Yes
2D_9 - IV fluids	2.3	3.6	7.0	±	Yes
2G_4 - Delee® tube-mouth suction device	2.1	3.5	7.0	±	Yes
2C_6 - Vitamin E	3.3	3.1	6.7	±	Yes
2G_7 - Nitrazine paper	2.6	3.2	6.7	±	Yes
2K_18 - Blood albumin	2.3	3.3	6.4	±	Yes
2K_21 - Progesterone	2.3	3.3	6.3	±	Yes
2K_17 - Genetic screening	2.49	3.18	5.97		Yes
2D_4 - Prescriptive ophthalmic ointment	2.73	2.99	5.81		Yes
2D_8 - Antibiotics for Group B Strep	2.41	3.29	5.78		Yes
2G_3 - Bulb syringe	2.33	2.81	5.07		Yes
2G_1 - Amnihook® or Amnicot®	2.26	2.87	4.99		Yes
2D_11 - Epinephrine	1.38	3.38	2.31		Yes
2G_24 - Laryngeal mask airway (LMA)	1.27	3.06	2.21		Yes
2G_25 - Indwelling catheter	1.22	2.15	1.26		No
Maternal Health Assessment	3.98	3.73	9.90		
3A7_9 - Rh type and plan of care if negative	4.91	4.68	14.58	+	Yes
3A_5 - Medical conditions	4.86	4.59	14.20	+	Yes
3A7_4 - Childbearing history	4.95	4.48	13.87	+	Yes
3B_3 - Vital signs	4.90	4.45	13.71	+	Yes
3A_10 - Mental health	4.70	4.39	13.25	+	Yes
3A7_6 - History of sexually transmitted infections	4.82	4.34	13.13	+	Yes
3A12_3 - Drug use	4.72	4.36	13.12	+	Yes
3A12_5 - Allergies (environmental and medical)	4.80	4.33	13.10	+	Yes
Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
3A_11 - Personal history including changes in health or behavior, and client's eval...	4.88	4.30	13.06	+	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
3A_6 - Surgical history	4.85	4.30	13.04	+	Yes
3A_9 - History of abuse	4.70	4.31	12.93	+	Yes
3A12_4 - Tobacco use	4.76	4.28	12.87	+	Yes
3A7_2 - Gynecologic history	4.88	4.23	12.78	+	Yes
3A12_2 - Alcohol use	4.73	4.26	12.74	+	Yes
3A_8 - Psychosocial history	4.75	4.22	12.61	+	Yes
3A7_1 - Menstrual history	4.89	4.12	12.37	+	Yes
3A7_8 - History of risk of exposure to blood borne pathogens	4.36	4.24	12.22	+	Yes
3A7_7 - History of behavioral risk factors for sexually transmitted infections	4.40	4.15	11.90	+	Yes
3A_1 - Personal information/demographics	4.91	3.95	11.69	+	Yes
3A7_3 - Sexual history	4.56	3.94	11.33	+	Yes
3A_7 - Family medical history	4.82	3.87	11.28	+	Yes
3A_4 - Potential exposure to environmental toxins	3.99	4.02	11.03	+	Yes
3A_2 - Personal history including religion, occupation, education, marital status...	4.85	3.76	10.88	+	Yes
3B_16 - Vascular system (edema, varicosities, thrombophlebitis)	4.27	3.90	10.86	+	Yes
3A7_5 - Contraceptive practice	4.75	3.77	10.82	+	Yes
3B_1 - General appearance/skin condition	4.58	3.66	10.25	+	Yes
3B_2 - Baseline weight and height	4.74	3.60	10.19	+	Yes
3A12_1 - Genetics	4.1	3.7	9.9	±	Yes
3A_3 - Increased risk for less-than-optimal outcomes due to allostatic stress from...	3.5	3.9	9.9	±	Yes
3B6_2 - An evaluation of the mother's knowledge of self breast examination techniqu...	3.9	3.7	9.9	±	Yes
3B_8 - Abdomen by palpation and observation for scars	4.2	3.6	9.8	±	Yes
3B_7 - Heart and lungs	3.9	3.7	9.8	±	Yes
3A13_4 - Tobacco use	4.1	3.7	9.7	±	Yes
3A13_3 - Drug use	3.9	3.7	9.5	±	Yes
3B_9 - Kidney pain (CVAT)	3.5	3.8	9.5	±	Yes
3A13_1 - Genetics	4.0	3.6	9.4	±	Yes
3A13_2 - Alcohol use	3.9	3.6	9.2	±	Yes
3A12_6 - History of vasovagal response or fainting	3.6	3.5	8.6	±	Yes
3B4_3 - Thyroid by palpation	3.3	3.3	7.6	±	Yes
3B_4 - Lymph glands of neck, chest, and under arms	3.5	3.2	7.5	±	Yes
3A12_7 - Foreign travel history	3.3	3.3	7.5	±	Yes
3B_6 - Baseline reflexes	3.4	3.2	7.4	±	Yes
3B_14 - Condition of the vulva, vagina, cervix, perineum, and anus	3.2	3.3	7.4	±	Yes
3B_10 - Deep tendon reflexes of the knee	3.2	3.2	7.2	±	Yes
3B_5 - Torso, extremities for bruising, abrasions, moles, and unusual growths	3.4	3.1	7.2	±	Yes
3A12_8 - Vaccination history/status	3.3	3.1	7.0	±	Yes
3B6_1 - A physical breast examination	2.9	3.2	6.9	±	No
3B_15 - Musculoskeletal system including spine straightness and symmetry and postur...	3.2	3.0	6.5	±	No
3A+_1 - Provide care to families who have conceived through assisted reproductive t...	2.4	3.4	6.5	±	No
3B4_2 - Eyes, pupils, whites, and conjunctiva	3.1	2.9	6.1	±	No

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
3B4_4 - Mouth, teeth, mucus membrane, and tongue	2.87	2.86	5.57		No
3A+_2 - Provide care for a client who plans to relinquish their baby for adoption o...	1.76	3.71	5.43		No
3B_13 - Size of uterus and ovaries by bimanual exam	2.65	2.83	5.24		No
3B_12 - Cervix by speculum exam	2.58	2.81	5.06		No
3B_11 - Internal pelvic landmarks	2.56	2.72	4.81		No
3B4_1 - Hair and scalp	2.64	2.58	4.48		No
Prenatal Care	3.79	4.11	11.00		
4A5_1 - Fetal heart rate/tones auscultated with fetoscope or Doppler	4.97	4.72	14.83	+	Yes
4A3C_1 - Blood pressure	4.96	4.68	14.65	+	Yes
4C22_4 - Monitor vital signs for infection	4.71	4.61	14.49	+	Yes
4_3 - Understand normal and abnormal changes during pregnancy.	4.93	4.60	14.34	+	Yes
4A5_3 - Fetal activity and responsiveness to stimulation	4.84	4.63	14.34	+	Yes
4C22_1 - Monitor fetal heart tones and movement	4.63	4.59	14.32	+	Yes
4C22_2 - Minimize internal vaginal examinations	4.73	4.56	14.28	+	Yes
4A3_5 - Vital signs	4.91	4.57	14.17	+	Yes
4_1 - Provide appropriate prenatal care and educate the family of significance.	4.95	4.55	14.14	+	Yes
4C18_1 - Fetal movement, growth, and heart tone variability	4.58	4.62	14.07	+	Yes
4C22_3 - Reinforce appropriate hygiene techniques	4.70	4.47	13.92	+	Yes
4A6_3 - Fetal lie	4.93	4.50	13.92	+	Yes
4C18_5 - Maternal tracking of fetal movement	4.50	4.53	13.61	+	Yes
4C16_2 - Educate for signs of pre-term labor.	4.37	4.55	13.53	+	Yes
4C22_5 - Encourage increased fluid intake	4.64	4.33	13.28	+	Yes
4_2 - Understand and educate about the anatomy and physiology of pregnancy and bi...	4.84	4.36	13.28	+	Yes
4A3C_9 - Hemoglobin/hematocrit	4.57	4.42	13.26	+	Yes
4A5_2 - Correlation of weeks gestation to fundal height	4.95	4.32	13.21	+	Yes
4C14_3 - Identify risk factors for uterine rupture such as type of uterine suturing...	3.80	4.63	13.08	+	Yes
4A3C_8 - Nutritional patterns, pica	4.68	4.33	12.97	+	Yes
4C14_2 - Indications/contraindications for out of hospital births.	3.93	4.55	12.95	+	Yes
4A3_1 - Maternal psycho-social and emotional health and well being; signs of abuse	4.40	4.37	12.88	+	Yes
4C14_1 - Identify previous cesarean through history and physical examination.	3.98	4.50	12.87	+	Yes
4C22_9 - Review Group B Strep status and inform of options	4.42	4.29	12.86	+	Yes
4C_1 - Antepartum bleeding (first, second, or third trimester)	3.33	4.65	12.85	+	Yes
4C18_2 - Estimated due date calculations	4.56	4.31	12.82	+	Yes
4_5 - Identify premature rupture of membranes.	3.62	4.56	12.82	+	Yes
4C25d_3 - Breastfeeding and infant care challenges after Cesarean birth	4.05	4.37	12.75	+	Yes
4C_2 - Pregnancy induced hypertension	3.13	4.70	12.73	+	Yes
4C11_1 - Identifying breech presentation	3.51	4.56	12.72	+	Yes
Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
4B_1 - Nutritional and non-allopathic dietary supplement support	4.77	4.23	12.69	+	Yes
4C25d_2 - Emotional healing	4.03	4.35	12.66	+	Yes
4C22_6 - Support nutritional/non-allopathic treatment	4.53	4.20	12.63	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
4B5_9 - Symptoms of anemia	4.14	4.37	12.60	+	Yes
4C_3 - Preeclampsia	2.86	4.82	12.59	+	Yes
4C14_4 - Management strategies for VBAC.	3.75	4.52	12.56	+	Yes
4_7 - Consult and refer for premature rupture of membranes in a PRE-TERM pregnanc...	2.94	4.77	12.46	+	Yes
4C16a_2 - Vaginal infections; urinary tract infection	4.04	4.35	12.42	+	Yes
4_4 - Practice the standard measures for treating a post-date pregnancy.	4.25	4.29	12.40	+	Yes
4B_3 - Exercise and movement	4.77	4.15	12.37	+	Yes
4C18_3 - Previous birth patterns	4.55	4.20	12.37	+	Yes
4C25d_1 - Physical healing	3.92	4.29	12.30	+	Yes
4A3_3 - Estimated due date based on standard methods.	4.84	4.12	12.30	+	Yes
4A3_2 - Vaginal discharge including signs and symptoms of infection.	4.27	4.24	12.22	+	Yes
4C18_4 - Amniotic fluid volume	4.30	4.24	12.22	+	Yes
4C_5 - Urinary tract infection	3.34	4.48	12.22	+	Yes
4C24_1 - Options for hospital transport including augmentation, pharmacological pain...	3.79	4.27	12.17	+	Yes
4A3D_2 - Protein	4.57	4.13	12.11	+	Yes
4A3_8 - Social support system	4.44	4.14	12.02	+	Yes
4A3_7 - Edema	4.70	4.04	11.84	+	Yes
4B_2 - Normal body changes in pregnancy	4.79	4.01	11.83	+	Yes
4C16a_5 - Review other factors that may contribute to pre-term birth such as stress a...	4.02	4.21	11.82	+	Yes
4C16a_4 - Prior pre-term birth	3.72	4.28	11.78	+	Yes
4C_11 - Standard measures for treating a post-date pregnancy	3.69	4.28	11.76	+	Yes
4C17_1 - Referral	3.07	4.54	11.73	+	Yes
4B5_2 - Nausea/vomiting	4.50	4.04	11.68	+	Yes
4C14_5 - Recognize signs and symptoms of uterine rupture and knowing emergency treat...	3.02	4.89	11.58	+	Yes
4B5_15 - Headache	4.02	4.14	11.58	+	Yes
4B5_21 - Fluid retention/swelling, edema	4.13	4.11	11.56	+	Yes
4C25_3 - Support before, during, and after (as permitted) the cesarean process	3.53	4.16	11.41	+	Yes
4C20_3 - Placenta previa	2.45	4.79	11.38	+	Yes
4C13_3 - Techniques to encourage rotation	4.20	4.04	11.35	+	Yes
4C_4 - Gestational diabetes	2.95	4.44	11.31	+	Yes
4A3D_3 - Glucose	4.55	3.93	11.30	+	Yes
4A3C_10 - Glucose levels	4.06	4.06	11.27	+	Yes
4A3C_7 - Energy levels	4.56	3.92	11.24	+	Yes
4C16a_1 - Smoking	3.55	4.27	11.23	+	Yes
4C11_2 - Management strategies for unexpected breech delivery	2.73	4.66	11.20	+	Yes
4B5_20 - Emotional changes	4.20	3.98	11.12	+	Yes
4A3C_11 - Breast conditions/implications for breastfeeding	4.06	4.01	11.12	+	Yes
4A6_2 - Fetal size	4.52	3.90	11.12	+	Yes
4C13_2 - Prevention	4.20	3.96	11.02	+	Yes
4C17_2 - Consults for pre-term labor	2.92	4.45	11.02	+	Yes
4B5_3 - Fatigue	4.52	3.87	10.99	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
4C_6 - Fetus small for gestational age	2.82	4.38	10.97	+	Yes
4C12_1 - Identifying multiple gestation	2.67	4.54	10.96	+	Yes
4C13_1 - Identification	3.97	4.00	10.94	+	Yes
4C_7 - Intrauterine growth retardation	2.58	4.61	10.86	+	Yes
4_8 - Provide education for parents in providing preparation for siblings at birt...	4.38	3.86	10.84	+	Yes
4B5_7 - Vaginal yeast infection	3.74	4.03	10.83	+	Yes
4A3C_6 - Sleep patterns	4.44	3.85	10.83	+	Yes
4B5_1 - Sleep difficulties	4.46	3.81	10.70	+	Yes
4C_10 - Polyhydramnios	2.67	4.38	10.68	+	Yes
4C18f_3 - Biophysical profile	3.67	4.03	10.68	+	Yes
4C22_8 - Consult for prolonged rupture of membranes	3.45	3.97	10.61	+	Yes
4A3C_5 - Elimination/urination patterns	4.28	3.82	10.58	+	Yes
4C_9 - Oligohydramnios	2.60	4.45	10.57	+	Yes
4B5_8 - Bacterial vaginosis	3.27	4.08	10.54	+	Yes
4C11_3 - Turning breech presentation with alternative positions (tilt board, exercis...	3.25	4.08	10.48	+	Yes
4B5_22 - Vision changes	3.44	4.05	10.48	+	Yes
4C22_7 - Stimulate labor	3.76	3.86	10.47	+	Yes
4C17_3 - Treat pre-term labor with standard measures	2.86	4.41	10.47	+	Yes
4C18f_2 - Non-stress test	3.62	4.00	10.46	+	Yes
4C_14 - Conditions from previous pregnancies, such as diastasis, prolapse, cyctocel...	3.10	4.16	10.38	+	Yes
4C_12 - Fetus large for gestational age	2.96	4.14	10.26	+	Yes
4C20_1 - Tubal, molar, or ectopic pregnancy	2.25	4.75	10.15	+	Yes
4A3D_8 - Blood	4.15	3.73	10.11	+	Yes
4B5_18 - Varicose veins	3.75	3.83	10.07	+	Yes
4C25_1 - Local options for cesarean birth	3.24	3.91	10.06	+	Yes
4A3D_7 - Nitrites	4.18	3.70	10.02	+	Yes
4A3D_4 - Ketones	4.10	3.71	10.01	+	Yes
4B5_11 - Constipation	4.1	3.7	10.0	±	Yes
4C20_2 - Placental abruption	2.2	4.8	10.0	±	Yes
4B5_17 - Backache	4.2	3.7	10.0	±	Yes
4B5_10 - Indigestion/heartburn	4.3	3.6	9.7	±	Yes
4B5_16 - Leg cramps	4.0	3.7	9.7	±	Yes
4C18f_1 - Ultrasound	3.6	3.8	9.7	±	Yes
4A3C_2 - Weight	4.5	3.5	9.6	±	Yes
4B5_6 - Skin itchiness	3.6	3.7	9.6	±	Yes
4C_13 - Cholestasis	2.4	4.4	9.6	±	Yes
4A6_1 - Fetal weight	4.1	3.6	9.6	±	Yes
4A3D_1 - Appearance: color, density, odor, and clarity	4.2	3.6	9.6	±	Yes
4A3D_6 - Leukocytes	4.2	3.6	9.5	±	Yes
4A3_6 - Respiratory assessment	3.5	3.7	9.5	±	Yes
4B5_12 - Hemorrhoids	4.0	3.6	9.5	±	Yes
4B5_4 - Inflammation of sciatic nerve	3.9	3.6	9.4	±	Yes
4B5_14 - Round ligament pain	4.2	3.5	9.4	±	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
4C_8 - Thrombophlebitis	2.4	4.6	9.3	±	Yes
4B_4 - Weight gain in pregnancy	4.3	3.5	9.3	±	Yes
4A6_4 - Degree of fetal head flexion	3.8	3.6	9.2	±	Yes
4C16a_3 - Periodontal health	3.2	3.8	9.2	±	Yes
4A3_4 - Clonus	2.9	3.8	8.9	±	Yes
4C16_1 - Educate and counsel a mother who requests early induction of labor.	2.6	4.0	8.8	±	Yes
4B5_19 - Sexual changes	3.6	3.5	8.6	±	Yes
4C25_2 - Procedures for cesarean birth	2.9	3.7	8.5	±	Yes
4C11_4 - Turning breech presentation with referral for external version	2.6	3.8	8.5	±	Yes
4C11_5 - Turning breech presentation with non-allopathic methods (moxibustion, homeo...	2.9	3.7	8.5	±	Yes
4B5_5 - Breast tenderness	3.8	3.3	8.2	±	Yes
4C12_2 - Management strategies for unexpected multiple births	2.2	4.5	7.9	±	Yes
4A3D_9 - Specific gravity	3.8	3.2	7.7	±	Yes
4A3D_5 - pH	3.9	3.1	7.5	±	Yes
4B5_13 - Carpal tunnel syndrome	3.1	3.3	7.4	±	Yes
4A3C_4 - General reflexes	3.0	3.3	7.3	±	Yes
4A3C_3 - Color of mucus membranes	3.2	3.2	7.0	±	Yes
4C16d_1 - Ultrasound for cervical length	2.4	3.3	6.1	±	No
4C16d_4 - Hormonal testing	2.12	3.34	5.53		No
4C16d_2 - Fetal fibronectin (fFN) test	1.78	3.22	4.34		No
4C16d_5 - Methylene Tetrahydrofolate Reductase (MTHFR) testing	1.78	3.18	4.08		No
4C16d_3 - Cerclage	1.49	3.33	3.01		No
Labor and Birth	3.73	3.84	11.34		
5_16 - Estimate and monitor ongoing blood loss.	4.79	4.69	15.21	+	Yes
5F_5 - Fetal heart tones	4.77	4.63	14.97	+	Yes
5M3_17 - Sound and rate of heart tones and respirations	4.50	4.33	14.80	+	Yes
5_1 - Understand and support the normal physiological process of labor and birth.	4.83	4.57	14.78	+	Yes
5W8_163 - Heart sounds (rate and irregularities)	4.44	4.20	14.70	+	Yes
5W8_157 - Ascultate the lungs, front and back, for breath sounds	4.43	4.19	14.64	+	Yes
5M_12 - Understand, recognize, and support normal newborn adjustment at birth.	4.53	4.25	14.51	+	Yes
5_14 - Recognize and respond to normal third stage including physiological and act...	4.73	4.48	14.32	+	Yes
5F_1 - Vital signs	4.71	4.48	14.29	+	Yes
5_4 - Assess and support normal progress of labor.	4.82	4.45	14.28	+	Yes
5W18_254 - Condition of the spine for holes	4.42	4.10	14.22	+	Yes
5_2 - Understand the relationship of maternal and fetal anatomy in relation to la...	4.79	4.44	14.21	+	Yes
Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5M_13 - Keep mother and baby warm and together for initial assessment.	4.54	4.17	14.15	+	Yes
5U_60 - Monitor maternal vital signs after birth	4.35	4.11	14.01	+	Yes
5L_10 - Prepare necessary equipment for immediate access	4.48	4.15	13.98	+	Yes
5L_8 - Monitor vital signs; understand normal and abnormal changes	4.39	4.17	13.97	+	Yes
5_15 - Assess condition of placenta and membranes, and recognize normal and abnorm...	4.81	4.37	13.93	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5V_85 - Normal newborn urine and stool output	4.45	4.06	13.90	+	Yes
5M3_20 - Chest retractions	3.93	4.28	13.87	+	Yes
5W5_152 - Flaring nostrils	4.33	4.04	13.86	+	Yes
5T1_43 - Assessing vital signs	4.12	4.22	13.86	+	Yes
5W20_262 - Sucking	4.44	4.01	13.85	+	Yes
5V_78 - Latching on	4.44	4.05	13.83	+	Yes
5W8_164 - Ascultate the lungs, front and back, for equal bilateral expansion	4.26	4.07	13.82	+	Yes
5V_77 - Skin to skin contact	4.46	4.02	13.76	+	Yes
5W12_243 - Patency	4.27	4.04	13.73	+	Yes
5T1_40 - Assessing origin	3.95	4.22	13.68	+	Yes
5M3_19 - Grunting	3.97	4.21	13.68	+	Yes
5W4_146 - Appearance and feel of palate	4.39	3.98	13.65	+	Yes
5M_17 - Respond to need for newborn resuscitation according to AAP/NRP recommendati...	3.23	4.39	13.57	+	Yes
5U2_67 - Tears, lacerations	4.25	4.04	13.57	+	Yes
5M3_22 - Central cyanosis	3.81	4.36	13.55	+	Yes
5V_79 - Maternal hydration and nutrition	4.43	3.98	13.54	+	Yes
5T1_41 - Assessing fundal height and uterine size	4.11	4.14	13.54	+	Yes
5K_1 - Abnormal fetal heart tones and patterns	3.00	4.63	13.54	+	Yes
5T2_48 - Fundal massage	4.04	4.16	13.53	+	Yes
5M3_18 - Nasal flaring	3.99	4.18	13.52	+	Yes
5_6 - Recognize, prevent, or treat maternal dehydration.	4.29	4.40	13.51	+	Yes
5W20_268 - Rooting	4.43	3.94	13.51	+	Yes
5W9_230 - Masses	4.32	3.98	13.51	+	Yes
5C_2 - Communicate in a calming voice, using kind and encouraging words.	4.79	4.27	13.50	+	Yes
5W21_270 - Color	4.44	3.93	13.48	+	Yes
5W4_149 - Lip cleft	4.32	3.97	13.44	+	Yes
5C_3 - Apply knowledge of emotional and psychological aspects of labor to provide...	4.75	4.26	13.40	+	Yes
5W18_253 - Condition of the spine for dimpling	4.43	3.91	13.37	+	Yes
5U2g_68 - Assess blood color and volume; identify source	4.14	4.03	13.33	+	Yes
5_3 - Recognize and counsel on signs of early labor and appropriate activities.	4.67	4.26	13.33	+	Yes
5W9_229 - Enlarged organs	4.22	3.98	13.31	+	Yes
5V_80 - Maternal rest	4.43	3.93	13.29	+	Yes
5L_5 - Recognize and assess progress in second stage	4.37	4.01	13.26	+	Yes
5L_6 - Support maternal instincts in pushing techniques and positions	4.47	3.98	13.24	+	Yes
5M_15 - Stimulate newborn respiration according to AAP/NRP recommendations.	3.69	4.17	13.21	+	Yes
5M_16 - Encourage parental touch and speech while keeping baby warm.	4.40	3.99	13.19	+	Yes
5N_23 - Provide appropriate care of the umbilical cord.	4.52	3.96	13.19	+	Yes
5M3_16 - Symmetry of chest	4.24	4.03	13.17	+	Yes
5U_61 - Promote timely food and drink	4.46	3.89	13.17	+	Yes
5K5_1 - Hydration and nutrition	4.08	4.26	13.15	+	Yes
5C_1 - Facilitate maternal relaxation and provide comfort measures throughout labo...	4.69	4.20	13.12	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5W5_151 - Patency	4.22	3.91	13.11	+	Yes
5C_4 - Apply knowledge of physical support in labor such as counter pressure, posi...	4.69	4.20	13.10	+	Yes
5V_75 - Colostrum	4.40	3.89	13.10	+	Yes
5W4_147 - Lip and mouth color	4.33	3.86	13.07	+	Yes
5W20_263 - Moro	4.42	3.84	13.05	+	Yes
5W9_233 - Rigidity	4.22	3.90	13.05	+	Yes
5T1_42 - Fundal massage	4.02	4.06	13.02	+	Yes
5V_76 - Positions for mother and baby	4.40	3.86	12.94	+	Yes
5U_48 - Assess for bladder distension by encouraging urination	4.15	3.92	12.94	+	Yes
5N_25 - Evaluate the cord, including number of vessels.	4.53	3.89	12.93	+	Yes
5V_81 - Feeding patterns	4.41	3.85	12.92	+	Yes
5U_59 - Provide instructions on care and treatment of perineum	4.42	3.84	12.91	+	Yes
5W20_264 - Babinski	4.42	3.80	12.89	+	Yes
5F_6 - Fetal lie, presentation, position, and descent	4.52	4.19	12.86	+	Yes
5W18_255 - Condition of the spine for straightness	4.42	3.79	12.85	+	Yes
5W20_265 - Plantar/palmar	4.41	3.80	12.84	+	Yes
5W4_150 - Signs of dehydration	4.04	3.91	12.83	+	Yes
5W9_232 - Bowel sounds	4.18	3.85	12.83	+	Yes
5W18_258 - Symmetry of hips, range of motion	4.41	3.79	12.83	+	Yes
5T2_52 - Administering medications	3.33	4.24	12.82	+	Yes
5F_2 - Food and fluid intake	4.66	4.13	12.81	+	Yes
5W1_94 - Hematoma	4.30	3.81	12.78	+	Yes
5M3_21 - Circumoral cyanosis	3.89	4.06	12.74	+	Yes
5W20_267 - Grasping	4.39	3.78	12.74	+	Yes
5W2_98 - Jaundice	4.17	3.84	12.74	+	Yes
5Q1_27 - Separation gush	4.44	3.87	12.73	+	Yes
5K3c_4 - Prepare for possible resuscitation	3.46	4.33	12.70	+	Yes
5F_4 - Uterine contractions such as frequency, duration, and intensity	4.65	4.11	12.69	+	Yes
5W9_231 - Hernias	4.27	3.80	12.68	+	Yes
5W11_237 - Position of urethral opening	4.32	3.78	12.67	+	Yes
5W4_151 - Tongue and lip tie	4.26	3.79	12.66	+	Yes
5W4_148 - Tongue	4.36	3.76	12.64	+	Yes
5W+_244 - Assess the weight of baby	4.46	3.74	12.64	+	Yes
5N_24 - Clamp and cut cord after pulsing stops.	4.45	3.84	12.63	+	Yes
5W21_271 - Lesions	4.40	3.74	12.58	+	Yes
5F_3 - Status of membranes	4.58	4.09	12.56	+	Yes
5T1_46 - Expressing clots	3.61	4.05	12.56	+	Yes
5W+_246 - Assess flexion of extremities and muscle tone	4.36	3.74	12.54	+	Yes
5W1_97 - Fontanels	4.41	3.72	12.50	+	Yes
5W23_249 - Review Group B Strep status and signs or symptoms	3.85	3.86	12.48	+	Yes
5W+_243 - Abduct hips for dislocation	4.37	3.72	12.45	+	Yes
5W12_244 - Meconium	4.40	3.70	12.45	+	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5W3_105 - Positioning	4.40	3.71	12.45	+	Yes
5W21_278 - Bruising	4.42	3.68	12.35	+	Yes
5Q1_28 - Contractions	4.41	3.79	12.33	+	Yes
5V_82 - Maternal comfort measures for engorgement	4.22	3.76	12.33	+	Yes
5W8_159 - Symmetry	4.34	3.70	12.32	+	Yes
5W23_243 - Assess for central nervous system disorder	3.87	3.86	12.31	+	Yes
5W15_248 - Abnormalities	4.37	3.68	12.31	+	Yes
5L_9 - Facilitate supportive environment and family involvement	4.34	3.80	12.29	+	Yes
5T1_44 - Empty bladder	3.77	3.93	12.24	+	Yes
5W16_252 - Movement	4.34	3.68	12.24	+	Yes
5K4_2 - Follow standard resuscitation procedures for meconium	3.44	4.23	12.23	+	Yes
5U2g4_73 - Perform suturing according to standard procedures and protocols	3.80	3.90	12.21	+	Yes
5W11_236 - Appearance	4.43	3.64	12.18	+	Yes
5W7_157 - Integrity	4.29	3.68	12.18	+	Yes
5M_14 - Determine APGAR score at one minute, five minutes, and if needed, at ten mi...	4.49	3.73	12.17	+	Yes
5K3f_2 - Reposition the mother to hands and knees (Gaskin Maneuver)	3.35	4.20	12.11	+	Yes
5W16_251 - Structure	4.32	3.64	11.99	+	Yes
5_5 - Advise on non-allopathic remedies for slow or stalled labor such as nipple...	4.16	4.05	11.97	+	Yes
5U2_66 - Prolapsed cervix or uterus	3.33	4.01	11.93	+	Yes
5W1_92 - Size/circumference	4.44	3.58	11.93	+	Yes
5W15_249 - Digits: number, webbing	4.39	3.60	11.93	+	Yes
5K5_2 - Rest/bath/removal of distractions	3.96	3.99	11.88	+	Yes
5W14_247 - Foot/ankle abnormality	4.27	3.62	11.88	+	Yes
5W14_246 - Equal length	4.30	3.61	11.85	+	Yes
5T1_45 - Breastfeeding or nipple stimulation	3.94	3.79	11.85	+	Yes
5U2g4_72 - Administer local anesthetic	3.78	3.83	11.83	+	Yes
5K4_1 - Recognize and assess degree of meconium	3.47	4.09	11.82	+	Yes
5W17_253 - Digits: number, webbing	4.39	3.57	11.81	+	Yes
5W1_96 - Suture lines	4.37	3.57	11.80	+	Yes
5W11_238 - Testicles for descent	4.42	3.56	11.79	+	Yes
5W7_158 - Symmetry	4.21	3.60	11.72	+	Yes
5H_4 - Maternal exhaustion	3.12	4.18	11.71	+	Yes
5K5_3 - Monitor maternal and fetal vital signs including urine ketones	3.64	4.04	11.71	+	Yes
5W21_277 - Rashes	4.39	3.54	11.71	+	Yes
5L_7 - Recommend/suggest pushing techniques and positions when needed	3.96	3.75	11.69	+	Yes
5U2_63 - Hematoma	3.52	3.83	11.68	+	Yes
5W14_245 - Symmetry of creases in the back of legs	4.21	3.57	11.62	+	Yes
5W17_255 - Palm creases	4.26	3.55	11.58	+	Yes
5W10_234 - Femoral pulses	3.93	3.64	11.58	+	Yes
5W11_240 - Testicles for herniation	4.11	3.60	11.54	+	Yes
5D_3 - Discuss specific management of complications during waterbirth	4.05	3.98	11.53	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5W2_101 - Spacing	4.11	3.57	11.49	+	Yes
5W20_266 - Stepping	4.02	3.58	11.47	+	Yes
5H_5 - Maternal fears and emotions	3.52	3.99	11.45	+	Yes
5T2_56 - A consult and/or transfer; activating emergency back up plan	2.29	4.28	11.35	+	Yes
5Q1_29 - Lengthening of cord	4.20	3.61	11.34	+	Yes
5L_11 - Use appropriate hand techniques for perineal support and birth of baby	4.10	3.63	11.33	+	Yes
5W1_95 - Caput	4.31	3.47	11.29	+	Yes
5W2_104 - Discharge	4.08	3.52	11.27	+	Yes
5T2_54 - Increasing maternal focus and participation	3.62	3.75	11.26	+	Yes
5D_1 - Educate on benefits and risks	4.36	3.83	11.26	+	Yes
5Q1_31 - Rise in fundus	3.65	3.73	11.23	+	Yes
5T2_57 - Treating for hypovolemic shock according to standard recommendations or pro...	2.34	4.37	11.15	+	Yes
5W15_250 - Creases	4.39	3.42	11.15	+	Yes
5W1_93 - Molding	4.41	3.41	11.13	+	Yes
5K5_4 - Evaluate for consultation or referral	3.17	4.01	11.10	+	Yes
5Q1_30 - Urge to push	4.04	3.59	11.08	+	Yes
5T2_49 - External bimanual compression	2.68	4.10	11.07	+	Yes
5H_6 - Abnormal labor patterns	3.19	3.97	11.05	+	Yes
5W20_269 - Blinking	3.82	3.54	11.01	+	Yes
5W2_103 - Hemorrhage	4.12	3.45	11.00	+	Yes
5W6_156 - Unusual range of motion	3.78	3.55	10.99	+	Yes
5W3_107 - Patency	3.88	3.54	10.92	+	Yes
5R_32 - Breast feeding/nipple stimulation	3.64	3.66	10.91	+	Yes
5V_83 - Letdown reflex	4.07	3.48	10.89	+	Yes
5H_2 - Posterior or asynclitic fetal position	3.27	3.92	10.88	+	Yes
5K3f_3 - Reposition the mother to exaggerated lithotomy (McRobert's Position)	2.98	4.02	10.86	+	Yes
5W8_162 - Measurement (chest circumference)	4.32	3.36	10.82	+	Yes
5W+_245 - Assess the length of baby	4.44	3.32	10.78	+	Yes
5W2_99 - Pupil condition	3.74	3.49	10.74	+	Yes
5M_19 - Recognize signs and symptoms of Meconium Aspiration Syndrome and consult or...	2.30	4.38	10.67	+	Yes
5W2_102 - Clarity	3.89	3.44	10.67	+	Yes
5U2g_71 - Suture 1st degree, 2nd degree, or labial tears	3.09	3.71	10.66	+	Yes
5W11_239 - Testicles for rugae	4.31	3.32	10.63	+	Yes
5W11_234 - Vagina for patency	3.82	3.47	10.62	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5W23_246 - Assess gestational age of the baby	4.15	3.36	10.61	+	Yes
5V_84 - Milk expression	3.88	3.46	10.59	+	Yes
5K3f_12 - Shift pelvic angle with lunge or runner's pose	2.96	4.00	10.57	+	Yes
5W11_235 - Maturity of clitoris and labia	4.25	3.31	10.54	+	Yes
5M_18 - Recognize and consult or transport for apparent birth defects.	2.32	4.28	10.52	+	Yes
5R_37 - Encouraging maternal awareness	3.67	3.55	10.49	+	Yes
5W10_235 - Swollen glands	3.73	3.45	10.48	+	Yes
5W3_106 - Response to sound	3.71	3.44	10.45	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5H_8 - Obstructed labor	2.36	4.28	10.45	+	Yes
5N_26 - Collect cord blood sample if needed.	3.24	3.65	10.41	+	Yes
5K3f_7 - Extract posterior arm	2.77	4.06	10.39	+	Yes
5W3_108 - Cartilage	4.20	3.29	10.37	+	Yes
5W6_153 - Enlarged glands, thyroid, and lymph	3.65	3.45	10.36	+	Yes
5K3a_1 - Understand mechanism of descent and rotation for complete, frank, or footli...	2.57	4.37	10.31	+	Yes
5U2g_69 - Apply direct pressure on tear	3.15	3.60	10.24	+	Yes
5K3f_6 - Reposition shoulders to oblique diameter	2.74	4.01	10.19	+	Yes
5T2_51 - Manual removal of clots	2.37	4.05	10.18	+	Yes
5W8_160 - Nipples	4.34	3.20	10.12	+	Yes
5R_34 - Performing guarded cord traction	3.37	3.54	10.12	+	Yes
5F_7 - Cervical effacement and dilation	3.82	3.68	10.08	+	Yes
5W6_155 - Soft tissue swelling	3.51	3.41	10.05	+	Yes
5H_1 - Anterior/swollen lip	3.21	3.73	10.04	+	Yes
5T2_53 - Non-allopathic treatments	3.2	3.5	10.0	±	Yes
5W2_100 - Tracking	3.6	3.3	9.9	±	Yes
5D_2 - Equip the birth site for a water birth	4.2	3.5	9.9	±	Yes
5R_33 - Changing maternal position	3.4	3.5	9.9	±	Yes
5W21_272 - Birthmarks	4.4	3.1	9.9	±	Yes
5U_49 - Assess for bladder distension by performing catheterization if needed	2.3	3.7	9.8	±	Yes
5K3c_3 - Press baby's head into perineum and somersault the baby out	2.9	3.8	9.8	±	Yes
5U2_61 - Cystocele	3.2	3.5	9.8	±	Yes
5T1_47 - Non-allopathic treatments	3.3	3.5	9.7	±	Yes
5H_7 - Deep transverse arrest	2.3	4.2	9.7	±	Yes
5W21_276 - Peeling	4.4	3.1	9.7	±	Yes
5T2_55 - Administering or refering for IV fluids	2.4	3.9	9.7	±	Yes
5W8_161 - Breast enlargement or discharge	4.3	3.1	9.7	±	Yes
5U2_65 - Bruising	3.8	3.3	9.7	±	Yes
5W18_257 - Temperature	3.4	3.3	9.7	±	Yes
5U2_62 - Rectocele	3.2	3.5	9.7	±	Yes
5U2_64 - Hemorrhoids	3.7	3.3	9.7	±	Yes
5K3e_1 - Identify multiple gestation	2.3	4.2	9.6	±	Yes
5W17_254 - Finger taper	3.7	3.2	9.5	±	No
5K3f_8 - Flex shoulders of newborn, then corkscrew	2.6	4.0	9.5	±	Yes
5K3e_2 - Consult or transport according to plan	2.5	4.2	9.5	±	Yes
5R_35 - Emptying the bladder	2.8	3.5	9.4	±	Yes
5W21_274 - Vernix	4.4	3.0	9.4	±	Yes
5H_3 - Pendulous belly inhibiting descent	2.8	3.7	9.4	±	Yes
5K3a_4 - Practice techniques for maintaining head flexion	2.3	4.3	9.4	±	Yes
5W21_275 - Lanugo	4.4	3.0	9.3	±	Yes
5K3d_1 - Understand mechanism of delivery for face or brow presentation	2.5	4.1	9.3	±	Yes
5W23_245 - Administer Vitamin K with informed consent of parents	3.2	3.3	9.3	±	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
5K3f_1 - Apply gentle traction while encouraging pushing	2.7	3.7	9.3	±	Yes
5K3f_9 - Apply supra-pubic pressure	2.5	3.8	9.2	±	Yes
5K3d_4 - Prepare for resuscitation or treatment of bruising/swelling/eye injury	2.4	4.2	9.2	±	Yes
5W21_279 - Mongolian spots	4.4	3.0	9.1	±	Yes
5W24_246 - Use a pulse for newborn assessment.	3.1	3.4	9.1	±	Yes
5K3a_2 - Practice cord management strategies specific to breech deliveries	2.2	4.3	9.0	±	Yes
5K3a_3 - Practice techniques for release of nuchal arms with breech	2.2	4.3	9.0	±	Yes
5U2g4_74 - Provide alternative repair methods (non-suturing)	3.0	3.3	9.0	±	Yes
5K3c_1 - Loop finger under cord, sliding over head or shoulder	3.0	3.5	8.9	±	Yes
5K3b_1 - Apply counter pressure to hand or arm and perineum	2.8	3.6	8.8	±	Yes
5W21_273 - Milia	4.3	2.9	8.8	±	Yes
5R_39 - Transporting for removal	1.7	4.2	8.8	±	Yes
5K3f_10 - Sweep arm across newborn's face	2.4	3.9	8.7	±	Yes
5T2_50 - Internal bimanual compression	1.8	4.1	8.6	±	Yes
5W6_154 - Trachea placement	2.9	3.4	8.6	±	Yes
5W17_256 - Length of nails	4.0	2.9	8.5	±	Yes
5K3e_3 - Prepare for attention to more than one	2.3	4.3	8.3	±	Yes
5R_36 - Administering non-allopathic treatments	2.8	3.3	8.3	±	Yes
5K3b_2 - Sweep arm out	2.6	3.6	8.3	±	Yes
5U2g_70 - Clamp vessel; if identified	2.1	3.8	8.1	±	Yes
5K3d_3 - Practice management strategies for face or brow presentation	2.1	3.9	8.0	±	Yes
5K3d_2 - Determine position of chin	2.2	4.0	7.8	±	Yes
5R_38 - Manual removal	1.6	4.1	7.8	±	Yes
5K_2 - Cord prolapse	1.8	4.7	7.8	±	Yes
5K3f_5 - Squat	2.4	3.4	7.7	±	Yes
5K_3 - Indications for performing an episiotomy	1.9	3.9	7.4	±	Yes
5K6_4 - Stillbirth	1.8	4.5	7.0	±	Yes
5K3f_4 - Reposition the mother to end of bed	2.2	3.3	6.9	±	Yes
5W2_105 - Red eye reflex	2.6	3.0	6.7	±	Yes
5W23_244 - Administer eye prohylaxis with informed consent of parents	2.6	2.8	6.6	±	Yes
5K6_1 - Uterine rupture	1.60	4.66	5.22		Yes
5K3c_2 - Clamp and cut cord	1.61	3.41	4.56		Yes
5W24_243 - Use a pulse oximeter for maternal assessment.	1.81	2.54	4.23		Yes
5K6_2 - Uterine inversion	1.49	4.60	4.05		Yes
5K6_3 - Amniotic fluid embolism	1.39	4.64	2.90		Yes
5T2_58 - Performing external aortic compression	1.17	3.93	2.59		Yes
5K3f_11 - Fracture baby's clavicle	1.24	3.61	2.22		Yes
Postpartum	3.60	3.78	11.63		
6A1_255 - Day one to day two	4.39	4.14	14.47	+	Yes
6_252 - Provide breastfeeding care and counseling.	4.36	4.04	14.01	+	Yes
6F2b_291 - Latch on	4.28	3.96	13.64	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
6F2b_293 - Sucking	4.25	3.96	13.60	+	Yes
6F2b_294 - Swallowing	4.23	3.95	13.54	+	Yes
6A2_261 - Lochia vs. abnormal bleeding	4.30	3.95	13.53	+	Yes
6F4_298 - Assessing for signs and symptoms of infection	3.99	3.97	13.33	+	Yes
6F4_297 - Encouraging adequate rest/relaxation	4.07	3.89	13.05	+	Yes
6F2b_287 - Flange of lips	4.19	3.86	13.03	+	Yes
6F2_286 - Treating sore nipples	4.11	3.85	12.93	+	Yes
6A2i_269 - Screen, recognize, and respond to mild postpartum depression.	3.82	3.94	12.93	+	Yes
6A2i_268 - Facilitating psycho-social adjustment.	4.06	3.87	12.90	+	Yes
6A1_257 - One to two weeks	4.27	3.79	12.76	+	Yes
6F2b_288 - Alternate nursing positions	4.23	3.78	12.74	+	Yes
6F2b_292 - Tongue tie	3.90	3.85	12.66	+	Yes
6A2i_270 - Mild postpartum depression: Counsel for appropriate support from family and...	3.51	3.92	12.48	+	Yes
6A2_263 - Vital signs, digestion, elimination patterns	4.26	3.72	12.44	+	Yes
6F4_291 - Providing immune support with nutrition/hydration	3.87	3.78	12.34	+	Yes
6B_275 - Urinary tract infection	3.17	3.98	12.31	+	Yes
6A1_256 - Day three to day four	3.89	3.77	12.27	+	Yes
6A2i_271 - Mild postpartum depression: Increase home or phone visits as needed.	3.39	3.89	12.24	+	Yes
6F4_294 - Encouraging multiple nursing positions	3.97	3.73	12.22	+	Yes
6A1_259 - Five to six weeks	4.26	3.61	11.97	+	Yes
6A2_260 - Postpartum subjective history	4.09	3.65	11.95	+	Yes
6F4_299 - Teaching mother to empty breasts at each feeding	3.87	3.66	11.86	+	Yes
6F4_300 - Providing or teaching gentle massage of sore spots	3.88	3.65	11.81	+	Yes
6F2_287 - Exposure to air	4.03	3.60	11.75	+	Yes
6A2_267 - Condition of vulva, vagina, perineum, and anus	3.91	3.65	11.73	+	Yes
6F1_285 - Pharmacological	3.53	3.72	11.63	+	Yes
6F4_301 - Consulting or refering to breastfeeding support groups, lactation counselor...	3.52	3.71	11.63	+	Yes
6F4_296 - Applying warmth, soaking in tub or by shower	3.85	3.61	11.59	+	Yes
6F3_292 - Non-allopathic remedies	3.65	3.67	11.59	+	Yes
6B_274 - Uterine infection	2.63	4.19	11.56	+	Yes
6F4_292 - Providing immune support with non-allopathic remedies	3.73	3.63	11.54	+	Yes
6_254 - Provide opportunity for verbal and written feedback from client.	3.88	3.61	11.48	+	Yes
6A2i_272 - Screen, recognize, and respond to increased severity of postpartum depressi...	2.55	4.20	11.47	+	Yes
6B_277 - Late postpartum bleeding/hemorrhage	2.55	4.18	11.40	+	Yes
6A2_266 - Condition of uterus (size and involution), ovaries, and cervix	3.86	3.58	11.38	+	Yes
6F2b_290 - Apply expressed breastmilk	3.94	3.54	11.38	+	Yes
6A2i_273 - Severe postpartum depression: Counsel client and family on resources for de...	2.49	4.23	11.32	+	Yes
6F3_291 - Drying nipples after nursing	3.58	3.57	11.05	+	Yes
6_251 - Provide direction for care of intact (uncircumcised) penis.	3.81	3.52	11.05	+	Yes
6_253 - Provide contraceptive and family planning education, counseling, and referr...	3.89	3.50	11.03	+	Yes

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Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
6F1_283 - Biological	3.53	3.58	10.99	+	Yes
6A2_265 - Condition and strength of pelvic floor	3.65	3.55	10.98	+	Yes
6F1_284 - Occupational	3.50	3.57	10.93	+	Yes
6F1_282 - Environmental	3.50	3.56	10.83	+	Yes
6A2_264 - Muscle prolapse of vagina and rectum (cystocele, rectocele)	3.25	3.64	10.83	+	Yes
6F4_295 - Applying herbal/non-allopathic compresses	3.58	3.47	10.62	+	Yes
6B_279 - Separation of abdominal muscles (diastasis recti)	3.33	3.51	10.42	+	Yes
6F2b_289 - Apply topical agents	3.64	3.40	10.41	+	Yes
6A2_262 - Return of menses	4.01	3.32	10.37	+	Yes
6B_276 - Infection of vaginal tear or incision	2.50	4.05	10.07	+	Yes
6_249 - Consult or refer for jaundice in the first 24 hours after birth.	2.2	4.1	9.9	±	Yes
6F3_293 - Allopathic treatments	2.7	3.4	9.3	±	Yes
6A1_258 - Three to four weeks	3.4	3.2	9.2	±	Yes
6B_278 - Thrombophlebitis	2.3	4.2	9.1	±	Yes
6B_280 - Separation of symphysis pubis	2.5	3.7	8.9	±	Yes
6B_281 - Postpartum preeclampsia	2.2	4.2	8.8	±	Yes
6_250 - Provide direction for care of circumcised penis.	2.4	3.3	8.4	±	Yes
Well Baby	3.56	3.78	11.36		
7B_310 - Heart rate, rhythm, and regularity	4.32	4.05	14.10	+	Yes
7B_311 - Respirations	4.33	4.03	14.03	+	Yes
7F_339 - Assessing and monitoring newborn for lethargy and hydration.	4.13	4.06	13.92	+	Yes
7B_312 - Appropriate weight gain	4.36	3.98	13.84	+	Yes
7A_307 - Normal/abnormal newborn activity, responses, vital signs, appearance, and b...	4.33	3.99	13.80	+	Yes
7A_306 - Basic needs of newborn including breathing, warmth, nutrition, and bonding	4.34	3.98	13.79	+	Yes
7B_319 - Urination and stool for frequency, quality, and color	4.38	3.92	13.57	+	Yes
7B_316 - Level of alertness	4.35	3.90	13.46	+	Yes
7B_318 - Feeding patterns	4.38	3.87	13.34	+	Yes
7F_337 - Encouraging mother to breastfeed every two hours.	4.14	3.88	13.15	+	Yes
7B_309 - Temperature	4.15	3.84	12.94	+	Yes
7B_321 - Condition of cord	4.35	3.78	12.91	+	Yes

Domain/Task	Frequency	Importance	Criticality	Recommendation (Data)	Keep?
7B_320 - Appearance of skin	4.36	3.76	12.86	+	Yes
7_304 - Support integration of baby into family.	4.13	3.82	12.83	+	Yes
7B_315 - Neuro-muscular response	4.11	3.82	12.77	+	Yes
7A_308 - Normal growth and development of the newborn and infant	4.21	3.77	12.67	+	Yes
7G_343 - Perform or refer for newborn metabolic screening.	4.17	3.76	12.54	+	Yes
7B_317 - Wake/sleep cycles	4.33	3.69	12.49	+	Yes
7E_327 - Infections	2.81	4.14	12.27	+	Yes
7_291 - Understand, respect, and counsel on traditional or cultural practices relat...	3.91	3.75	12.24	+	Yes
7D_326 - Cord care	4.15	3.62	11.98	+	Yes
7_292 - Provide information for referral for continued well-baby care.	4.04	3.65	11.96	+	Yes
7E_328 - Cardio-respiratory abnormalities	2.65	4.19	11.85	+	Yes

7F_338 - Exposing front and back of newborn to sunlight through window glass.	3.93	3.63	11.79	+	Yes
7A_305 - Principles of newborn adaptation to extrauterine life including physiologic...	3.92	3.61	11.62	+	Yes
7_302 - Support and educate parents during grieving process for loss of pregnancy,...	2.56	4.01	11.57	+	Yes
7E_336 - Dehydration	2.62	4.13	11.47	+	Yes
7_303 - Support and educate parents of newborns transferred to hospital or with spe...	2.69	3.93	11.34	+	Yes
7F_340 - Consulting or refering for additional screening and/or treatment.	2.90	3.83	11.29	+	Yes
7G_341 - Educate about options for pediatrician or family practitioner.	4.00	3.48	11.15	+	Yes
7E_331 - Failure to thrive	2.51	4.16	11.14	+	Yes
7E_330 - Birth defects	2.48	4.08	10.91	+	Yes
7G_342 - Educate about health care providers for immunizations or non-immunizations...	3.80	3.40	10.64	+	Yes
7G_344 - Perform or refer for newborn hearing screening.	3.79	3.39	10.46	+	Yes
7B_314 - Measurement of circumference of head	3.70	3.36	10.29	+	Yes
7D_325 - Colic	3.27	3.44	10.15	+	Yes
7E_329 - Glucose disorders	2.40	4.04	10.00	+	Yes
7G_346 - Educate about referral for integrative/complimentary/alternative practition...	3.6	3.3	9.9	±	Yes
7G_345 - Perform or refer for pulse oximetry newborn screening for critical congenit...	3.3	3.5	9.8	±	Yes
7B_313 - Length	3.7	3.2	9.7	±	Yes
7D_322 - Diaper rash	3.5	3.3	9.6	±	Yes
7D_324 - Heat rash	3.3	3.1	8.7	±	Yes
7D_323 - Cradle cap	3.2	2.9	7.9	±	Yes
7E_332 - Newborn hemorrhagic disease (early and late onset)	2.0	4.2	6.9	±	Yes
7E_333 - Polycythemia	2.0	4.0	6.8	±	Yes
7E_334 - Non-accidental injuries	1.9	4.1	6.4	±	Yes
7E_335 - Congenital syphilis	1.67	4.12	4.74		No

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF LICENSED MIDWIVES

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-130-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: January 27, 2016

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Part I. General Provisions.

18VAC85-130-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2957.7 of the Code of Virginia.
"Midwife"
"Practicing midwifery"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:
"Board" means the Virginia Board of Medicine.
"Client" means a person receiving midwifery care and shall be considered synonymous with the word "patient."
"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI as set out in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).
"CPM" means the Certified Professional Midwife credential issued by the North American Registry of Midwives.
"NARM" means the North American Registry of Midwives.

18VAC85-130-20. Public participation.

A separate board regulation, 18 VAC 85-10, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-130-30. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as a midwife shall be $277.

2. The fee for biennial active license renewal shall be $312; the additional fee for late renewal of an active license within one renewal cycle shall be $105.

3. The fee for biennial inactive license renewal shall be $168; the additional fee for late renewal of an inactive license within one renewal cycle shall be $55.

4. The fee for reinstatement of a license that has expired for a period of two years or more shall be $367 in addition to the late fee. The fee shall be submitted with an application for licensure reinstatement.

5. The fee for a letter of good standing/verification of a license to another jurisdiction shall be $10.

6. The fee for an application for reinstatement if a license has been revoked or if an application for reinstatement has been previously denied shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.

9. The fee for a returned check shall be $35.

10. For 2017, the fee for renewal of an active license shall be $250, and the fee for renewal of an inactive license shall be $125.

18VAC85-130-31. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter given by the board to any such licensee shall be validly given when mailed to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

Part II.
Requirements for Licensure and Renewal of Licensure.

18VAC85-130-40. Criteria for initial licensure.

A. An applicant for board licensure shall submit:
1. The required application on a form provided by the board and the application fee as prescribed in 18 VAC 85-130-30;
2. Evidence satisfactory to the board of current certification as a CPM; and
3. A report from NARM indicating whether there has ever been any adverse action taken against the applicant.

B. If an applicant has been licensed or certified in another jurisdiction, the applicant shall provide information on the status of each license or certificate held and on any disciplinary action taken or pending in that jurisdiction.

18VAC85-130-45. Practice while enrolled in an accredited midwifery education program.

A person may perform tasks related to the practice of midwifery under the direct and immediate supervision of a licensed doctor of medicine or osteopathic medicine, a certified nurse midwife, or a licensed midwife while enrolled in an accredited midwifery education program or during completion of the North American Registry of Midwives' Portfolio Evaluation Process Program without obtaining a license issued by the board until such person has taken and received the results of any examination required for CPM certification or for a period of three years, whichever occurs sooner. For good cause shown, a person may request that the board grant any extension of time beyond the three years, for a period not to exceed one additional year.

18VAC85-130-50. Biennial renewal of licensure.

A. A licensed midwife shall renew licensure biennially during the midwife's birth month in each odd-numbered year by:
1. Paying to the board the renewal fee as prescribed in 18 VAC 85-130-30; and

2. Attesting to having current, active CPM certification by NARM.

B. A licensed midwife whose license has not been renewed by the first day of the month following the month in which renewal is required shall not be considered licensed in Virginia.

C. An additional fee to cover administrative costs for processing a late application renewal shall be imposed by the board as prescribed by 18 VAC 85-130-30.

18VAC85-130-60. Inactive licensure.

A. A licensed midwife who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license.
1. The holder of an inactive license shall not be required to maintain current, active certification by NARM.
2. An inactive licensee shall not be entitled to perform any act requiring a license to practice midwifery in Virginia.

B. An inactive licensee may reactivate licensure by:
1. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and
2. Submission of documentation of having current, active certification by NARM.
C. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provision of this chapter.

18VAC85-130-70. Reinstatement.

A. A licensed midwife who allows licensure to lapse for a period of two years or more and chooses to resume practice shall submit to the board a reinstatement application, information on practice and licensure in other jurisdictions for the period in which the license was lapsed in Virginia, proof of current, active certification by NARM, and the fee for reinstatement of licensure as prescribed in 18 VAC 85-130-30.

B. A licensed midwife whose license has been revoked by the board and who wishes to be reinstated must make a new application to the board, hold current, active certification by NARM, and pay the fee for reinstatement of a revoked license as prescribed in 18 VAC 85-130-30.

Part III.
Practice Standards.

18VAC85-130-80. General disclosure requirements.

A licensed midwife shall provide written disclosures to any client seeking midwifery care. The licensed midwife shall review each disclosure item and obtain the client's signature as evidence that the disclosures have been received and explained. Such disclosures shall include:
1. A description of the licensed midwife's qualifications, experience, and training;
2. A written protocol for medical emergencies, including hospital transport, particular to each client;
3. A statement as to whether the licensed midwife has hospital privileges;

4. A statement that a licensed midwife is prohibited from prescribing, possessing or administering controlled substances;
5. A description of the midwife's model of care;
6. A copy of the regulations governing the practice of midwifery;
7. A statement as to whether the licensed midwife carries malpractice or liability insurance coverage and, if so, the extent of that coverage;
8. An explanation of the Virginia Birth-Related Neurological Injury Compensation Fund and a statement that licensed midwives are currently not covered by the fund; and
9. A description of the right to file a complaint with the Board of Medicine and with NARM and the procedures and contact information for filing such complaint.

18VAC85-130-81. Disclosures on health risks.

A. Upon initiation of care, a midwife shall review the client's medical history in order to identify pre-existing conditions or indicators that require disclosure of risk for home birth. The midwife shall offer standard tests and screenings for evaluating risks and shall document client response to such recommendations. The midwife shall also continually assess the pregnant woman and baby in order to recognize conditions that may arise during the course of care that require disclosure of risk for birth outside of a hospital or birthing center.

B. If any of the following conditions or risk factors are presented, the midwife shall request and review the client's medical history, including records of the current or previous pregnancies; disclose to the client the risks associated with a birth outside of a hospital or birthing center; and provide options for consultation and referral. If the client is under the care of a physician for any of the following medical conditions or risk factors, the midwife shall consult with or request documentation from the physician as part of the risk assessment for birth outside of a hospital or birthing center.

1. Antepartum risks:

Conditions requiring ongoing medical supervision or ongoing use of medications;
Active cancer;
Cardiac disease;
Severe renal disease -- active or chronic;
Severe liver disease -- active or chronic;
HIV positive status with AIDS;
Uncontrolled hyperthyroidism;
Chronic obstructive pulmonary disease;
Seizure disorder requiring prescriptive medication;
Psychiatric disorders;
Current substance abuse known to cause adverse effects;
Essential chronic hypertension over 140/90;
Significant glucose intolerance;
Genital herpes;
Inappropriate fetal size for gestation;
Significant 2nd or 3rd trimester bleeding;
Incomplete spontaneous abortion;
Abnormal fetal cardiac rate or rhythm;
Uterine anomaly;

Platelet count less than 120,000;
Previous uterine incision and/or myomectomy with review of surgical records and/or subsequent birth history;
Isoimmunization to blood factors;
Body mass index (BMI) equal to or greater than 30;
History of hemoglobinopathies;
Acute or chronic thrombophlebitis;
Anemia (hematocrit less than 30 or hemoglobin less than 10 at term);
Blood coagulation defect;
Pre-eclampsia/eclampsia;
Uterine ablation;
Placental abruption;
Placenta previa at onset of labor;
Persistent severe abnormal quantity of amniotic fluid;
Suspected chorioamnionitis;
Ectopic pregnancy;
Pregnancy lasting longer than 42 completed weeks with an abnormal nonstress test;
Any pregnancy with abnormal fetal surveillance tests;
Rupture of membranes 24 hours before the onset of labor;
Position presentation other than vertex at term or while in labor; or
Multiple gestation.

2. Intrapartum risks:

Current substance abuse;
Documented intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term;
Suspected uterine rupture;
Active herpes lesion in an unprotectable area;
Prolapsed cord or cord presentation;
Suspected complete or partial placental abruption;
Suspected placental previa;
Suspected chorioamnionitis;
Pre-eclampsia/eclampsia;
Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent;
Position presentation other than vertex at term or while in labor;
Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones;
Excessive vomiting, dehydration, or exhaustion unresponsive to treatment;
Blood pressure greater than 140/90 that persists or rises and birth is not imminent;
Maternal fever equal to or greater than 100.4°F; or
Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date.

3. If a risk factor first develops when birth is imminent, the individual midwife must use judgment taking into account the health and condition of the mother and baby in determining whether to proceed with a home birth or arrange transportation to a hospital.

C. If the risks factors or criteria have been identified that may indicate health risks associated with birth of a child outside of a hospital or birthing center, the midwife shall provide evidence-based

information on such risks. Such information shall be specified by the board in guidance documents and shall include evidence-based research and clinical expertise from both the medical and midwifery models of care.

D. The midwife shall document in the client record the assessment of all health risks that pose a potential for a high risk pregnancy and, if appropriate, the provision of disclosures and evidence-based information.

18VAC85-130-90. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a client. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

18VAC85-130-100. Client records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of client records.
B. Practitioners shall provide client records to another practitioner or to the client or the client's personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage client records and shall maintain timely, accurate, legible and complete client records. Practitioners shall clearly document objective findings, decisions and professional actions based on continuous assessment for ongoing midwifery care.

D. Practitioners shall document a client's decisions regarding choices for care, including informed consent or refusal of care. Practitioners shall clearly document when a client's decisions or choices are in conflict with the professional judgment and legal scope of practice of the licensed midwife.

E. Practitioners shall maintain a client record for a minimum of six years following the last client encounter with the following exceptions:
1. Records of a minor child shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last client encounter regardless of the age of the child;
2. Records that have previously been transferred to another practitioner or health care provider or provided to the client or the client's personal representative do not have to be kept for a minimum of six years following the last client encounter; or
3. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

F. Practitioners shall in some manner inform all clients concerning the time frame for record retention and destruction. Client records shall only be destroyed in a manner that protects client confidentiality, such as by incineration or shredding.

G. When a practitioner is closing, selling or relocating a practice, the practitioner shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the client's choice or provided to the client.

18VAC85-130-110. Practitioner-client communication; termination of relationship.

A. Communication with clients.
1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a client or the client's legally authorized representative of the client's assessment and prescribed plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure directed by the practitioner.
2. A practitioner shall present information relating to the client's care to a client or the client's legally authorized representative in understandable terms and encourage participation in the decisions regarding the client's care.
3. Before any invasive procedure is performed, informed consent shall be obtained from the client. Practitioners shall inform clients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent licensed midwife practicing in Virginia would tell a client. In the instance of a minor or a client who is incapable of making an informed decision on the client's own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.
B. Termination of the practitioner/client relationship.
1. The practitioner or the client may terminate the relationship. In either case, the practitioner shall make a copy of the client record available, except in situations where denial of access is allowed by law.
2. Except as provided in § 54.1-2962.2 of the Code of Virginia, a practitioner shall not terminate the relationship or make services unavailable without documented notice to the client that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-130-120. Practitioner responsibility.

A. A practitioner shall:
1. Transfer care immediately in critical situations that are deemed to be unsafe to a client or infant and remain with the client until the transfer is complete;
2. Work collaboratively with other health professionals and refer a client or an infant to appropriate health care professionals when either needs care outside the midwife's scope of practice or expertise; and
3. Base choices of interventions on empirical and/or research evidence that would indicate the probable benefits outweigh the risks.

B. A practitioner shall not:
1. Perform procedures or techniques that are outside the scope of the midwife's practice or for which the midwife is not trained and individually competent;
2. Knowingly allow apprentices or subordinates to jeopardize client safety or provide client care outside of the apprentice's or subordinate's scope of practice or area of responsibility. Practitioners shall delegate client care only to those who are properly trained and supervised; and
3. Exploit the practitioner/client relationship for personal gain.

18VAC85-130-130. Advertising ethics.

A. Any statement specifying a fee, whether standard, discounted or free, for professional services that does not include the cost of all related procedures, services and products that, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the client and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee shall disclose the complete name of the board that conferred the certification when using or authorizing the use of the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for the licensee's practice.

E. A licensee of the board shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

18VAC85-130-140. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable client outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual client's overall medical condition and medications.

C. The practitioner shall conform to the standards of the practitioner's particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-130-150. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility as defined in § 37.2-100 of the Code of Virginia, or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320a-7b(b), as amended, or any regulations promulgated thereto.

18VAC85-130-160. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:
1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the client, or both; or
2. May reasonably be interpreted as romantic involvement with a client regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a client.
1. The determination of when a person is a client for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a client until the client-practitioner relationship is terminated.
2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a client does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former client after termination of the practitioner-client relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on client care. For purposes of this section, key third party of a client shall mean: spouse or partner, parent or child, guardian, or legal representative of the client.

E. Sexual contact between a supervisor and a trainee or apprentice shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on client care.

18VAC85-130-170. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

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Disclosures by Licensed Midwives for High-Risk Pregnancy Conditions

Virginia Board of Medicine

The Code of Virginia (Law) requires that licensed midwives "disclose to their patients, when appropriate, options for consultation and referral to a physician and evidence-based information on health risks associated with birth of a child outside of a hospital or birthing center." Regulations for Licensed Midwives specify that:

> *Upon initiation of care, a midwife shall review the client's medical history in order to identify pre-existing conditions or indicators that require disclosure of risk for home birth. The midwife shall offer standard tests and screenings for evaluating risks and shall document client response to such recommendations. The midwife shall also continually assess the pregnant woman and baby in order to recognize conditions that may arise during the course of care that require disclosure of risk for birth outside of a hospital or birthing center.*

The risk factors or conditions that require disclosures are listed in regulation. If any of these conditions or factors are presented, the midwife is to:

> *1) Request and review the client's medical history, including records of the current or previous pregnancies;*
>
> *2) Disclose to the client the risks associated with a birth outside of a hospital or birthing center; and*
>
> *3) Provide options for consultation and referral.*

Regulations require that if the risks factors or criteria have been identified that may indicate health risks associated with birth of a child outside a hospital or birthing center, the midwife must provide evidence-based information on such risks and must document in the client record the assessment of all health risks that pose a potential for a high risk pregnancy and, if appropriate, the provision of disclosures and evidence-based information. **The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit.**

For each of the risks factors or conditions identified, this guidance document provides evidence-based information and a format to record in a client's record the disclosure of information and options for consultation and referral.

To access the evidence-based information and disclosure for a particular conditions or risk, click on the link in the index below. The midwife may then print the form for that condition or risk for presentation and discussion with the client and have the form signed for inclusion in the client record.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Intrapartum Risk Factors

1. Abnormal fetal cardiac rate or rhythm
2. Active cancer
3. Acute or chronic thrombophlebitis
4. Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)
5. Any pregnancy with abnormal fetal surveillance tests
6. Blood coagulation defect
7. Body Mass Index (BMI) equal to or greater than 30
8. Cardiac disease
9. Chronic obstructive pulmonary disease including asthma
10. Ectopic pregnancy
11. Essential chronic hypertension over 140/90
12. Genital herpes or partner with genital herpes
13. History of hemoglobinopathies
14. HIV positive status with AIDS
15. Inappropriate fetal size for gestation – Macrosomia (Large for gestational age)
16. Inappropriate fetal size for gestation – IUGR (Small for gestational age)
17. Incomplete spontaneous abortion
18. Isoimmunization to blood factors
19. Multiple gestation
20. Persistent severe abnormal quantity of amniotic fluid
21. Platelet count less than 120,000
22. Position presentation other than vertex at term or while in labor
23. Pre-eclampsia/eclampsia
24. Pregnancy lasting longer than 42 completed weeks with an abnormal non-stress test
25. VBAC (vaginal birth after cesarian) previous uterine incision or myomectomy
26. Psychiatric disorders (Mental Health Disorders)
27. Rupture of membranes 24 hours before the onset of labor
28. Seizure disorder requiring prescriptive medication

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29. Severe liver disease -- active or chronic
30. Severe renal disease - active or chronic
31. Significant 2nd or 3rd trimester bleeding
32. Significant glucose intolerance (Preexisting diabetes, gestational diabetes, PCOS)
33. Uncontrolled hyperthyroidism
34. Uterine ablation (endometrial ablation)
35. Uterine anomaly

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1. Intrapartum Risk Factors

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications

Clients with chronic medical conditions, on prescribed medications, or under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any medical conditions they have or medications that they are taking may increase their risk of complications.

Current substance abuse (including alcohol and tobacco)

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from abusing other drugs include:

- Heroin and cocaine consumption result in medical, nutritional and social neglect
- Cocaine and amphetamine cause hypertension, placental abruption
- Intravenous abuse also increases the risk of contracting infectious disease.[1]
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause NAS (Neonatal abstinence syndrome).[2] NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Documented intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term

Complications[3] for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

"IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins."[4]

Suspected uterine rupture

Consequences of uterine rupture:

- There have been no reported maternal deaths due to uterine rupture
- Overall, 14 percent to 33 percent of women will need a hysterectomy when the uterus ruptures
- Approximately 6 percent of uterine ruptures will result in perinatal death
- This is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- "For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3 percent. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterine rupture."[5]

Prolapsed cord or cord presentation

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1000 of pregnancies. Although uncommon, it is considered a true obstetrical emergency most often necessitating a caesarean delivery. Prolapsed cord is associated with other complications of pregnancy and delivery as well.

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[1] Pregnancy and substance abuse, G. Fischer, M. Bitschnau, A. Peternell, H. Eder, A. Topitz. Archives of Women's Mental Health. August 1999, Volume 2, Issue 2, pp 57-65.
[2] Casper, Tammy, and Megan W. Arbour. "Identification of the Pregnant Woman Who Is Using Drugs: Implications for Perinatal and Neonatal Care." Journal of Midwifery & Women's Health (2013).
[3] Lerner, Jodi P. "Fetal growth and well-being." Obstetrics and gynecology clinics of north America 31.1 (2004): 159-176.
[4] Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990
[5] Guise, Jeanne-Marie, et al. "Vaginal birth after cesarean: new insights." (2010).

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Fetal risks:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency[6] of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa

Pregnancies complicated with placenta previa had significantly higher rates[7] of

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis

Chorioamnionitis is a potentially serious complication:[8]

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.
- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

[6] Ananth, Cande V., et al. "Placental abruption and adverse perinatal outcomes." JAMA: the journal of the American Medical Association 282.17 (1999): 1646-1651.
[7] Sheiner, E., et al. "Placenta previa: obstetric risk factors and pregnancy outcome." Journal of Maternal-Fetal and Neonatal Medicine 10.6 (2001): 414-419.
[8] Thomas, Wolfgang, and Christian P. Speer. "Chorioamnionitis: important risk factor or innocent bystander for neonatal outcome?." Neonatology 99.3 (2010): 177-187.

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Pre-eclampsia/eclampsia

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include: [9]

- DIC
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death rates of 0-13.9% have been reported

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of: [10]

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption
- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of: [11]

- Cerebral palsy

[9] Norwitz, Errol R., Chaur-Dong Hsu, and John T. Repke. "Acute complications of preeclampsia." Clinical obstetrics and gynecology 45.2 (2002): 308-329.
[10] de Souza Rugolo, Ligia Maria Suppo, Maria Regina Bentlin, and Cleide Enoir Petean Trindade. "Preeclampsia: effect on the fetus and newborn." Neoreviews 12.4 (2011): e198-e206.
[11] Rahman, Shimma, Jeffrey Unsworth, and Sarah Vause. "Meconium in labour." Obstetrics, Gynaecology & Reproductive Medicine 23.8 (2013): 247-252.

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- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system[12]
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted[13]
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result[14]

Blood pressure greater than 140/90 which persists or rises and birth is not imminent

Women with chronic hypertension are at increased risk of: [15]

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure
- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°

Fever can indicate infection. Fever in labor is associated with: [16]

- Early neonatal and infant death
- Hypoxia

[12] Watanabe, Takashi, et al. "Effect of labor on maternal dehydration, starvation, coagulation, and fibrinolysis." Journal of perinatal medicine 29.6 (2001): 528-534.
[13] Frye, Anne, Holistic Midwifery, Volume II, Labrys Press, Portland, OR, 2004, p. 1055.
[14] Davis, Elizabeth, Heart and Hands: A Midwife's Guide to Pregnancy and Birth, Celestial Arts, New York, NY, 2004, p. 141.
[15] Hypertension. 2003; 41: 437-445 Published online before print February 10, 2003, doi: 10.1161/01.HYP.0000054981.03589.E9
[16] PETROVA, Anna, et al. "Association of maternal fever during labor with neonatal and infant morbidity and mortality." Obstetrics and gynecology 98.1 (2001): 20-27.

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- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby:

Risks to Baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal Risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

HOME

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2. Abnormal Fetal Cardiac Rate or Rhythm

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Disclosure of risks related to: Abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
    - may indicate severe systemic disease
    - may have the potential to compromise the fetal circulation
    - May require intensive antepartum and/or neonatal care

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Home

Congenital heart disease: Rhythm abnormalities of the fetus. Lisa K Hornberger, David J Sahn. Heart 2007;93:10 1294-1300 doi:10.1136/hrt.2005.069369

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3. Active cancer

Preamble:

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Disclosure of risks related to: Active Cancer

Maternal risks:

- maternal infection due to immune suppression,
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery.

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

http://www.nlm.nih.gov/medlineplus/cancerandpregnancy.html J Obstet Gynaecol Can. 2013 Mar;35(3):263-80.

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4. Acute or Chronic Thrombophlebitis

Preamble:

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Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the non-pregnant population. The risk for VTE is further elevated in the postpartum period.

The risk for VTE in pregnancy is increased in women with:

- **Prior history of VTE**
- **Advanced maternal age**
- **Collagen-vascular disease, especially antiphospholipid antibody syndrome**
- **Obesity (BMI > 30)**
- **Multiparity**
- **Hypercoaguable state**
- **Nephrotic syndrome**
- **Operative delivery**
- **Prolonged bed rest**
- **Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias).**
- **Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)**
- **Smoking**
- **Preeclampsia**

Maternal complications:

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- **hypoxemia**
- **post-phlebitic syndrome**
- **pulmonary infarction**
- **death**

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- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Chisholm CA, James AH, Ferguson JE. Thromboembolic disorders. In: Evans AE, Manual of Obstetrics, 8th edition. 2014, Wolters Kluwers Health.

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5. Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)

Preamble:

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Disclosure of risks related to: Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic.[17]

Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality.[18]

...a woman who is already anemic is unable to tolerate blood loss that a healthy woman can.[19]

Maternal Risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression

Fetal/Neonatal Risks related to maternal severe or untreated anemia:

- prematurity
- low-birth-weight
- anemia
- developmental delays

[17] Benoist B, McLean E, Egli I, et al. Worldwide Prevalence of Anaemia 1993-2005. Geneva, Switzerland: World Health Organization; 2008.
[18] Allen, Lindsay H. "Anemia and iron deficiency: effects on pregnancy outcome." The American journal of clinical nutrition 71.5 (2000): 1280s-1284s.
[19] McCormick, M. L., et al. "Preventing postpartum hemorrhage in low-resource settings." International journal of gynecology & obstetrics 77.3 (2002): 267-275.

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6. Any Pregnancy with abnormal Fetal Surveillance Tests

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Disclosure of risks related to: Pregnancy with abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery (Price, 2014)." Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

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O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology*, *55* (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Sruveilannce. *Am Fam Physician*.
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology*, *28* (8), 779-782.

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7. Blood coagulation defect

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Disclosure of risks related to: Blood coagulation defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1-15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

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Inherited Thrombophilia in Pregnancy. Practice Bulletin 138, November 2013. American College of Obstetricians and Gynecologists.

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8. Body Mass Index (BMI) equal to or greater than 30

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Disclosure of risks related to: Body Mass Index (BMI) equal to or greater than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of Obesity Include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother's obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother's BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.

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- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having ~~babies~~ diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

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Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

9. CARDIAC DISEASE

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Disclosure of risks related to: Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

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Midwife ______________________________ Date ____________

Nanda S, Nelson-Piercy C, Mackillop L. Cardiac disease in pregnancy. Clin Med 2012;12:553-560.

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10. CHRONIC OBSTRUCTIVE PULMONARY DISEASE INCLUDING ASTHMA (1)

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Asthma affects approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

RISKS

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

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Client ______________________________ Date ______________

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(1) http://www.glowm.com/section_view/heading/Pulmonary%20Disease%20in%20Pregnancy/item/170#1199

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11. ECTOPIC PREGNANCY (1)

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Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated with surgery.

RISKS

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future.
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock.
- Death

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

(1) http://www.webmd.boots.com/pregnancy/tc/ectopic-pregnancy-complications-of-ectopic-pregnancy

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12. ESSENTIAL CHRONIC HYPERTENSION (1)

Preamble:

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Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

MATERNAL RISKS

- Preterm delivery
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Death

FETAL RISKS

- Fetal growth restriction
- Fetal death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ____ Date ________________

Midwife ____ Date ________________

(1) http://www.nhlbi.nih.gov/health/public/heart/hbp/hbp_preg.htm

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13. GENITAL HERPES OR PARTNER WITH GENITAL HERPES

Preamble:

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Disclosure of Risks Related to: Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for ***HSV - Herpes Simplex Virus*** (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. In an effort to reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. ***However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.***[20]

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.[21]

Risks of HSV infection to the fetus include:

[20] Kimberlin, David W., et al. "Guidance on management of asymptomatic neonates born to women with active genital herpes lesions." Pediatrics 131.2 (2013): e635-e646.
[21] Meytal Avgil, Asher Ornoy, Herpes simplex virus and Epstein-Barr virus infections in pregnancy: consequences of neonatal or intrauterine infection, Reproductive Toxicology, Volume 21, Issue 4, May 2006, Pages 436-445, ISSN 0890-6238, http://dx.doi.org/10.1016/j.reprotox.2004.11.014.

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- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations),
- ophthalmologic findings (chorioretinitis, microphtalmia),
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.[22]

Risks of HSV infection to the neonate (newborn) include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomacia),
- growth restriction,
- psychomotor development impairment
- skin vesicles or scarring,
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts),
- hearing loss and/or deafness

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- ❑ Decline consultation with a physician regarding my risk factors.

Client ____________________________________ Date _______________

Midwife __________________________________ Date _______________

[22] Anzivino, Elena, et al. "Herpes simplex virus infection in pregnancy and in neonate: status of art of epidemiology, diagnosis, therapy and prevention." Virol J 6.1 (2009): 1-11.

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14. HISTORY OF HEMOGLOBINOPATHIES

Preamble:

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Disclosure of risks related to: History of hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks include:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks include:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth

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- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client ____ Date _______________

Midwife _______________________________________ Date _______________

Villers, Margaret S., et al. "Morbidity associated with sickle cell disease in pregnancy." American journal of obstetrics and gynecology 199.2 (2008): 125-e1.
Naik, Rakhi P., and Sophie Lanzkron. "Baby on board: what you need to know about pregnancy in the hemoglobinopathies." ASH Education Program Book 2012.1 (2012): 208-214.
John C. Morrison and Marc R. Parrish. "Sickle Cell Disease and Other Hemoglobinopathies" Protocols for High-Risk Pregnancies (2010): 158-159.
American College of Obstetricians and Gynecologists, Practice Bulletin 78, "Hemoglobinopathy in Pregnancy," January 2007

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15. HIV POSITIVE STATUS WITH AIDS

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Disclosure of risks related to: HIV positive status with AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given, the virus becomes undetectable, and breastfeeding is avoided.[23]

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

16. INAPPROPRIATE FETAL SIZE FOR GESTATION – MACROSOMIA (LARGE FOR GESTATIONAL AGE)

[23] http://www.cdc.gov/hiv/risk/gender/pregnantwomen/index.html

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning ***big body***), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as ***large for gestational age***, fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.[24]

Risks to the mother related to macrosomia include:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby related to macrosomia at the time of birth include:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
    - broken clavicle (collar) bone(s);
    - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
    - cerebral palsy;
    - hypoxia, resulting in permanent brain damage;
    - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
    - bruising and/or injury to the scalp, head and/or face;

[24] MARK A. ZAMORSKI, M.D., M.H.S.A., and WENDY S. BIGGS, M.D., University of Michigan Medical School, Ann Arbor, Michigan. Am Fam Physician. 2001 Jan 15;63(2):302-307.

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    - temporary weakness in the facial muscles (facial palsy);
    - external eye and/or ear trauma;
    - broken clavicle (collar) bone(s);
    - brachial plexus injury (see description above);
    - cerebral palsy;
    - skull fracture;
    - bleeding within the skull;
    - seizures;
    - lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU);

Risks to the newborn related to macrosomia and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);
- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life.

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☐ Consult with a physician regarding my risk factors.
☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

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17. INAPPROPRIATE FETAL SIZE FOR GESTATION – IUGR (SMALL FOR GESTATIONAL AGE)

Preamble:

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.[25]

Risks to the baby related to IUGR, known as Small for Gestation Age:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);

[25] Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990

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- stillbirth (fetal death during labor or birth).

Risks to the mother related to IUGR:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client ______________________________________ Date ________________

Midwife ______________________________________ Date ________________

18. INCOMPLETE SPONTANEOUS ABORTION OR INCOMPLETE MISCARRIAGE (10)

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Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

STILLBIRTH OR INTRAUTERINE FETAL DEMISE (IUFD)

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

MATERNAL FETAL RISKS OF EARLY OR LATE FETAL LOSS

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

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- ☐ Consult with a physician regarding my risk factors.

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- [ ] Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

(10)http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Management_of_Stillbirth

(10)http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Early_Pregnancy_Loss

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19. ISOIMMUNIZATION TO BLOOD FACTORS

Preamble:

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Disclosure of risks related to: Isoimmunization to blood factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.[26]

Risks to the baby related to maternal isoimmunization include:

- destruction of fetal red blood cells (hemolysis);
  - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment).
  - severe hemolysis leads to red blood cell production by the spleen and liver.
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);
- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth.

[26] Urbaniak, S. J., and M. A. Greiss. "RhD haemolytic disease of the fetus and the newborn." Blood reviews 14.1 (2000): 44-61.

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Midwife ______________________________ Date ______________

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20. Multiple gestation

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Disclosure of risks related to: Multiple gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Rao, Anita, Shanthi Sairam, and Hassan Shehata. "Obstetric complications of twin pregnancies." Best Practice & Research Clinical Obstetrics & Gynaecology 18.4 (2004): 557-576.
Spellacy, W. N. "Antepartum complications in twin pregnancies." Clinics in perinatology 15.1 (1988): 79-86.

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21. Persistent Severe Abnormal Quantity of Amniotic Fluid (Oligohydramnios and Polyhydramnios)

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Disclosure of risks related to: Persistent severe abnormal quantity of amniotic fluid

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- antepartum hospitalization
- induction of labor
- cesarean delivery

Fetal risks:

- pulmonary hypoplasia (underdevelopment of the lungs)
- limb contractures
- abnormal fetal heart rate patterns
- acidosis
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- stillbirth or neonatal death

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Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- cesarean delivery
- post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

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Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Shanks, Anthony, et al. "Assessing the optimal definition of oligohydramnios associated with adverse neonatal outcomes." Journal of Ultrasound in Medicine 30.3 (2011): 303-307.
Magann EF, Sandlin AT, Ounpraseuth ST. Amniotic fluid and the clinical relevance of the sonographically estimated amniotic fluid volume: oligohydramnios. J Ultrasound Med 2011;30:1573-85.
Moore, Thomas R. "Abnormal Amniotic Fluid Volume." Protocols for High-Risk Pregnancies (2010): 399.

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22. PLATELET COUNT LESS THAN 120,000

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Disclosure of risks related to: Platelet count less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). With the exception of gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders:

- ITP: chronic disorder associated with:
  - fluctuating platelet counts that may be lower than 50,000
  - need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.
- TTP: acute or chronic disorder generally associated with:
  - severe thrombocytopenia of 20,000 or less
  - hepatic impairment
  - renal impairment
  - CNS impairment
  - increased risk of death for both mother and fetus.

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- HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:
    - thrombocytopenia
    - elevated liver enzymes
    - hemolytic anemia
    - potential for severe maternal illness including:
        - liver failure
        - hepatic subcapsular hematoma
        - excess maternal blood loss
        - seizure
        - maternal death
        - preterm birth
        - intrauterine growth restriction
        - fetal death

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Client ______________________________ Date ______________

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Gernsheimer T, James AH, Stasi R. How I treat thrombocytopenia in pregnancy. Blood 2013;121:38-47.
Thrombocytopenia during pregnancy. Importance, diagnosis and management. Boehlen F. Hamostaseologie. 2006 Jan;26(1):72-4

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23. Position presentation other than vertex at term or while in labor

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Presentation Risks

Non-vertex presentations occur in less than 4% of all pregnancies. This would include breech, brow, face, transverse lie, and compound presentations. Non-vertex presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations would increase risk to the mother/baby in addition to the actual risks associated with non-vertex delivery.

C-section has become the standard mode of delivery for babies in non-vertex positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-vertex presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal position cannot be rotated.

Disclosure of risks related to: Position presentation other than vertex at term or while in labor:

Risks to Babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth

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- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal Risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

de Leeuw, J. (2002). Mortality and early morbidity for abdominal and vaginal deliveries in breech presentation. *Journal of Obstetrics and Gynaecology*, *22* (2), 127-139.
Tidy, C. R. (2010). *patient.co.uk/doctor/malpresentations*. Retrieved from patient.co.uk.

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24. Pre-eclampsia/Eclampsia

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Disclosure of risks related to Pre-eclampsia:

Pre-eclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of pre-eclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal Risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP syndrome
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

Fetal Risks:

- Small for gestational age (IUGR)
- Premature Birth
- Stillbirth

American College of Obstetricians and Gynecologists. (2011). *Frequently Aksed Questions: Pregnancy: High Blood Pressure During Pregnancy.* ACOG.
Cunningham, C. L. (2010). *Williams Obstetrics* (23rd Edition ed.). New York, NY: McGraw-Hill.
Frye, A. (1998). *Holistic Midwifery* (Vol. 1). Portland, OR: Labry's Press.

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25. Pregnancy lasting longer than 42 completed weeks with an abnormal stress test

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Pregnancy is considered to be postdates at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks ***with*** an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery. (Price, 2014)

Maternal Risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal Risk

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia

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- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspirtation
- Death

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Client ______________________________ Date ____________

Midwife ______________________________ Date ____________

Hilder, C. T. (1998). Prolonged Pregnancy: evaluating gestation-specific risks of fetal and infact mortality. *BJOG* .
O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology* , *55* (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Sruvellannce . *Am Fam Physician* .
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology* , *28* (8), 779-782.

26. VBAC (VAGINAL BIRTH AFTER CESARIAN) PREVIOUS UTERINE INCISION OR MYOMECTOMY (8)

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Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. But if problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery. Because uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency. Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC so review of prior surgical records is essential part of the evaluation.

RISKS

Maternal risks

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks

- Hypoxic Ischemic Encephalopathy
- Stillbirth

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- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success

Increased Probability of Success
- Prior vaginal birth
- Spontaneous labor

Decreased Probability of Success
- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Non-white ethnicity
- Gestational age greater than 40 weeks
- Maternal obesity
- Preeclampsia
- Short interpregnancy interval
- Increased neonatal birth weight

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- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

(8) http://www.webmd.com/baby/tc/vaginal-birth-after-cesarean-vbac-risks-of-vbac-and-cesarean-deliveries

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27. PSYCHIATRIC DISORDERS (MENTAL HEALTH DISORDERS)

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Clients with mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

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Works Cited

Sinclair, C. (2004) A Midwife's Handbook St. Louis, MO: Saunders

Vesga-Lopez O, B.C. (2008) *Psychiatric Disorders in Pregnant and Postpartum Women in the United States,* Archives of General Psychiatry, 65(7) 805-815

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

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28. RUPTURE OF MEMBRANES 24 HOURS BEFORE THE ONSET OF LABOR (7)

Preamble:

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The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

MATERNAL COMPLICATIONS

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- bacteremia
- postpartum hemorrhage
- postpartum hemorrhage
- bacteremia most commonly involving GBS

Rarely

- septic shock
- disseminated intravascular coagulation
- adult respiratory distress syndrome

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- maternal death

FETAL COMPLICATIONS

- fetal death
- neonatal sepsis

NEONATAL COMPLICATIONS

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

(7) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008318/

(7) http://www.nejm.org/doi/full/10.1056/NEJM199611143352013

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29. Seizure disorder requiring prescriptive medication

Preamble:

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Disclosure of risks related to: Seizure disorder requiring prescriptive medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
  - Intrauterine growth restriction
  - Preterm birth
  - Stillbirth
- Some medications are associated with an increased risk of birth defects

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Best practice guidelines for the management of women with epilepsy. Crawford, P., Epilepsia. 2005:46 Suppl 9:117-24.
McPherson JA, harper LM, Odibo AO, et al. Maternal seizure disorder and risk of adverse pregnancy outcomes. Am J Obstet Gynecol 2013;208:378.e1-5.
Management of epilepsy during pregnancy. Battino D., Tomson T. Drugs, 2007:67(18):2727-46.

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30. Severe Liver Disease -- Active or Chronic

Preamble:

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Disclosure of risks related to: Severe liver disease -- active or chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- is usually acute in onset
- can be life-threatening to the mother
- associated with a high risk of stillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Liver Disease in Pregnancy, Cleveland Clinic Disease Management Project, Jamilé Wakim-Fleming, August 10, 2010.
Joshi D, James A, Quaglia A et al. Liver Disease in Pregnancy. Lancet 2010;375:594-605.

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31. SEVERE RENAL DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe Renal Disease — Active or Chronic

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal:

- Hypertension
- abruptio placentae
- deterioration of renal function including permanent end-stage renal failure;

Fetal:

- Intrauterine growth restriction
- abruptio placentae
- stillbirth

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- ☐ Consult with a physician regarding my risk factors.

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- ☐ Decline consultation with a physician regarding my risk factors.

Client ____ Date __________________

Midwife ____ Date __________________

Williams DJ, Davison JM. Renal Disorders. In: Creasy & Resnick's Maternal-Fetal Medicine, Principles and Practice. 6th edition, 2009: Saunders Elsevier.

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32. SIGNIFICANT 2ND OR 3RD TRIMESTER BLEEDING

Preamble:

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Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placenta abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal Risk Factors:

- C-section
- Hemorrhage
- Anemia
- Hypovolemic Shock
- Death
- Coagulation Defects (DIC)
- Damage to Kidneys and Brain

Fetal Risk Factors:

- Poor fetal growth (IUGR)
- Birth Defects

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- Premature Birth
- Anemia
- Hypovolemic Shock
- Stillbirth

American College of Obstetricians and Gynecologists. (2011).*Frequently Asked Questions in Pregnancy: Bleeding During Pregnancy.* ACOG.
Karim, S. e. (1998). Effects of first and second trimester vaginal bleeding on pregnancy outcome.". *JPMA* .
Nielson, E. M. (1991). The Outcome of Prengancies complicated by bleeding during the second trimester. *Surgery, Gynecology, & Obstetrics* .
Oylese, Y. (2010). Third Trimester Bleeding. *Protocols for High Risk Pregnancies* .

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33. SIGNIFICANT GLUCOSE INTOLERANCE (PREEXISTING DIABETES, GESTATIONAL DIABETES, PCOS)

Preamble:

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Disclosure of risks related to: Significant glucose intolerance

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean dellivery
- Uncontrolled diabetes may result in:
    - kidney damage
    - retinopathy resulting in vision loss
    - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:

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- hypertensive disorders
- large for gestational age babies
- stillbirth
- abnormal progression of labor
- cesarean delivery
- shoulder dystocia with resultant brachial plexus injury

- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being ~~are prescribed~~ may be indicated.
- In the newborn period
  - hypoglycemia
  - hyperbilirubinemia
  - polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

Pre-gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 60, March 2005.
Gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 137, August 2013.
Landon MB, Gabbe SG. Gestational Diabetes Mellitus. Obstet Gynecol 2011;118:1379-93.

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34. UNCONTROLLED HYPERTHYROIDISM

Preamble:

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Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases.

The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

RISKS

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor or delivery.

RISKS

- Shock
- Stupor
- Coma

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- ❑ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

(1)http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Thyroid_Disease_in_Pregnancy

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35. Uterine Ablation (Endometrial ablation)

Preamble:

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Disclosure of risks related to Uterine Ablation (Endometrial Ablation):

Endometrial Ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research and the maternal and fetal complications are poorly defined.

Maternal Risks:

- Miscarriage
- Placenta acreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-Section
- Hysterectomy
- Death

Fetal Risks:

- Prematurity
- Death
- Possible increase in anomalies

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

American College of Obstetricians and Gynecologists. (2013).*Frequently Asked Questions: Special Procedures: Endometrial Ablation.* ACOG.
Jenny, S. L. (2006). Pregnancy after endometrial ablation: English literature review and case report . *The Journal of Minimally Invasive Gynecology , 13* (2), 88-91.
Laberge P. (2008, Oct). Serious and deadly complications from pregnancy after endometrail ablation reports and review of the literature. *J Gynecology Obstertics Biological Reproduction (Paris)* .

36. UTERINE ANOMALY

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Uterine anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for

- PTB (preterm birth)
- Fetal presentation other than vertex
- Hemorrhage
- Retained placenta
- Kidney malformation

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife ______________________________ Date ______________

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Board of Medicine

Guidance Document on Compliance with Law for Licensed Midwives

The following sections of the Code of Virginia have been identified as applicable to the practice of a licensed midwife. *The listing is not intended to be all-inclusive but should be regarded as a reference for the legal responsibilities of a midwife.* Each section is listed as an electronic link to the actual language in the Code. Every licensed midwife should familiarize herself with these and any other legal responsibilities relating to her care of an expectant mother and her newborn child.

Below the listing of Code sections may be found links and contact information that may be used for additional resources on compliance with law and regulation.

§ 32.1-49. Tuberculosis required to be reported.

§ 32.1-60. Prenatal tests required.

§ 32.1-61. Definition.

§ 32.1-62. Procedure upon infant's birth.

§ 32.1-64.1. Virginia Hearing Impairment Identification and Monitoring System.

§ 32.1-65. Certain newborn screening required.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.

§ 32.1-73. Failure to comply with provisions; grounds for revocation of license or permit.

§ 32.1-127.1:03. Health records privacy.

§ 32.1-134.01. Certain information required for maternity patients.

§ 32.1-257. Filing birth certificates; from whom required; signatures of parents.

§ 32.1-257.1. Parents to report social security account number at time of child's birth.

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by medical examiner; confidentiality of information concerning abortions.

§ 32.1-285.1. Death of infants under eighteen months of age; autopsies required; definition of Sudden Infant Death Syndrome.

§ 54.1-2403.01. Routine component of prenatal care.

§54.1-2403.02. Prenatal education; cord blood banking.

§54.1-2403.1. Protocol for certain medical history screening required.

For additional information or guidance on compliance with law in Chapter 32.1 of the Code of Virginia, contact: Joan Corder-Mabe, Director of Division of Women's and Infant's Health at Joan.Corder-Mabe@vdh.virginia.gov or (804) 864-7750.

You may access further information and additional resources at: http://www.vahealth.org/wih/ and http://www.vahealth.org/childadolescenthealth/

Board of Medicine
Guidance Document
Role of Licensed Midwives in Newborn Hearing Screening, Documentation, and Reporting

1. Record risk indicators for hearing loss, as recommended by the Joint Committee on Infant Hearing in the most recent position statement.
    a. That statement can be found at the following Web site: http://www.jcih.org/ .
    b. Clarifications for these risk indicators can be found on the Virginia Department of Health (VDH) Virginia Early Hearing Detection and Intervention Web site, under, http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/hospitals.htm, Hospital Protocols for Newborn Hearing Screening as well as Risk Indicators for Progressive or Delayed-Onset Hearing Loss.

2. Report infants with risk indicators, regardless of whether or not the CPM conducts a physiological newborn hearing screening, to the VDH Early Hearing Detection and Intervention (EHDI) Program.
    a. Screening/Audiological Reporting Form (revised 01/12) can be downloaded from http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/audiologists.htm
    b. Instructions can be downloaded from http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/audiologists.htm

3. Conduct initial physiological hearing screen or refer to an audiologist for the initial hearing screen.
    a. If the CPM elects to perform the physiological newborn hearing screening, the results should be reported on the same form referenced in 2. a. above.
    b. If the CPM elects to perform the physiological newborn hearing screening and the parent refuses the screening, this also should be reported on the above-referenced form.

4. The results of the newborn hearing screening conducted by the CPM can be reported on the form, in Section E. Parent refusal should be noted in the same section. When the form is revised, screening results can be recorded in Section E; refusals should be recorded under Notes/Comments. The CPM should not use this form to report results of screening conducted by other parties.

5. If the CPM elects to refer the infant for the physiological newborn hearing screening, a list of audiologists approved for full assessment can be found on the program Web site www.vahealth.org/hearing by selecting the Audiological Facilities tab or by visiting the Early Hearing Detection and Intervention Pediatric Audiology Links to Services (EHDIPALS) web site http://www.ehdipals.org/SmartTool/EP_SmartTool.aspx

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6. Information about newborn hearing screening equipment can be found on the National Center for Hearing Assessment and Management (NCHAM) Web site, http://www.infanthearing.org/screening/equipment.html . NCHAM is the National Resource Center for Early Hearing Detection and Intervention and is supported by grant funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

7. Questions regarding protocols and the VDH EHDI Program management can be directed to Ruth Frierson, Program Manager, at 804-864-7713 or ruth.frierson@vdh.virginia.gov. Questions about managing referrals can be directed to Daphne Miller, toll free at 866-493-1090.

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Guidance document: 85-28 Adopted: June 22, 2017

Virginia Board of Medicine
Authority of Licensed Midwives to Order Tests

Code of Virginia 54.1-2957.9 indicates that the scope of practice for licensed midwives in Virginia is to "be consistent with the North American Registry of Midwives' current job description for the profession and the National Association of Certified Professional Midwives · standards of practice."

The Board has based the following items on The *North American Registry of Midwives (NARM) 2016 Job Analysis Survey Comprehensive Report* Exam Content Outline for the NARM Written Examination. The document was recommended by the NARM Job Analysis Committee and approved by the NARM Board of Directors.

From *General Healthcare Skills*:

- Obtains or refers for urine screening tests
- Obtains or refers for vaginal culture
- Obtains or refers for blood screening tests

From *Prenatal Care*:

Assess and evaluate a post-date pregnancy by consulting or referring for:

- Ultrasound
- Non-stress test
- Biophysical profile

Virginia Board of Medicine
2018 Board Meeting Dates

Full Board Meetings

February 15-17, 2018	DHP/Richmond, VA	Board Rooms TBA
June 14-16, 2018	DHP/Richmond, VA	Board Rooms TBA
October 18-20, 2018	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 13, 2018	DHP/Richmond, VA	Board Rooms TBA
August 3, 2018	DHP/Richmond, VA	Board Rooms TBA
December 7, 2018	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 19, 2018	DHP/Richmond, VA	Board Rooms TBA
May 18, 2018	DHP/Richmond, VA	Board Rooms TBA
September 7, 2018	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

Credentials Committee Meetings

January 24, 2018	February 28, 2018	March 21, 2018
April 25, 2018	May 30, 2018	June 27, 2018
July 25, 2018	August 22, 2018	September 26, 2018
October 24, 2018	November 14, 2018	December (TBA), 2018

Times for the Credentials Committee meetings - TBA

Advisory Board on:

Advisory Board			Time
Behavioral Analysts			**10:00 a.m.**
January 29	June 4	October 1	
Genetic Counseling			**1:00 p.m.**
January 29	June 4	October 1	
Occupational Therapy			**10:00 a.m.**
January 30	June 5	October 2	
Respiratory Care			**1:00 p.m.**
January 30	June 5	October 2	
Acupuncture			**10:00 a.m.**
January 31	June 6	October 3	
Radiological Technology			**1:00 p.m.**
January 31	June 6	October 3	
Athletic Training			**10:00 a.m.**
February 1	June 7	October 4	
Physician Assistants			**1:00 p.m.**
February 1	June 7	October 4	
Midwifery			**10:00 a.m.**
February 2	June 8	October 5	
Polysomnographic Technology			**1:00 p.m.**
February 2	June 8	October 5	

Joint Boards of Medicine and Nursing

TBA