

DEPARTMENT OF REGULATORY AGENCIES

COLORADO MIDWIVES REGISTRATION

RULES AND REGULATIONS

4 CCR 739-1

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RULE 1 – Repealed eff. 7/1/2007

RULE 2 – STANDARDS FOR EDUCATION

The purpose of this rule is to establish the minimum entry level education and training requirements for an applicant to become registered as a direct-entry midwife as required by Section 12-37-103(6) and 106(1)(c), C.R.S.

- A. To become registered in Colorado, an applicant must have graduated from an accredited midwifery educational program approved by the Midwifery Education and Accreditation Council (“MEAC”).
- B. An applicant may also become registered if such applicant has obtained a “substantially equivalent” education approved by the Director of Registrations (“Director”). A “substantially equivalent” education may be obtained by one of the following methods:
 - 1. An applicant who is currently credentialed as a Certified Professional Midwife (“CPM”), in good standing, as established and administered by the North American Registry of Midwives (“NARM”) shall be deemed eligible for registration.
 - 2. Completion of and certification under NARM’s entry-level Portfolio Evaluation Process (“PEP”). If the PEP determines that the applicant has obtained a substantially equivalent education as that required in Colorado, then such applicant shall be eligible for registration. All expenses associated with PEP shall be the applicant’s responsibility.
 - 3. A credential review performed by the International Credentialing Associates (“ICA”) or International Consultants of Delaware (“ICD”) that determines the applicant has obtained a substantially equivalent education as that required in Colorado shall deem the applicant eligible for registration. The Director will only accept a credentials evaluation from an organization listed in this rule. All expenses associated with the credential review shall be the applicant’s responsibility.
 - 4. Education, training, or service gained in military services outlined in § 24-34-102(8.5), C.R.S., to be accepted and applied towards receiving a license, must be substantially equivalent, as determined by the Director, to the qualifications otherwise applicable at the time of receipt of application. It is the applicant’s responsibility to provide timely and complete evidence for review and consideration. Satisfactory evidence of such education, training, or service will be assessed on a case by case basis.
- C. Applicant’s failure to verify their educational qualifications as established by this Rule 2 shall result in the Director denying the application.

RULE 3 – EDUCATIONAL STANDARDS FOR THE ADMINISTRATION OF OXYGEN

The purpose of this rule is to establish minimum training requirements for direct-entry midwives with respect to the safe administration of oxygen to clients pursuant to Section 12-37-105(13), C.R.S.

The Director has determined that the minimum training requirements for the safe administration of oxygen are included in the entry level education and training requirements for direct-entry midwives as provided in Rule 2.

RULE 4 – PRACTICE RESTRICTIONS

The purpose of this rule is to define and clarify the practice restrictions applicable to a direct-entry midwife pursuant to Sections 12-37-105 and 12-37-106(1)(a) C.R.S.

- A. The direct-entry midwife shall not provide care to any client who has a medical history of or who exhibits signs or symptoms including but not limited to:
1. diabetes mellitus or gestational diabetes;
 2. hypertensive disease (blood pressure greater than 140/90 at rest);
 3. pulmonary disease or cardiac disease which interferes with activities of daily living;
 4. a history of thrombophlebitis or pulmonary embolism;
 5. hematological or coagulation disorders, *i.e.*, leukemia or sickle cell anemia;
 6. seizures controlled by medication if the client has seized within the last year;
 7. Hepatitis B, HIV positive, or AIDS;
 8. current use of psychotropic medications if client is not under the care and monitoring of a physician during the pregnancy;
 9. current substance abuse of drugs or alcohol;
 10. Rh sensitization (positive antibody titre), an incompetent cervix, or previous uncontrollable postpartum hemorrhage;
 11. Vaginal Birth after Cesarean Section (VBAC) unless compliant with Rule 12;
 12. delivery of an infant who was premature or stillborn, or a neonatal death associated with maternal health conditions, *i.e.*, hypertension, Diabetes Mellitus, Rh Sensitization, clotting disorders; or
 13. delivery of an infant with a major genetic anomaly unless there is a normal prenatal screening ruling out genetic anomalies, or an intervening normal pregnancy.
- B. The direct-entry midwife shall not:
1. perform any operative or surgical procedures;
 2. utilize forceps, vacuum extraction or other instruments or mechanical means to facilitate birth;
 3. perform versions; or

4. administer any medications or IV fluids, except as permitted in Section 12-37-105.5, C.R.S., and in Rules 17 and 18.

RULE 5 – MINIMUM PRACTICE REQUIREMENTS REGARDING ANTEPARTUM CARE

The purpose of this rule is to define and clarify the minimum requirements of safe care for women and infants regarding antepartum care pursuant to Sections 12-37-105 and 25-4-201, C.R.S., which include but are not limited to:

- A. The direct-entry midwife shall schedule client visits at least once a month beginning in the first trimester through 28 weeks; every 2 weeks from 28 weeks through 35 weeks; and weekly from 36 weeks to delivery.
- B. At the time of the initial visit, the direct-entry midwife shall at a minimum:
 1. obtain a medical, obstetrical, family and nutritional history;
 2. determine the estimated due date and perform a baseline physical examination;
 3. arrange to or obtain laboratory testing including but not limited to: blood group and Rh type, if unknown; Coombs test for all Rh negative mothers; CBC with differential; rubella titre; serology for syphilis; hepatitis B screen, urine for protein and glucose, culture if indicated; Gonococcal Culture screen and Chlamydia culture if needed based on social history. Additionally, the blood specimen obtained shall be submitted to an approved laboratory for a standard serological test for syphilis and HIV. If the client refuses consent for syphilis or HIV testing the direct-entry midwife shall document such refusal in the client record;
 4. arrange to or obtain laboratory testing for a culture for Group B Streptococci at 35 – 37 weeks, and, if the culture is positive, inform the client about antibiotic treatment options and recommend an appropriate health care provider;
 5. discuss home birth, alternatives to home birth, risk assessment, and referral procedures;
 6. provide the client with the “Mandatory Disclosure” form and obtain informed consent in a manner approved or provided by the Director; and
 7. complete the emergency plan.
- C. Safe care for women and infants during each prenatal visit shall, at a minimum, include but not be limited to:
 1. obtaining vital signs and weight;
 2. performing a urine dipstick for protein and glucose;
 3. assessing for:
 - (a) edema, headaches, visual disturbances, dizziness or sharp pains in legs, abdomen, chest or head and reflexes if indicated,
 - (b) mother's psychological and emotional status,

- (c) nutritional status,
 - (d) fundal height, and
 - (e) fetus for gestational age, presentation and position; estimated fetal weight; fetal activity, listen for fetal heart tones and record when first audible;
 - 4. record all findings, interventions, and outcomes including the quickening date;
 - 5. provide teaching, guidance, and referral as appropriate; and
 - 6. discuss the emergency plan, and revise if needed.
- D. Laboratory studies that should be repeated during pregnancy include Indirect Coombs test at 28 and 36 weeks, if indicated; Hemoglobin or Hematocrit at 28 and 36 weeks; and a one-hour Glucose Tolerance Test with a minimum of a 50 Gram glucose loading dose shall be offered to the client at 26-28 weeks.
- E. At least one home visit shall be made during the third trimester to assure that environmental conditions are appropriate, supplies are procured, and birth participants are prepared for the home birth.
- F. The direct-entry midwife shall refer clients for evaluation by a qualified licensed health care provider, and shall not continue as the care provider, when a multiple gestation or a presentation other than vertex at the onset of labor are noted.
- G. The direct-entry midwife shall refer a client for evaluation by a qualified licensed health care provider, and shall not continue as the primary care provider when any of the following conditions are noted:
- 1. urine glucose of 2+ or greater on two sequential visits or if other signs or symptoms of gestational diabetes occur with the urine glucose;
 - 2. hyperemesis beyond the 24th week of gestation;
 - 3. hypertension - blood pressure greater than 140/90 or an increase from the baseline of greater than 30 mm Hg in the systolic or 15 mm Hg in the diastolic pressure;
 - 4. signs and symptoms of preeclampsia including but not limited to persistent edema, increased blood pressure or proteinuria, increased reflexes, persistent headaches, epigastric pain or, visual disturbances;
 - 5. seizures;
 - 6. vaginal bleeding after 20 weeks;
 - 7. signs and symptoms of urinary infections or sexually transmitted disease;
 - 8. oral temperature in excess of 101° F for more than 24 hours accompanied by other signs or symptoms of clinically significant infection or which does not resolve within 72 hours;
 - 9. laboratory results indicating need for medical treatment, for example, a positive culture;

10. anemia not responding to over the counter iron therapy as measured by Hemoglobin below 11 grams or Hematocrit below 34% at term;
 11. signs and symptoms of polyhydramnios or oligohydramnios;
 12. suspected fetal demise - lack of fetal movement, inability to auscultate fetal heart tones;
 13. decreased fetal movements;
 14. gestation longer than 42 weeks;
 15. rupture of membranes for:
 - (a) longer than 12 hours without labor for Group B Streptococci positive clients; or
 - (b) longer than 18 hours without labor for Group B Streptococci negative clients;
 16. premature labor - less than 37 completed weeks gestation;
 17. active herpes;
 18. intrauterine growth retardation; or
 19. suspected abnormality of pelvis;
- H. Once any of the conditions provided in paragraph G. are noted, the direct-entry midwife shall not resume care for the client until a qualified health care provider assesses the client and determines that the client is not exhibiting signs or symptoms of increased risk of medical, obstetrical, or neonatal complications, or problems during the completion of the pregnancy, labor, delivery, or the postpartum period, and is not exhibiting signs and symptoms of increased risk that the infant may develop complications or problems during the first six weeks of life.
- I. The registered direct-entry midwife shall perform pelvimetry by 36 weeks gestation.

RULE 6 – MINIMUM PRACTICE REQUIREMENTS REGARDING SAFE INTRAPARTUM CARE

The purpose of this rule is to define and clarify minimum practice requirements of safe care for women and infants regarding intrapartum care pursuant to Section 12-37-105, C.R.S., which include but are not limited to:

- A. The direct-entry midwife is responsible for making arrangements to be with the client by the time active labor has been established as determined by contractions occurring every 5 minutes and lasting for 60 seconds or cervical dilation of 5 cm or more. Once labor has been so established, the direct-entry midwife shall remain with the client.
- B. When membranes rupture, the direct-entry midwife shall perform a sterile vaginal exam for prolapsed cord if the presenting part is not engaged and record fetal heart tones. In the case of premature rupture of the membranes, no further vaginal checks shall be made until active labor.
- C. Aseptic technique and universal precautions shall be used while rendering care.

- D. The direct-entry midwife is responsible for monitoring the status of the client and fetus during labor and delivery including but not limited to:
1. maternal vital signs and physical well being such as:
 - (a) measurement of maternal temperature, pulse and respirations at least every 4 hours,
 - (b) measurement of maternal blood pressure at least every four hours in early labor and hourly during the active phase of labor, and
 - (c) checking for bladder distention, signs of maternal fatigue, and hydration status;
 2. evaluating fetal vital signs and well being such as:
 - (a) fetal heart tones in response to contractions as well as when the uterus is at rest. These tones shall be assessed, at a minimum, every hour during early labor, every half hour during active labor, and every 5-10 minutes during the second stage of labor, and
 - (b) normality of fetal lie, presentation, attitude and position;
 3. progress of labor including cervical effacement and dilation, station, presenting part and position;
 4. coaching the birthing family;
 5. obtaining a cord blood specimen, if feasible, which shall accompany the infant in case of transport;
 6. checking the placenta and blood vessels and estimating blood loss;
 7. checking the perineum and vaginal vault for tears; and
 8. checking the cervix for tears and, if present, making appropriate referral.
- E. The direct-entry midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist:
1. bleeding other than capillary bleeding (“show”) prior to delivery;
 2. signs of placental abruption including continuous lower abdominal pain and tenderness;
 3. prolapse of the cord;
 4. any meconium staining without reassuring fetal heart tones, moderate or greater meconium staining regardless of status of fetal heart tones;
 5. significant change in maternal vital signs such as:
 - (a) temperature greater than 101°F,

- (b) pulse over 100 with decrease in blood pressure, or
 - (c) increase in blood pressure greater than 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic;
6. failure to progress in labor such as:
- (a) lack of steady progress in dilation and descent after 24 hours in the primipara or 18 hours in the multipara,
 - (b) second stage of labor without steady progress of descent through the mid-pelvis and/or pelvic outlet longer than two hours in the primipara or one hour in the multipara, or
 - (c) third stage of labor longer than one hour;
7. fetal heart rate below 120 or above 160 between contractions;
8. protein or glucose in the urine;
9. seizures;
10. atonic uterus;
11. retained placental fragments;
12. vaginal or cervical lacerations requiring repair; or
13. client requests transport.

RULE 7 – MINIMUM PRACTICE REQUIREMENTS REGARDING POSTPARTUM CARE

The purpose of this rule is to define and clarify minimum practice requirements of safe care for women and infants regarding postpartum care pursuant to Sections 12-37-105 and 12-37-105.5, C.R.S., which include but are not limited to:

- A. The direct-entry midwife who is authorized to administer medications may administer Oxytocin (Pitocin) in accordance with Rule 17.
- B. The direct-entry midwife shall remain with the client and infant for a minimum of two (2) hours after the birth or until the client and infant are stable, whichever is longer.
- C. At a minimum, the direct-entry midwife shall make follow up visits to assess the progress of the client and infant within 24 to 48 hours postpartum, 3 to 7 days postpartum, 2-4 weeks postpartum and 6 weeks postpartum. If the client is seen by an appropriate health care provider at any of these intervals, the direct-entry midwife need not visit the client for that particular interval. Such visits shall include, but not be limited to, an assessment of the fundus, lochia, perineum, breasts, nutrition, hydration, elimination, emotional adjustment and bonding.
- D. The direct-entry midwife shall instruct the client and family in self care at each follow up visit.

- E. The direct-entry midwife who is authorized to administer medications may administer Rh(D) Immune Globulin to Rh negative mothers in accordance with Rule 17. Otherwise, the direct-entry midwife shall refer all Rh negative mothers for Rhogam within seventy two (72) hours of the birth.
- F. The direct-entry midwife shall arrange for consultation and/or transport when:
 - 1. There is maternal blood loss of more than 500 cc;
 - 2. The client has a fever of greater than 101°F on any of the 2nd through 10th days postpartum;
 - 3. The client cannot void within 6 hours after birth;
 - 4. The lochia is excessive, foul smelling, or otherwise abnormal; or
 - 5. The client exhibits signs of clinically significant depression (not the “baby blues”).

RULE 8 – MINIMUM PRACTICE REQUIREMENTS REGARDING NEWBORN CARE

The purpose of this rule is to define and clarify minimum practice requirements of safe care for women and infants regarding newborn care pursuant to Sections 12-37-105.5 and 12-37-106 C.R.S.

- A. The direct-entry midwife will perform care for the infant including but not limited to:
 - 1. Apgar scores at one minute and five minutes after birth and at 10 minutes if the 5 minute score is below 7;
 - 2. a physical assessment including assessing presence of femoral pulses
 - 3. eye prophylaxis within 1 hour after birth as provided by Section 25-4-303, C.R.S.;
 - 4. weigh the infant, measure height and head circumference, and check for normal reflexes;
 - 5. perform a gestational age assessment;
 - 6. arrange to or obtain laboratory testing on the infant of an Rh negative mother to include blood type and Coombs test; and
 - 7. ensure first latch and encourage first feeding prior to departure.
- B. The direct-entry midwife shall arrange for or obtain the required newborn screenings required by Section 25-4-1004, C.R.S.
- C. The direct-entry midwife authorized to administer medications may administer Vitamin K in accordance with Rule 17. Otherwise, the direct-entry midwife shall recommend that the mother arrange for the administration of Vitamin K by a licensed health care provider birth within seventy two (72) hours.
- D. The direct-entry midwife shall arrange for immediate transport for the infant who exhibits the following signs:
 - 1. Apgar of 7 or less at ten minutes after birth;

2. respiratory distress exhibited by respirations greater than 60 per minute, grunting, retractions, nasal flaring at one hour of age that is not showing consistent improvement;
 3. inability to maintain body temperature;
 4. medically significant anomaly;
 5. seizures;
 6. fontanel full and bulging;
 7. suspected birth injuries;
 8. cardiac irregularities;
 9. pale, cyanotic, gray newborn; or
 10. lethargy or poor muscle tone.
- E. The direct-entry midwife shall arrange for consultation and transport for an infant who exhibits the following:
1. signs of hypoglycemia including jitteriness;
 2. abnormal cry;
 3. passes no urine in 12 hours or meconium in 24 hours;
 4. projectile vomiting;
 5. inability to suck;
 6. pulse greater than 180 or less than 80 at rest;
 7. jaundice within 24 hours of birth; or
 8. positive Coombs test.
- F. At a minimum, the direct-entry midwife shall make a referral to an appropriate pediatric healthcare provider within 7 days of birth; and shall perform follow up visits to assess the progress of the client and infant within 24 to 48 hours postpartum, 3 to 7 days postpartum, 2-4 weeks postpartum and 6 weeks postpartum. If the client and infant are seen by an appropriate pediatric healthcare provider at any of these intervals, the midwife need not see the client and infant for that particular interval. Follow-up visits shall include assessment of the infant to include umbilical cord, temperature, pulse, respirations, weight, skin color and hydration status, feeding and elimination, sleep/wake patterns, and bonding.

RULE 9 – MINIMUM PRACTICE REQUIREMENTS REGARDING RECORD KEEPING

The purpose of this rule is to clarify the minimally appropriate records of direct-entry midwifery related activity that are required pursuant to Sections 12-37-105(5)(a) and 25-4-201, C.R.S.

- A. The direct-entry midwife shall keep appropriate records on all clients. All records shall, at a minimum:
1. be accurate, current, and comprehensive, giving information concerning the condition and care of the client and associated observations;
 2. provide a record of any problems that arise and the actions taken in response to them;
 3. provide evidence of care required, interventions by professional practitioners and client responses;
 4. include a record of any factors (physical, psychological or social) that appear to affect the client;
 5. record the chronology of events and the reasons behind decisions made;
 6. provide baseline data against which improvement or deterioration may be judged;
 7. reflect any recommendation for, or initiation of, transfer to a hospital;
 8. have a signature and date for each entry; and
 9. all records shall be made available to the receiving health care provider in the event of transfer of care or the transport of client or newborn.

- B. The client records shall include, at a minimum:
1. the risk assessment as required in Section 12-37-105(11), C.R.S.;
 2. mandatory disclosure form;
 3. informed consent form and emergency plan;
 4. assessments, interventions and recommendations for each prenatal visit;
 5. progress of labor and maternal assessments during labor;
 6. fetal assessments during labor;
 7. Apgar scores and newborn examination;
 8. administration of any medications and/or intravenous fluids;
 9. refusal of care by the client;
 10. filing the birth certificate as required by Section 25-2-112, C.R.S.;
 11. follow-up postpartum visits;
 12. statement of verification that one copy of the record was provided to the client or the health care provider of her choice;

13. baseline blood pressure determined prior to the end of the second trimester or upon the initial visit if such visit occurs subsequent to the second trimester; and
 14. documentation of laboratory referral for syphilis, HIV, and Group B Streptococci testing, or documentation of the client's refusal for such tests.
- C. A copy of the record shall be provided to the client and/or other health care provider(s) at the completion of care or when requested.

RULE 10 – EMERGENCY PLAN

The purpose of this rule is to establish the following emergency plan parameters pursuant to Section 12-37-105(6), C.R.S.:

- A. The time required for transportation to the nearest facility capable of providing appropriate treatment shall not exceed 30 minutes unless the emergency plan prepared by the direct-entry midwife and the client, in a manner approved by the Director, includes an estimate of time for transportation for appropriate treatment for the conditions listed above in Rules 5G, 6E, 7F, 8D, and 8E, and such plan is agreed to by both the client and the direct-entry midwife. A copy of such plan shall be given to the client.

RULE 11 – DECLARATORY ORDERS

The purpose of this rule is to establish procedures for the handling of requests for declaratory orders filed pursuant to the Colorado Administrative Procedures Act at Section 24-4-105(11), C.R.S.

- A. Any person registered pursuant to Article 37, Title 12, C.R.S., may petition the Director of Registrations ("Director") for a declaratory order to terminate controversies or remove uncertainties as to the applicability of any statutory provision or of any rule or order of the Director.
- B. The Director will determine, in his/her discretion and without notice to petitioner, whether to rule upon such petition. If the Director determines that s/he will not rule upon such a petition, the Director shall promptly notify the petitioner of his/her action and state the reasons for such decision.
- C. In determining whether to rule upon a petition filed pursuant to this rule, the Director will consider the following matters, among others:
1. Whether a ruling on the petition will terminate a controversy or remove uncertainties as to the applicability to petitioner of any statutory provisions or rule or order of the Director.
 2. Whether the petition involves any subject, question or issue that is the subject of a formal or informal matter or investigation currently pending before the Director or a court involving one or more petitioners.
 3. Whether the petition involves any subject, question or issue which is the subject of a formal or informal matter or investigation currently pending before the Director or a court but not involving any petitioner.

4. Whether the petition seeks a ruling on a moot or hypothetical question or will result in an advisory ruling or opinion.
 5. Whether the petitioner has some other adequate legal remedy, other than an action for declaratory relief pursuant to CRCP 57, that will terminate the controversy or remove any uncertainty as to the applicability to the petitioner of the statute, rule, or order in question.
- D. Any petition filed pursuant to this rule shall set forth the following:
1. The name and address of the petitioner and whether the petitioner is registered pursuant to Article 37, Title 12, C.R.S.
 2. The statute, rule, or order to which the petition relates.
 3. A concise statement of all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule, or order in question applies or potentially applies to the petitioner.
- E. If the Director determines that s/he will rule on the petition, the following procedures shall apply:
1. The Director may rule upon the petition based solely upon the facts presented in the petition. In such a case:
 - a. Any ruling of the Director will apply only to the extent of the facts presented in the petition and any amendment to the petition.
 - b. The Director may order the petitioner to file a written brief, memorandum, or statement of position.
 - c. The Director may set the petition, upon due notice to petitioner, for a non-evidentiary hearing.
 - d. The Director may dispose of the petition on the sole basis of the matters set forth in the petition.
 - e. The Director may request the petitioner to submit additional facts in writing. In such event, such additional facts will be considered as an amendment to the petition.
 - f. The Director may take administrative notice of facts pursuant to the Colorado Administrative Procedures Act at Section 24-4-105(8), C.R.S., and may utilize his/her experience, technical competence, and specialized knowledge in the disposition of the petition.
 2. If the Director rules upon the petition without a hearing, s/he shall promptly notify the petitioner of his/her decision.
 3. The Director may, at his/her discretion, set the petition for hearing, upon due notice to petitioner, for the purpose of obtaining additional facts or information or to determine the truth of any facts set forth in the petition or to hear oral argument on the petition. The hearing notice to the petitioner shall set forth, to the extent known, the factual or other matters that the Director intends to inquire. For the purpose of such a hearing, to the extent necessary, the petitioner shall have the burden of proving all of the facts stated in the

petition, all of the facts necessary to show the nature of the controversy or uncertainty and the manner in which the statute, rule or order in question applies or potentially applies to the petitioner and any other facts the petitioner desires the Director to consider.

- F. The parties to any proceeding pursuant to this rule shall be the Director and the petitioner. Any other person may seek leave of the Director to intervene in such a proceeding, and leave to intervene will be granted at the sole discretion of the Director. A petition to intervene shall set forth the same matters as are required by Paragraph D of this rule. Any reference to a "petitioner" in this rule also refers to any person who has been granted leave to intervene by the Director.
- G. Any declaratory order or other order disposing of a petition pursuant to this rule shall constitute agency action subject to judicial review pursuant to Section 24-4-106, C.R.S.

RULE 12 – STANDARDS FOR VAGINAL BIRTH AFTER CESAREAN SECTION (VBAC)

The purpose of this rule is to establish parameters for VBAC clients seeking midwifery care during pregnancy in order to safeguard the client's welfare pursuant to Section 12-37-105(11), C.R.S.

- A. A direct-entry midwife shall not assume primary responsibility for prenatal care and birth attendance for women who have had a previous cesarean section unless all of the following conditions are met:
 - 1. All prospective VBAC women shall sign an informed consent statement, which shall be retained in the client's records and include the following:
 - (a) VBAC educational information including history of VBAC and client's own personal information;
 - (b) Associated risks and benefits of VBAC at home;
 - (c) A workable hospital transport plan;
 - (d) Alternatives to VBAC at home; and
 - (e) Other information as required by the Director.
 - 2. A workable hospital transport plan must be established for home VBAC. The plan shall be in writing and include:
 - (a) Place of birth within 30 minutes of transport to the nearest hospital or emergency medical center able to perform an emergency cesarean;
 - (b) Readily available emergency numbers for the nearest hospital or emergency medical center; and
 - (c) Provision for phone contact with the nearest hospital or emergency medical center prior to any transport notifying the destination that transport is in progress.
 - 3. There has been at least 18 months from the client's cesarean delivery to the due date of the current pregnancy.

4. The client with 2 or more cesarean deliveries has also had a vaginal delivery since the last cesarean delivery.
- B. The direct-entry midwife shall obtain prior client cesarean written records, shall analyze the indication for the previous cesarean, and retain the records along with a written assessment of the physical and emotional considerations in the client's files. If the direct-entry midwife is unable to obtain the written records, the direct-entry midwife shall not retain the woman as a client.
- C. Records that show a previous classical uterine/vertical incision or any previous uterine surgery which required an incision into the uterine fundus are a contraindication to VBAC at home and shall require immediate transfer of care of the client.
- D. Direct-entry midwife shall not induce or augment labor by the use of chemicals or herbal supplements or nipple stimulation.
- E. A direct-entry midwife shall be present and manage the VBAC delivery from the onset of active labor throughout the immediate postpartum period.

RULE 13 – REQUIREMENTS FOR REINSTATEMENT

The purpose of this rule is to state the requirements for reinstatement of a registration that has expired pursuant to Sections 12-37-103 and 24-34-102(8), C.R.S.

- A. A direct-entry midwife applying for reinstatement of an expired registration shall complete a reinstatement application and pay a reinstatement fee in the manner approved by the Director.
- B. If the registration has been expired for more than two (2) years from the date of receipt of the reinstatement application, but less than five (5) years an applicant shall establish “competency to practice” under Sections 24-34-102(8)(d)(II)(A) and (D), and 24-34-105 C.R.S., as follows:
 1. Verification of registration in good standing from another state along with proof of active practice in that state for two (2) years of the previous five (5) years from the date of receipt of the application for reinstatement; or
 2. Completion of twenty (20) hours of continuing education courses related to the practice of direct-entry midwifery during the two (2) years immediately preceding the application for reinstatement. The continuing education must meet the approval of and shall be attested to in a manner prescribed by the Director; or
 3. Retaking and achieving a passing score on the national NARM Examination within two (2) years immediately preceding receipt of an application for reinstatement; or
 4. Any other means approved by the Director.
- C. An applicant seeking to reinstate a registration that has been expired for more than five (5) years shall demonstrate “competency to practice” as required in Sections 24-34-102(8)(d)(II)(B) and (F), C.R.S., by:
 1. Verification of registration in good standing from another state along with proof of active practice for two (2) years of the previous five (5) years prior to an application for reinstatement; or

2. Supervised practice for a period no less than six (6) months subject to the terms established by the Director; or
3. Retaking and achieving a passing score on the national NARM Examination within two (2) years immediately preceding receipt of an application for reinstatement; or
4. By any other means approved by the Director.

RULE 14 – REPORTING CONVICTIONS AND OTHER ADVERSE ACTIONS

The purpose of the rule is to clarify the procedures for reporting convictions, and other adverse actions to include judgments and administrative proceedings pursuant to Section 12-37-106(1)(a), C.R.S.

A direct-entry midwife, as defined in Section 12-37-102(1), C.R.S., shall inform the Director, within ninety (90) days of any of the following events:

- A. The conviction of the registrant of a felony under the laws of any state or of the United States, which would be a violation of Section 12-37-107, C.R.S. A guilty verdict, a plea of guilty, or a plea of nolo contendere (no contest) accepted by the court is considered a conviction;
- B. A disciplinary action imposed upon the registrant by another jurisdiction that registers or licenses direct-entry midwives, which would be a violation of Section 12-37-107, C.R.S., including, but not limited to, a citation, sanction, probation, civil penalty, or a denial, suspension, revocation, or modification of a license or registration whether it is imposed by consent decree, order, or other decision, for any cause other than failure to pay a license or registration fee by the due date or failure to meet continuing professional education requirements;
- C. Revocation or suspension by another state board, municipality, federal or state agency of any health services related license or registration, other than a lapsed license or registration for midwifery as described in Section 12-37-107, C.R.S.;
- D. Any judgment, award or settlement or a civil action or arbitration in which there was a final judgment or settlement against the registrant for malpractice of direct-entry midwifery.
- E. The notice to the Director shall include the following information:
 1. If the event is an action by governmental agency (as described above), the name of the agency, its jurisdiction, the case name, and the docket, proceeding or case number by which the event is designated, and a copy of the consent decree, order or decision;
 2. If the event is a felony conviction, the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court. The registrant shall also provide to the Director a copy of the imposition of sentence related to the felony conviction and the completion of all terms of the sentence with ninety (90) days of such action;
 3. If the event concerns a civil action or arbitration proceeding, the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict, the court or arbitration decision, or, if settled, the settlement agreement and court's order of dismissal;

- F. The registrant notifying the Director may submit a written statement with the notice to be included in the registrant's records.

RULE 15 – EXCEPTIONS AND DIRECTOR'S REVIEW OF INITIAL DECISIONS Repealed eff. 12/15/2010

RULE 16 – REGARDING THE CONTINUING DUTY TO REPORT INFORMATION TO THE DIRECTOR'S OFFICE.

The purpose of this rule is to clarify the requirement of registrants to notify the Director of a change in submitted information pursuant to Sections 12-37-103(2) and 24-34-107, C.R.S.

- A. Each person licensed under this article, upon changing his or her address, shall inform the board of their new address within thirty (30) days after such change.

RULE 17 – ADMINISTRATION OF MEDICATIONS

The purpose of this rule is to clarify the limited administration of medications by a direct-entry midwife as authorized by Sections 12-37-105.5(1) through (5), C.R.S.

- A. A direct-entry midwife may obtain and administer medications only as set forth in this rule. A direct-entry midwife shall obtain authorized medications only from a Colorado-registered prescription drug outlet, manufacturer, or wholesaler.
- B. A direct-entry midwife must receive prior approval from the Director to obtain and administer medications. A direct-entry midwife who seeks such approval must submit a Medication Authority application in a manner approved by the Director of the Division of Registrations and pay the applicable fee.
 - 1. A direct-entry midwife applying for medication authority must have satisfactorily completed a course in pharmacology, within six months prior to submitting an application, that:
 - (a) is offered by a post-secondary educational institution accredited by an accrediting board recognized by the Council for Higher Education Accreditation of the American Council on Education, is a program or course approved by the Midwifery Education and Accreditation Council ("MEAC"), or is a program or course otherwise approved by the Director;
 - (b) is, at a minimum, eight clock hours in length and includes basic pharmacotherapeutic principles and administration of medications, including the drugs listed in paragraph (C) of this Rule; and
 - (c) includes the following elements:
 - i. Mechanism of Pharmacological Action;
 - ii. Indications;
 - iii. Therapeutic Effects;

- iv. Side Effects/Adverse Reactions;
 - v. Contraindications;
 - vi. Incompatibilities/Drug Interactions;
 - vii. Drug administration, including:
 - 1. Dosage;
 - 2. Dosage Form and Packaging;
 - 3. Routes of Administration;
 - 4. Onset of Action;
 - 5. Peak Effect; and
 - 6. Duration of Action;
 - viii. Administration of medications through injection, which includes:
 - 1. Universal precautions including the use and disposal of sharps;
 - 2. Safe injection practices;
 - 3. Equipment, including:
 - a. Needles;
 - b. Filter Needles (for use with glass ampules);
 - c. Syringes;
 - d. Skin surface disinfectants; and
 - e. Medication containers (ampules, single-use vials);
 - ix. Appropriate injection sites;
 - x. Procedures for drawing up and administering drugs;
 - xi. Proper disposal of hazardous and other contaminated materials; and
 - xii. Student demonstration of competence in administering medications.
2. An applicant who does not meet the requirements of subparagraph (1) above may request to demonstrate competency to obtain and administer medications by other means. The Director shall consider such a request on a case-specific basis. The decision to approve such a request shall be at the sole discretion of the Director. In considering whether to approve such a request, the Director shall consider public safety and such other factors as the Director deems appropriate. If the Director grants approval under this subparagraph (2)

to obtain and administer medications, the Director may subject such approval to lawful conditions the Director finds necessary to protect the public.

C. The preferred drug list of medications a direct-entry midwife may obtain and administer consists of:

1. Vitamin K₁ (phyloquinone, phytonadione) to a newborn, as prophylaxis for vitamin K deficiency bleeding. One 1 mg dose of 2 mg / ml concentration vitamin K₁ is authorized via intramuscular injection.
2. Rho D immune globulin to Rh-negative, antibody negative mothers, for the prevention of isoimmunization in Rh (D) negative women. One 300 mcg dose (or as recommended by the manufacturer) at 26 – 28 weeks gestation is authorized via intramuscular injection. In addition, one 300 mcg dose (or as recommended by the manufacturer) administered via intramuscular injection to the mother is authorized within 72 hours of delivery of an Rh-positive infant (or an infant with unknown blood type) to an Rh-negative, antibody negative mother.
3. Antihemorrhagic drugs for control of postpartum bleeding, limited to the following:
 - a. Oxytocin (Pitocin) for postpartum hemorrhage or, following delivery of the newborn, to prevent postpartum hemorrhage. One or two doses of 10 units/ml in a 1 ml vial may be administered via intramuscular injection. If a second dose is administered, for any reason, transport must be initiated in accordance with the emergency plan.
 - b. Methylergonovine (Methergine) for postpartum hemorrhage (only), one 0.2 mg per 1 ml dose ampule administered via intramuscular injection. If Methylergonovine (Methergine) is administered, transport must be initiated in accordance with the emergency plan.
 - c. Misoprostol (Cytotec) for postpartum hemorrhage (only), in an 800 mcg dose (four 200 mcg tabs) administered rectally or a 400-600 mcg dose (two or three 200 mcg tabs) administered sublingually. If Misoprostol (Cytotec) is administered, transport must be initiated in accordance with the emergency plan.
4. Erythromycin Ophthalmic Ointment to a newborn, for prophylaxis of neonatal ophthalmia, as provided by Section 25-4-303, C.R.S. A single topical dose of Erythromycin Ophthalmic Ointment USP (0.5%) is to be administered within one (1) hour after birth via topical application of a ribbon of ointment approximately 1 cm in length into each eye.

D. Client refusals of medication or treatment.

1. Informed consent. If a client refuses the administration of either Vitamin K₁ to her infant or Rho D immune globulin to herself, the direct-entry midwife shall provide the client with an informed consent form containing a detailed statement of the benefits of the medication and the risks of refusal, and shall retain a copy of the form acknowledged and signed by the client.
2. Transport. If a client experiences uncontrollable postpartum hemorrhage, the direct-entry midwife shall immediately initiate the transportation of the client in accordance with the emergency plan.
3. Eye prophylaxis. If a client refuses the administration of eye prophylaxis to her infant, the direct-entry midwife shall:

- (a) provide the client with a form setting forth the requirements of Section 25-4-303, C.R.S.; and
 - (b) retain a copy of the form acknowledged and signed by the client.
- E. Medication administration procedures must meet safe and professional standards and must be performed in a manner consistent with generally accepted parameters, including safe injection practices and the standards of the Centers for Disease Control and Prevention (“CDC”).
- F. In order to best serve the needs and ensure the safety of their clients, direct-entry midwives who obtain and administer medications shall maintain competency regarding their use through continuing education and other professional development activities.
- G. A direct-entry midwife must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the direct-entry midwife is not competent and not permitted to obtain or administer medications.

RULE 18 – ADMINISTRATION OF INTRAVENOUS FLUIDS

The purpose of this rule is to clarify the administration of intravenous fluids by a direct-entry midwife to a client in order to restore fluid volume lost due to postpartum hemorrhage, as authorized by Section 12-37-105.5(1), (4)(b), and (5), C.R.S.

- A. A direct-entry midwife may obtain and administer intravenous (“IV”) fluids only as set forth in this rule. A direct-entry midwife shall obtain authorized IV fluids only from a Colorado-registered prescription drug outlet, manufacturer, or wholesaler.
- B. A direct-entry midwife must receive prior approval from the Director to obtain IV fluids and administer IV therapy. A direct-entry midwife who seeks such approval must:
 - 1. submit an IV Authority application in a manner approved by the Director of the Division of Registrations and pay the applicable fee; and
 - 2. satisfactorily complete an intravenous therapy course, within six months prior to submitting an application, that:
 - (a) is offered by a post-secondary educational institution accredited by an accrediting board recognized by the Council for Higher Education Accreditation of the American Council on Education, is a program or course approved by the Midwifery Education and Accreditation Council (“MEAC”), or is a program or course otherwise approved by the Director;
 - (b) is at least at least six clock hours in length and includes basic principles of the administration of medications intravenously, including the IV fluids listed in paragraph (C) of this Rule; and
 - (c) includes the following elements:
 - i. Basic principles of intravenous therapy, including when to initiate and when to discontinue IV therapy;

- ii. Purpose of IV fluid therapy;
 - iii. Safe infusion and infection control practices;
 - iv. Equipment;
 - v. Appropriate sites;
 - vi. Procedure and technique;
 - vii. Rate of administration;
 - viii. Care of equipment;
 - ix. Proper disposal of hazardous and other contaminated materials; and
 - x. Student demonstration of competence in the ability to administer IV fluids.
3. A direct-entry midwife who does not meet the requirements of subparagraph (2) above may request to demonstrate completion of an equivalent IV course or program to obtain and administer IV fluids. The Director shall consider such a request on a case-specific basis. The decision to approve such a request shall be at the sole discretion of the Director. In considering whether to approve such a request, the Director shall consider public safety and such other factors as the Director deems appropriate. If the Director grants approval under this subparagraph (3) to obtain and administer IV fluids, the Director may subject such approval to lawful conditions the Director finds necessary to protect the public.
- C. The preferred drug list of IV fluids a direct-entry midwife may obtain and administer to restore fluid volume lost due to postpartum hemorrhage consists of:
1. 0.9% sodium chloride in sterile water (Normal saline)
 2. Lactated Ringer's solution (LR)
- D. A direct-entry midwife may administer IV fluids only to restore fluid volume lost due to postpartum hemorrhage. If IV therapy is initiated, transport must be initiated in accordance with the emergency plan.
- E. IV therapy procedures must meet safe and professional standards and must be performed in a manner consistent with generally accepted parameters, including safe infusion and infection control practices consistent with the standards of the Centers for Disease Control and Prevention ("CDC").
- F. In order to best serve the needs and ensure the safety of their clients, direct-entry midwives who obtain and administer IV fluids shall maintain competency regarding their use through continuing education and other professional development activities.
- G. A direct-entry midwife must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the direct-entry midwife is not competent and not permitted to obtain or administer IV fluids.

RULE 19 – IMPOSITION OF FINES

Section 12-37-107(2)(a), C.R.S., provides authority for the Director to impose fines against a direct-entry midwife for violations of the statutory or rule provisions governing direct-entry midwifery or any violation of an Order of the Director. The purpose of this rule is to establish a fine structure and the circumstances under which fines may be imposed by the Director.

- A. The Director may impose a fine in lieu of or in addition to any other disciplinary sanction.
- B. The Director may impose a separate fine for each violation of Article 37 of Title 12, C.R.S., any rule adopted by the Director, or any Order issued by the Director.
- C. The Director may impose fines consistent with the following structure:
 - 1. For a registrant's first violation, a fine of no more than one thousand dollars (\$1000.00).
 - 2. For a registrant's second violation, a fine of no more than two thousand five hundred dollars (\$2500.00).
 - 3. For a registrant's third and any additional violations, a fine of no more than five thousand dollars (\$5000.00).
- D. A total fine amount of five hundred dollars (\$500.00) or less imposed by the Director must be paid in full, including the applicable surcharge, at the time the Final Agency Order is entered or a Stipulation is reached between the parties. A total fine amount greater than five hundred dollars (\$500.00) imposed by the Director must be paid in full, including the applicable surcharge, in accordance with the time frame set forth in the Final Agency Order or Stipulation. A registrant who fails to pay a fine required pursuant to a Final Agency Order or Stipulation is subject to additional disciplinary action as set forth in Section 12-37-107(3)(d), C.R.S., including suspension or revocation of his or her direct-entry midwife registration.
- E. Payment of a fine does not exempt the registrant from compliance with the statutes and rules governing the practice of direct-entry midwifery or any orders of the Director.