



MEDICAL BOARD OF CALIFORNIA Licensing Program



MEMBERS OF THE COUNCIL

Carrie Sparrevohn, L.M., Chair
James Byrne, M.D.
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Monique Webster
Barbara Yaroslavsky

MIDWIFERY ADVISORY COUNCIL AGENDA

Medical Board of California
 Hearing Room
 2005 Evergreen Street
 Sacramento, CA 95815
 (916) 263-2382

Action may be taken on any item listed on the agenda.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

Thursday, August 13, 2015
1:00 p.m. – 4:00 p.m.
 (or until conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.

1. Call to Order/Roll Call
2. Public Comment on Items not on the Agenda
Note: The Council may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]
3. Approval of the March 26, 2015 Midwifery Advisory Council Meeting Minutes
4. Report from the Midwifery Advisory Council Chairperson – Ms. Sparrevohn
5. Update on Licensed Midwife Annual Report (LMAR) Taskforce– Ms. Sparrevohn
 - A. LMAR Data Collection Tool
 - B. Discussion for Consideration of Presenting Edits to the LMAR to the Medical Board of California
6. Update on Licensed Midwifery Legislation – Ms. Simoes
 - A. AB 1306
 - B. SB 407
 - C. SB 408
7. Update on Continuing Regulatory Efforts Required by Assembly Bill 1308 – Ms. Webb
8. Update on the Challenge Mechanism – Ms. Lowe

9. Program Update – Ms. Lowe
 - A. BreEZe Update
 - B. Licensing Statistics
 - C. Enforcement Statistics
 - D. 2014 Licensed Midwife Annual Report

10. Presentation on Best Practices for Home to Hospital Transfers by Midwives – Diane Holzer, L.M.

11. Agenda Items for the December 3, 2015 Midwifery Advisory Council Meeting in Sacramento

12. Adjournment

The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lisa Toof at (916) 263-2389 or sending a written request to that person at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the Chair may apportion available time among those who wish to speak.

For additional information call (916) 263-2389.



MEDICAL BOARD OF CALIFORNIA

Licensing Program



MIDWIFERY ADVISORY COUNCIL

March 26, 2015

Department of Consumer Affairs
Hearing Room
1625 North Market Blvd., 1st Floor
Sacramento, CA 95834

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by MAC Chair Carrie Sparrevohn at 1:16 p.m. A quorum was present and notice was sent to interested parties.

Members Present:

Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Monique Webster
Barbara Yaroslavsky

Members Absent:

James Byrne, M.D.

Staff Present:

Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Natalie Lowe, Licensing Manager
Elizabeth Rojas, Business Services Officer
AnnaMarie Sewell, Licensing Analyst
Jennifer Simoes, Chief of Legislation
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:

Ryan Arnold, Department of Consumer Affairs
Wendy Askew
Tashina Benning
Rosanna Davis, L.M., California Association of Midwives
Sarah Davis, L.M., California Association of Midwives
Rachel Fox-Tierney, L.M.

Nancy Greenwood
Lora Hart, California Association of Midwives
Kaleem Joy, L.M.
Rebekah Lake, L.M., California Association of Midwives
Lesley Nelson, L.M.
Gail Root
Yen Truong
Laura Marina Perez, L.M.
Linda Walsh, C.N.M., California Nurse-Midwives Association

Agenda Item 2 Public Comments on Items not on the Agenda

No comments were provided.

Agenda Item 3 Approval of the December 4, 2014 Midwifery Advisory Council Meeting Minutes

Ms. Sparrevohn asked for public comment. No comments were provided.

Ms. Sparrevohn made a motion to approve the December 4, 2014 minutes; s/Ms. Ehrlich. Motion carried.

Agenda Item 4 Report from the Midwifery Advisory Council Chairperson

Ms. Sparrevohn requested an interim MAC meeting, via teleconference, be scheduled to discuss rescheduling the August 13, 2015 MAC meeting.

Agenda Item 5 MAC Membership

Ms. Lowe provided an update regarding MAC membership, stating that following the last MAC meeting it was requested during the January 29th and 30th Quarterly Board meeting, to extend all positions currently on the MAC for one year. The Board approved the request to extend the term expiration dates for the current MAC members. Ms. Sparrevohn and Ms. Yaroslavsky's terms will expire June 30, 2015; Dr. Byrne, Ms. Ehrlich, and Ms. Webster's terms will expire June 30, 2016; and Ms. Marceline's term will expire June 30, 2017.

Ms. Lowe stated that with the extension granted, Ms. Sparrevohn and Ms. Yaroslavsky's terms would be expiring June 30, 2015. Following the Board meeting, staff advertised the two available member positions and sent notice to all Licensed Midwives regarding the ability to apply to the MAC.

Ms. Lowe presented the vacancy for the licensed midwife position, a three-year term, set to expire June 30, 2018. Three applications were received at the Board for this vacancy. Applicants included Ms. Farren Jones, Ms. Angelika Nugent, and Ms. Carrie Sparrevohn. Ms. Lowe stated that all applicants would be provided an opportunity to address the MAC and to introduce themselves and make a comment if they would like. Ms. Lowe confirmed that Ms. Jones and Ms. Nugent were not present to address the MAC, and asked if Ms. Sparrevohn would like to make a comment.

Ms. Sparrevohn introduced herself and provided a brief statement to the MAC indicating that she had enjoyed her position on the MAC and looked forward to continuing with the important work that was being done for the midwifery community.

Ms. Lowe asked the MAC for a nomination, to recommend one of the licensed midwife applicants to the full Board to fill the vacancy.

Ms. Yaroslavsky nominated Ms. Carrie Sparrevohn for the midwife position to be recommended for approval at the next Quarterly Board meeting; s/Ms. Ehrlich. Motion carried.

Ms. Lowe presented the vacancy for the public member position, a three-year term, set to expire June 30, 2018. Six applications were received at the Board for this vacancy. Applicants included Ms. Wendy Askew, Ms. Tashina Benning, Ms. Anne Doan, Ms. Whitney Smith, Ms. Dawn Thompson, and Ms. Barbara Yaroslavsky. Ms. Lowe asked if any of the applicants that were in attendance would like to address the MAC to introduce themselves and make a comment.

Ms. Benning introduced herself and stated that she has both professional and personal interest in access to midwifery care in California and would appreciate the opportunity to be involved with the MAC.

Ms. Askew introduced herself and asked for consideration to serve on the MAC, as a member of the public representing consumers that are her peers and other women with whom she works with as a volunteer in the State of California. Ms. Askew stated that she has been engaged in the birth world through her mother for her entire life, but does not work professionally as a birth worker or in the birth field. Ms. Askew added that she volunteers at different agencies and nonprofits to encourage consumers to gain information about their options for midwifery care, and maternity care in general; as well as, working in her local community to increase access to midwifery care and to increase access to all options for women to receive quality maternity care that they feel is appropriate for them.

Ms. Yaroslavsky introduced herself and stated that it had been an honor to serve on the MAC and remembers when the MAC started, with division in the community as to what was considered appropriate care and treatment, and how far the MAC and midwifery community had come. She stated that her interest has been to get everyone at the table to elevate the profession, to have checks and balances, and for it to be accepted as an alternative method for those that are interested in having a safe and healthy birthing experience. Ms. Yaroslavsky applauded those that have participated and continue to participate.

Ms. Lowe asked the MAC for a nomination, to recommend one of the public member applicants to the full Board to fill the vacancy.

Ms. Sparrevohn nominated Ms. Barbara Yaroslavsky for the public position to be recommended for approval at the next Quarterly Board meeting; s/Ms. Ehrlich. Motion carried.

Ms. Ehrlich thanked all of the applicants who had shown interest in the MAC and in the work of midwives in California. Ms. Ehrlich informed the MAC and the public that her term will expire in June of 2016, and her plan is to not reapply. She encouraged midwives in California to come forward and be a part of the MAC.

Ms. Sparrevohn added that there is a lot work to be done within California as well as nationally and encouraged the applicants to consider volunteering with California Family for Access to Midwives, Midwives Alliance of North America, or Citizens for Midwifery. Ms. Sparrevohn thanked the applicants that were present for attending the meeting.

Agenda Item 6 Update on Licensed Midwife Annual Report (LMAR) Taskforce

Ms. Sparrevohn provided an update on the LMAR Taskforce stating that after review of the report, many changes would need to be made to enhance the data that was being collected. Some of the suggested changes would require legislative changes, and others would require updating the report to meet the new requirements outlined in law, and to remove items that were no longer required. Ms. Sparrevohn made the following recommendations:

- As there are multiple places where a midwife can list a death, which could result in the numbers not being accurate, confine all information regarding deaths into one section on the report so that duplicate data cannot be entered.
- For each definition, provide a pop-up box that automatically appears providing the user with the definition, which will assist in providing correct data.
- Remove or change the requirement to report by county as it could easily identify who the midwife and her client are in counties with low population.
- When zeros are entered on the online system, and the next step is to click the "no data to report" button, the system will not allow the user to click the button until all zeros are removed. Allow the entry of zeros and remove the "no data to report button." Ms. Sparrevohn stated that it would also serve the purpose of having to read every item so that items are not missed.
- Allow for the entire report to be printed after submission including any comments. Ms. Sparrevohn stated that the zeros and comments do not appear on the printed form after submission. Ms. Sparrevohn stated that when the reports are received from OSHPD yearly, the MAC needs to view the comments as a whole to acknowledge where changes are needed.
- Data should be collected in a prospective manner rather than a retrospective manner, as it would be easier to enter data as it occurs rather than waiting until the end of the year to gather the data.
- For line 14, which reads, "Number of clients who left care for non-medical reasons", it is recommended that the wording be changed to "Number of clients who were either lost to care, or who left care for non-medical reasons." The definition of lost to care would be: clients who never returned for appointments, despite efforts to contact them.
- Remove line 15 which reads "total number of clients served, whose births were still pending on the last day of the year" as it does not serve any purpose and is not required by statute.
- Change line 16, which refers to collaborative care, to "The number of times referrals were made", and acknowledge that there might be more than one referral per client. Also include reasons for the referral from the list currently being developed in regulation. This

recommendation may need to be incorporated in the coming years pending the adoption of the regulation implementing AB 1308.

- Remove line 17, which relates to supervision.
- Section E, which shows the outcomes per county in which birth, fetal demise, or infant or maternal death occurred, remove everything from that section that refers to deaths. The county must remain since it is required by statute, but would recommend removing it at some point.
- Section E should be changed to capture the number of live births for each county, and to collect data on preterm births before transfer to care, after transfer of care, and number of low birth weight infants under 2500 grams, which should be delineated between out of hospital and after transfer, in hospital.
- For Section F, outcomes of out of hospital births, line 21 referring to breech should be split it into “delivered out of hospital” and “delivered after transfer” in order to capture when a midwife identifies a breech while in the process of transferring.
- For line 22, relating to Vaginal Birth after Cesarean (VBAC), a separate VBAC section should be provided.
- For line 23, relating to twins, there is data collection on both “delivered out of hospital” or “none delivered out of hospital,” but not “one delivered out of hospital and transfer for the second twin”. Data should be collected on “both delivered out of hospital” along with the outcomes for both, “one delivered out of hospital” along with the outcomes for both, and “transferred for both” along with the outcomes for both.
- For line 24, relating to higher order multiples, data should be collected on “all delivered out of hospital” along with the outcomes, “one delivered out of hospital” along with the outcomes, “more than one delivered out of hospital” along with the outcomes, and “transferred for all” along with the outcomes.

Ms. Sparrevohn stated that there were no recommended changes to Section G.

- For Section H, relating to antepartum transfer of care for urgent reasons, remove line 52, which is fetal demise, and place it in a separate section.
- For Section I, relating to intrapartum transfer of care, elective and recommended, remove line 64 regarding “Multiple Gestation” and capture the data in Section F.
- For Section J, relating to intrapartum transfer of care, urgent, and recommended, remove line 76 regarding “Multiple Gestation” and capture it in Section F.

Ms. Sparrevohn stated that there were no recommended changes for Sections K, L, M, and N.

- For Section O, relating to birth outcomes after transfer of care, change the directions for lines

116 through 131 to read: "For any mother or infant who transferred care as reported in Section I, J, K, L, M, and N from the licensed midwife to another healthcare provider, please provide the outcome information regarding the mother and the infant in the spaces provided. Deaths will be reported in a separate section." Lines 119, 126, 127, and 128 all relate to deaths and should be removed and captured in a separate section.

- For Section P, it should be specifically for VBACs. The section currently captures more data on outcomes, but because that data would be captured in a separate section specific to deaths, and in Section O for other outcomes, this section should only relate to VBACs. Data should be collected for the number of planned out of hospital VBACs on the onset of term labor or term rupture of membranes; number of completed VBACs out of hospital; number of completed VBACs after transfer; number of cesarean sections after transfer; number of diagnosed uterine dehiscence; and the outcome, excluding those resulting in death. Any complications leading to death related to VBAC would be captured in a separate section.

Ms. Sparrevojn referred to the separate section capturing data related to deaths (Section X). Section X will capture all deaths; fetal, neonatal, and maternal. Each death will be recorded individually, not as an aggregate and it will capture all the components that are asked for in law.

Ms. Sparrevojn referred to the Task Force Report provided in the meeting materials and indicated that the highlighted areas were the number of pregnancy losses from any cause prior to 20 weeks of gestation. Ms. Sparrevojn indicated that if needed, it can be separated into spontaneous, therapeutic, therapeutic for medical indications, or fetal anomaly which can be discussed at a later time.

Ms. Sparrevojn stated that the number of fetal demises prior to the onset of labor, or after rupture of membranes without labor between 20 weeks and 37 weeks, is the designation for preterm. Ms. Sparrevojn stated that if needed, it could capture the exact number of weeks gestation, the number of fetal demises prior to the onset of labor rupture of membranes after 37 weeks, the number of fetal demises between 20 and 37 weeks that happened out of hospital, and the number of demises during labor after 37 weeks.

Ms. Sparrevojn stated she and Ms. Ehrlich discussed making the statistics comparable to national and international standards when it came to discussing neonatal and infant deaths. Ms. Sparrevojn suggested capturing data related to: deaths in the first seven days of extra-uterine life; deaths between seven and 28 days of extra-uterine life (and the causes will be captured), and the number of maternal deaths, which is defined internationally as the death of a mother as a result of pregnancy. In other words, while pregnant or within 42 days of the end of the pregnancy.

Ms. Sparrevojn suggested a separate line item for the number of fetal demises of any category, that were diagnosed prior to labor by a physician, who were subsequently delivered out of hospital by the licensed midwife by maternal request, in order to capture how many women are choosing to deliver at home. Ms. Sparrevojn continued to state that she would like to capture data on whether or not the death was attributable to diagnosed anomalies that were incompatible with life; complete information on VBACs that resulted in the death of a mother or an infant; the complications that contributed to the deaths of mothers or infants; and the place of death, whether it was out of hospital or after transfer.

Ms. Yaroslavsky complimented Ms. Sparrevojn and Ms. Ehrlich for their time and energy that was put

into the LMAR. She indicated that it was an amazing job and quite a task. Ms. Yaroslavsky suggested creating a mechanism that would not allow the form to be submitted if required areas were left blank.

Ms. Sparrevohn agreed with the suggestion.

Ms. Marceline thanked Ms. Sparrevohn for including the breech mode of birth, and questioned if there was a way to capture whether the baby was born by cesarean or vaginal birth after the transfer.

Ms. Sparrevohn confirmed that it could be included, and asked if the information should be captured for the twins as well.

Ms. Marceline confirmed that she would like the information captured for the twins also.

Ms. Ehrlich stated she understood the need to have information for twins, breeches, and higher order multiples, but wondered about having it on the report, given that it was not in compliance with the law. Ms. Ehrlich stated that she was hesitant about the issue and would like to not change the title of Section P to Vaginal Birth After Cesarean. Ms. Ehrlich stated that she had spent years compiling data onto her "Overview Report" and would prefer VBAC have their own section.

Ms. Sparrevohn agreed with Ms. Ehrlich.

Ms. Ehrlich referred to number four, on the last page of the Task Force Report, regarding fetal demises from 20 and 07 to 36 and 6/7 days, stating that nothing was documented regarding a woman going past 42 weeks.

Ms. Sparrevohn suggested adding a field that would ask, "What were the gestational weeks at the time of the demise?"

Ms. Webster suggested placing reminders in all sections of the report indicating that data related to deaths would be captured in a separate section, to prevent duplicate data.

Ms. Sparrevohn agreed with Ms. Webster.

Ms. Sparrevohn completed her overview of recommended changes and suggested that if the August MAC meeting was rescheduled prior to the July Board meeting, as per her request during her "Chair Report", it would allow the MAC to present a complete and thorough recommendation to the Board for moving forward with fixing the current LMAR, and/or to strongly recommend reconsideration of reporting to the Midwives Alliance of North America (MANA) statistical database.

Ms. Sparrevohn suggested that perhaps Missy Cheney, Ph.D., a professor in Oregon and the head of the Department of Research for MANA, could provide a presentation to the Board. Ms. Sparrevohn stated that in her opinion, moving to MANA would be the better option, but the Board would need to be convinced of that, as they would be making the recommendation to move forward with legislative changes.

Ms. Yaroslavsky stated that it was unclear as to what the process would be for providing the suggested changes to the Board, as it seemed that prior to presenting to the Board, changes should be presented to

the community to make sure that it was mutually agreed upon by all parties. Ms. Yaroslavsky questioned if there had been discussion regarding the topic at a previous Interested Parties meeting.

Ms. Lowe stated that there are technical issues with the online reporting system, in which the staff will need to work with Office of Statewide Health Planning and Development (OSHPD) to get the issues resolved, or to determine what other options are available. Ms. Lowe stated that staff and legal counsel will need to review the entire document prepared by the taskforce, line by line, to ensure that requested items being removed and/or added are in compliance with the current law. Ms. Lowe stated that the next step would be to work on the actual language to present to the Board. After the Board is provided an opportunity to review the requested changes, the document can be disseminated to the public for review. Following the opportunity for the public to comment on the items, it will again be presented to the Board for action.

Ms. Yaroslavsky questioned what would be a reasonable expectation for the process.

Ms. Lowe stated that staff will have the month of May to work on the LMAR prior to the next Board meeting.

Ms. Sparrevohn stated OSHPD had provided her the Memorandum of Understanding (MOU) that it has with the Board and that any changes to the LMAR for the collection of data for 2015 must be received by OSHPD by September 1st.

Ms. Sparrevohn stated that an attempt will be made to move the August MAC meeting prior to the July board meeting so that the MAC can vote on whether they want to send the final document to the Board. Ms. Sparrevohn questioned if it was possible to present the document to the Board at its July meeting.

Ms. Lowe stated she was hopeful that it could be completed by July.

Ms. Ehrlich stated that she would like to clarify one point that had been made, which is when they first began looking at the possibility of moving to MANA for data collection, it was thought that the process would be MANA would do its prospective collection, and that based on the information provided, MANA would then provide a printed report to the licensed midwife of the required data outlined in law, which they could provide to OSHPD. The licensed midwife would still report to OSHPD, but it would be based on what they had been doing all year long.

Ms. Sparrevohn stated that would be the case unless there was a legislative change to submit it differently. Ms. Sparrevohn stated that the MAC could ask the legislature to have midwives submit their data to MANA, and MANA could then provide the required data directly to OSHPD.

Ms. Lowe added that the MAC had previously presented the idea of pursuing the option of MANA to the Board, and that it had been denied. Ms. Lowe stated that if the MAC was again considering the option of MANA then the MAC would have to pursue that option by presenting it again to the Board with new and additional information to support their cause.

Ms. Yaroslavsky stated that the Board would support whatever was considered best practice, but in order to determine what that was, the MAC and Board staff would need to do due diligence and provide the Board with a clear understanding of the options and whether reporting is provided to MANA, or

whether it goes to OSHPD is really not the discussion at this time. Ms. Yaroslavsky clarified that the option of pursuing MANA would only be considered if OSHPD was unable to meet the needs of the Board.

Ms. Ehrlich stated that she would like it on the record that she would like to move the statistical reporting to MANA.

Ms. Sarah Davis stated that the legislative fixes were completed and that Business and Professions code 2516 (a)(3)(B) and (C) no longer refer to supervision or collaborative care. Ms. Davis indicated that it refers to the number of county live births and demises by county. Ms. Davis stated that in the process of AB 1308, references to collecting data on physician supervision and collaborative care was removed.

Ms. Perez introduced herself as a licensed midwife in San Francisco. Ms. Perez referred to Section D, line 14 regarding the number of clients who left care in the antepartum period. Ms. Perez recommended to clarify that the only information being captured is the number of clients who left in the antepartum period and not intrapartum or postpartum period.

Ms. Perez stated that she was unsure what the section related to fetal demise was trying to capture as it asks to track the fetal demise that was discovered in the care as a licensed midwife or if it was discovered in the hospital.

Ms. Sparrevohn suggested to add language that will make it clear that if a midwife did not get heart tones and went to the hospital to get an ultrasound, and the ultrasound showed that there was a demise, then the midwife discovered it. Ms. Sparrevohn added that it should include a pop-up box with a definition so that everyone is reporting the same way, because it is very open to interpretation by the individual midwife.

Ms. Perez referred to the question "Did you provide midwifery services or midwifery care, to someone who was potentially going to have a baby this year?" Ms. Perez stated she was unclear if that question wanted to capture licensed midwives who are providing well-women care as part of midwifery services.

Ms. Sparrevohn stated that well-woman care data was not required in statute and that the statute was written to capture data surrounding pregnancy and birth. Ms. Sparrevohn suggested adding a question in the future that would ask "How many women did you serve this year who were not pregnant who came to you for basic well-women services?"

Ms. Perez suggested that it should state that "came to you for midwifery services and were expecting a child" because the word "and" is not included, so it is not necessarily knowing that a midwife is not including women that the midwife provided midwifery maternity care services.

Ms. Sparrevohn agreed with Ms. Perez.

Agenda Item 7 Update on Midwifery Assistant Legislative Proposal

Ms. Simoes provided an update on Senate Bill 408, stating that the bill is set to be heard by the Senate Business and Professions Committee on April 6, 2015. Interested parties have raised some issues, and staff are currently working on amending the language.

Agenda Item 8 Update on Implementation of Assembly Bill 1308

Ms. Webb stated that an Interested Parties meetings had been held on October 15th and December 15th of 2014 to discuss language for the regulations needed to define preexisting maternal disease or condition likely to affect the pregnancy, as well as significant disease arising from the pregnancy, pursuant to Business and Professions Code section 2507.

Ms. Webb felt that the discussions were very productive, and that the biggest hurdle continued to be a great divide over whether midwives can assist their clients with any VBACs without a prior physician consult and determination by the physician that the risk factors presented by the client's disease or condition were not likely to significantly affect the course of the pregnancy or childbirth.

Ms. Webb stated that she was informed that the American Congress of Obstetricians and Gynecologist's (ACOG) position is that no VBACs assisted by midwives should be performed without first having a physician consult and determination. Ms. Webb has also heard from midwives and consumer groups that they have taken the position that midwives should be able to assist with certain categories of VBACs without a prior physician consult and determination.

Ms. Webb stated that it is at an impasse at this point, and that Board staff will continue to reach out to parties involved. Resolution is still in process.

Ms. Sparrevohn asked if there were any suggestions for how the midwifery community or physician community could come together in a different way to move forward.

Ms. Webb stated that she thought there would need to be compromise between ACOG and the midwifery community in order to have regulations move forward in a successful way.

Ms. Simoes stated that she and Ms. Kirchmeyer had discussed the issue and would provide an update at the next meeting to clarify what other options would be available.

Ms. Marceline suggested that the patient could preregister and the midwife could recommend the patient see a doctor prior to taking on care for a VBAC.

Ms. Sparrevohn stated that she is hopeful that if there is a separate section for capturing data regarding VBACs on the LMAR, it may be a helpful bargaining chip. Ms. Sparrevohn indicated that the change would allow data to be extrapolated and would show that women and babies are not dying because women are having VBACs at home without a physician referral first.

Ms. Sparrevohn thought that a strong case could be made for continuing with the recommendations that were previously in regulation, as a result of the standard of care being adopted in 2005.

Ms. Sparrevohn stated that as heard at the Interested Parties meetings, there are many places in California where a woman's only ability to have a VBAC is at home with a licensed midwife, as many hospitals will not allow her that choice. Ms. Sparrevohn added that without solid evidence that midwives are putting women in danger by not requiring a physician referral, she thought that midwives need to be very careful on how to proceed with that.

Ms. Sparrevohn stated that she has not seen ACOG provide any conclusive evidence that shows without a physician referral first, women are in danger by only seeking care from a licensed midwife. Ms. Sparrevohn indicated that it is the job of the MAC to protect the public, not only to protect them from doing things that may harm them, but to also protect their rights as autonomous citizens to make reasonable choices regarding their health care.

Ms. Yaroslavsky stated that there are rules and regulation in place, and in order to change those rules and regulations, you have to move to a position where you are getting the data and the information necessary so that people will understand why the request is being made or why the situation should be different.

Ms. Sparrevohn suggested that ACOG provide the data to support changing the regulation that was adopted in 2005.

Ms. Ehrlich stated that the data that exists reflects that it was completely reasonable in 2005 and it is reasonable in 2015.

Ms. Greenwood introduced herself as a registered midwife from Canada and stated that there was a new position paper available from the American Association of Family Physicians on the issue that maybe helpful for the discussion.

Ms. Yaroslavsky requested that the information be provided to Ms. Sparrevohn.

Ms. Webb stated that a future Interested Parties meeting would be scheduled to discuss Business and Professions Code section 2510 that relates to the transfer form. Ms. Webb stated that there is a basic form in use now for when a client needs to be transferred from a planned home birth to a hospital and that Board staff intend to hold further meetings in order to modify the form and officially adopt it into regulation.

Ms. Sarah Davis requested that staff provide an update regarding the number of reports that had been submitted as she would like to see how it is evolving through the year.

Ms. Sparrevohn indicated that the information would be provided during the program update.

Ms. Webb continued with information regarding the Challenge Mechanism, referring to Business and Professions Code section 2513. Ms. Webb stated that the Challenge Mechanism is still available; however, clinical experience may no longer be substituted for formal didactic education. Board staff sent letters to the two schools that previously provided a Challenge Mechanism pathway, inquiring how they intended to comply with the section. Maternidad La Luz provided information that appears to reflect that they have an appropriate Challenge Mechanism process. The information will need to go before the Board for full approval in order for Maternidad La Luz to continue to offer a Challenge Mechanism. Ms. Webb added that National Midwifery Institute, Inc. has not responded despite several requests for information.

Ms. Greenwood questioned how the challenge mechanism would work for a situation like hers.

Ms. Sparrevohn stated that currently there was not a pathway for applicants with education outside of the country to be approved. Ms. Sparrevohn added that the law is written that the school needs to be approved by the Board, and it would be very difficult for the Board to approve schools that are outside the United States.

Ms. Marceline commented that there is reciprocity with different states.

Ms. Lowe clarified that the Business and Professions Code 2512.5(b) does allow for reciprocity with another state if the licensee meets the requirements of the section that states: successful completion of an educational program that the Board has determined satisfies the criteria *and* current licensure as a midwife by a state with licensing standards that have been found by the Board to be equivalent. Ms. Lowe continued to state that the applicant would still need to meet the educational requirements, that the law would only exempt an applicant from the examination requirement.

Ms. Marceline mentioned that when the MAC was looking for states that met the same criteria as California, Florida and Washington were identified. Ms. Marceline questioned if the same procedure could be done for different provinces in Canada.

Ms. Lowe stated that approved education would still be required.

Agenda Item 9 Update on Licensed Midwives Interested Parties Meeting

Ms. Lowe provided an update on the December 15, 2014 Interested Parties meeting that was held to further discuss the Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting form as well as the regulations needed to define "pre-existing maternal disease or condition likely to affect the pregnancy." Extensive discussion ensued regarding the definition of pre-existing maternal disease or condition likely to affect the pregnancy; however, as a consensus was once again not received regarding how it should be defined, further discussion is still needed. During the meeting there was not sufficient time to discuss the transfer reporting form. Ms. Lowe added that an Interested Parties meeting would be scheduled to discuss the transfer reporting form in the next couple of months to address those specific needs.

Because of the inability to discuss the transfer reporting form, no further outreach had been done. Ms. Lowe stated that she was hopeful that after the next Interested Parties meeting, a clear understanding of what will be required on the form will be identified and will allow staff to provide outreach to licensees and hospitals, as well as to provide further direction on the Board's website. Ms. Lowe added that once a date is set for the Interested Parties meeting, staff will notice the meeting on the Board's website and will provide notice through the Board's subscribers' list.

Agenda Item 10 Program Update

Ms. Lowe stated that Board staff were in the process of updating the initial application for midwives as new laws had gone into effect at the beginning of the year. Some of the changes that would be implemented on the application would include allowing for an Individual Taxpayer Identification Number (ITIN) to be provided in-lieu of a Social Security Number.

Mr. Worden stated that other items to be added to the application related to being in the military or being a spouse or registered partner of someone in the military, which would allow for the review and issuance of the license to be expedited.

Ms. Lowe continued with the general program update stating that staff had been communicating with licensees regarding submission of their LMAR. She indicated that there were 363 reports expected to be submitted, and of those 125 were still pending submission. Ms. Lowe emphasized the importance of timely submission of the LMAR stating that any reports received after the March 30th deadline would not be included in the yearly report, resulting in unreliable data. Ms. Lowe also stated that failure to submit the LMAR was a violation of the laws pertaining to the practice of midwifery.

A. BreEZe Update

Ms. Lowe provided an update on the BreEZe system stating that there were still issues being addressed by Board staff and DCA and that upon resolution of pending tickets some of the issues would be resolved. For example, when certain data extracts are not completed correctly due to system issues, the print vendor is provided incorrect information resulting in staff having to manually review information to ensure that the correct documents are being sent. Board staff are hopeful that issues like the one discussed will be resolved in the very near future alleviating some of the work arounds required because of the system.

B. Licensing Statistics

Ms. Lowe referred to the licensing statistics on page 16 of the packets, tab 10, and stated that from October 1st through December 31st, applications received increased from 3 to 20 in that quarter. At the end of the quarter, there were seven pending applications all of which had been reviewed, indicating that there was no delay in reviewing incoming applications. Ms. Lowe referred to "LM License Statuses" reflected at the bottom of the page, and stated that per the recommendation by the MAC at the last meeting, all of the license statuses were now provided. Ms. Lowe added that previously only those licenses that were current and delinquent were provided.

Ms. Sparrevohn questioned if the revoked, surrendered, or deceased statuses were cumulative and not within the last five years.

Ms. Lowe confirmed that the data provided was a snapshot reflecting what the status was at the time, regardless of when the status change had occurred.

C. Enforcement Statistics

Ms. Lowe referred to the enforcement statistics on page 17 of the packets, tab 10, and stated that staff had reformatted the chart to exclude numbers of hospital transfer reporting forms received from the complaints received data to provide a better representation of the two different data sets.

Agenda Item 11 Presentation on Best Practices for Home to Hospital Transfers by Midwives

Ms. Sparrevohn informed the MAC that the presentation by Diane Holzer, L.M. on Best Practices for Home to Hospital Transfers by Midwives would be moved to the next MAC meeting.

Agenda Item 12 Agenda Items for the next Midwifery Advisory Council Meeting in Sacramento

The following agenda items were identified by Ms. Sparrevohn for the next MAC meeting to be held on August 13, 2015:

- Report from the MAC Chair
- Midwifery Program Update
- Update on Assembly Bill 1308
- Update on Midwifery Assistant Legislation
- Presentation by Diane Holzer, L.M. - Best Practices for Home to Hospital Transfer by Midwives
- Further Consideration and Approval of Changes to the LMAR
- Update on Challenge Mechanism
- Update on Licensed Midwives Interested Parties Meeting

Agenda Item 11 Adjournment

Ms. Sparrevohn adjourned the meeting at 3:32 p.m.

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2015/

Licensed Midwife Annual Report
 Task Force Report
 Submitted by Karen Ehrlich and Carrie Sparrevohn
 Finalized 3-17-2015

Following are recommendations from the Midwifery Advisory Council Task Force for adjustments to the Licensed Midwife Annual Reporting (LMAR) Tool.

The overall recommendation of this task force is to seek legislative change to permit moving data collection for Licensed Midwives to the Midwives Alliance of North America (MANA) Department of Research statistical data-base. Reasons for this move has been delineated in former reports to this council and to the Board as a whole, however, it is important to review the main advantages of that system. First among them is that the MANA Stats reporting tool was designed by those with knowledge on how to collect this type of data. Additionally, it has a dedicated staff of researchers, computer coders and others working to make sure it continues to be the best tool of its kind. A number of other states have already made the choice to capture data in this manner. And finally, the MANA data collection is essentially done in a prospective rather than retrospective (how the LMAR functions) manner. This is the gold standard in data collection and should be what is used in California. Since a move of this nature cannot be accomplished in an expedient manner, we submit the following items for review and incorporation, either in part or in total, into the LMAR.

A legislative fix is now needed to remove language from B&P Section 2516 that is no longer appropriate given changes to our authorizing statute by AB 1308.

- Remove B&P Sec 2516 (3)(B) "*The total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon*", originally included to capture data on how many midwives had some type of relationship with a physician. Suggest capturing data on consultation/referrals in another way on the reporting tool
- Remove B&P Sec 2516 (3)(C) "*The total number of clients served under the supervision of a licensed physician and surgeon*", supervision is no longer required by law

General Recommendations:

- Confine all information regarding deaths in a separate section (see below and Appendix A), removing the collection of data relating to deaths from all other sections.
- For each item that has a definition, have a pop up box with the definition that is not one you scroll over to select but one that automatically comes up when the cursor is put into the answer box
- Remove the requirement to report by county. It too easily identifies the midwife and her client, especially in counties with a low population. This will require a legislative fix.
- General workings of the on-line tool
 - ✓ The 'No Data to Report' button is confusing. If you are filling in the form with zeros as you go down a column and then notice the 'no data' button at the bottom you have to remove the zeros before you can select that button. Recommend allowing zeros to be inserted and removing the button. This would mandate reporters reading each item before answering.
 - ✓ Zeros are allowed to be entered in some sections and not in others and then do not show on the final form, including print view. Recommend allowing zeros in all fields if that is the answer and have the zeros print on the saved form.

- ✓ Comments made in each section do not show on the finalized form, including the print view. This should be corrected, with all comments made by the reporter showing on both their copy and on what is sent to the OSHPD.
- ✓ Ideally, it would be good if midwives could enter their data as it occurs, over the course of the reporting year. This could be easily accomplished by asking the legislature to mandate data be submitted to the Midwives Alliance of North America as is the case for a number of other states.

Recommendations by current reporting tool section as follows:

Section D Client Services:

- Line 14 *Number of clients who left care for non-medical reasons*: Change wording to: Number of clients who were either lost to care or who left care for non-medical reasons (definition of lost to care: clients who never returned for appointments despite efforts to contact them)
- Line 15 *Total number of clients served whose births were still pending on the last day of the year*: Remove. It serves no purpose, is not required by statute, and confuses the numbers
- Line 16 *Collaborative Care*: Change to number of times referrals were made (acknowledge that it might be more than one referral per client) and include the reasons for the referral from the list currently being developed in regulation. This may need to be incorporated in coming years pending the adoption of the regulation implementing AB 1308.
- Line 17 *Supervision*: will need to be removed after legislative fix noted above re: supervision

Section E Outcomes per county in which birth, fetal demise, or infant or maternal death occurred

General recommendations:

It is desired that more in-depth information be captured regarding the nature of all deaths. Therefore we recommend having a separate Section X for reporting of all deaths.

Change Section E to capture information on live births only:

- Column A change to county in which live birth occurred
- Column B keep the same
- Column C move to Section X
- Column D move to Section X
- Column E move to Section X

Specific recommendations for additional fields of data:

- Retain Columns A & B
- Add the following Columns:
 - ✓ Number of live preterm births (before 37 0/7 weeks gestation) delivered after transfer of care
 - ✓ Number of low birth weight infants (under 2500 grams/5# 8oz). Delineate between OOH and after transfer, in hospital.
 - ✓ Number of live preterm births completed out of hospital (before 37 0/7 weeks gestation)

Section F Outcomes of out of hospital births

- Line 19 and 20 no change
- Line 21 *Breech*: split to delivered OOH and delivered after transfer (it should be recognized that occasionally Breech babies will be born with an LM in attendance secondary to precipitous, undiagnosed Breech)
- Line 22 *VBAC*: create a separate section for VBAC. See notes for Section P

- Line 23 *Twins*: collect data on both delivered OOH along with outcome, one delivered OOH and outcomes for both, and transferred for both with outcomes
- Line 24: *Higher Order Multiples*: collect data on all delivered OOH along with outcomes, one delivered OOH and outcomes, more than one delivered OOH and outcomes, and transferred for all with outcomes.

Section G Antepartum Transfer, elective: no changes

Section H Antepartum Transfer of Care, urgent

- Line 52 *Fetal Demise*: remove to Section X

Section I Intrapartum transfer of care, elective

- Line 64 *Multiple Gestation* Remove, data captured in Section F (this eliminates duplicate data)

Section J Intrapartum transfer of care, urgent

- Line 76: *Multiple Gestation* Remove, data captured in Section F (this eliminates duplicate data)

Sections K, L, M, N no recommended changes

Section O Birth Outcomes after transfer of care:

- Wording change in directions “Lines 116-131: For any mother or infant who transferred care as reported in section I, J, K, L, M and N, from the licensed midwife to another healthcare provider, please provide the outcome information regarding the mother and the infant in the spaces provided. Deaths will be reported in a separate section”.
- Lines 119 *Death of mother*: Capture data in new Section X
- Line 126 *Fetal demise diagnosed prior to labor*: Capture data in new Section X
- Line 127 *Fetal demise diagnosed during labor or at delivery*: Capture data in new Section X
- Line 128 *Live born infant who subsequently died*: Capture data in new Section X
- Make it clear that this Section O is for morbidity only. Deaths will be captured **ONLY** in Section X.

Section P Vaginal Birth After Cesarean (completely restructured)

- Eliminate current questions in favor of Section X
- Use this Section to capture VBAC information only, as follows
 - Number of planned OOH VBACs at onset of term labor or term rupture of membranes at term
 - Number of completed VBACs OOH
 - Number of completed VBACs after transfer to hospital
 - Number of cesarean sections after transfer to hospital
 - Number of diagnosed uterine dehiscence and outcome (morbidity only, deaths captured in Section X)
 - Number of diagnosed uterine ruptures and outcome (morbidity only, deaths captured in Section X)
 - Consider capturing data on: VBAC after one prior CS and VBAC after more than one prior CS
- Complications leading to death related to VBAC will be captured in Section X

Section X

This new section will capture all deaths; fetal, neonatal and maternal. Each death will be recorded individually, not as an aggregate. This allows for all of the details of each death to be individually gathered. No data regarding the death of a mother or an infant will be entered elsewhere on this form. A summary of captured data is included here, all components (cause, OOH, after transfer) are collected as they have been previously. For exact language please see Appendix A.

1. Number of pregnancy losses (from any cause) prior to 20 completed weeks of gestation (*could be separated into SAB/TAB/TAB for medical indication or fetal anomaly if desired, though not necessary*)
2. Number of fetal demise(s) prior to onset of labor or after rupture of membranes without labor, from 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation (pre-term) (*could capture data on exact number of weeks gestation*)
3. Number of fetal demise(s) prior to onset of labor or rupture of membranes without labor, after 37 0/7 weeks gestation (term)
4. Number of fetal demise(s) during labor between 20 0/7 weeks gestation and 36 6/7 weeks gestation (pre-term) (*While LMs should not be intentionally caring for these women there is the possibility that an LM would go check on a woman that meets this criteria and find both active labor and a demise. Variables re place of death, place of labor, etc are collected on proposed form*)
5. Number of fetal demise(s) during labor after 37 0/7 weeks gestation (term)
6. Number of neonatal (presumes live born infant) deaths prior to the 7th day of extra-uterine life
7. Number of neonatal (presumes live born infant) deaths from day 7 to day 28 of extra-uterine life
8. Number of maternal deaths (*Definition: death of mother as a result of pregnancy; while pregnant or within 42 days of the end of a pregnancy*)
9. Number of fetal demise(s) (of any category) diagnosed prior to labor by a physician who were subsequently delivered OOH by the LM on maternal request (*This information is captured for each death, rather than as an aggregate*)
10. Whether death attributable to diagnosed anomalies incompatible with life
11. Information on VBAC that resulted in the death of a mother or an infant
12. Complications contributing to deaths of mother or infant
13. Place of death, OOH or after transfer

Appendix A

Proposed Section X

Of the number reported in Section D, Line 13 how many pregnancies resulted in maternal, infant or fetal deaths? Include terminations prior to 20 weeks gestation (miscarriages, abortions and abortions for medical reasons). Include deaths discovered **BOTH** at home and after transfer to another provider or facility. You will be given an opportunity to further elaborate on these deaths in future screens and details for each death will be entered separately.

Fetal deaths (pregnancy losses prior to birth of a live neonate)

1. Was the death discovered OOH? (If yes continue, If no skip to #2 below)
 - A. Which county was the death discovered in?
 - B. Was the death prior to 20 weeks gestation (if yes continue, if no skip to C below)
 - i. Was the loss the result of a fetal anomaly? (yes, no, unkn) *it is not required by statute to collect cause of death for fetal deaths prior to 20 completed weeks gestation*
 - C. Was the loss greater than 20 0/7 weeks gestation **AND** diagnosed by a physician **AND** by maternal request, subsequently delivered OOH by you? (if yes continue, if no skip to D below)
 - i. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (If yes continue, if no skip to (ii) below)
 - a. Was the loss prior to onset of labor or after rupture of membranes without labor, **AND** between 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation **OR**
 - b. Was the loss prior to onset of labor or after rupture of membranes without labor **AND** after 37 0/7 weeks gestation **OR**
 - c. Was the loss during labor **AND** between 20 0/7 weeks gestation and 36 6/7 weeks gestation **OR**
 - d. Was the loss during labor **AND** after 37 0/7 weeks gestation
 - ii. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (no)
 - a. Was the loss prior to onset of labor or after rupture of membranes without labor, **AND** between 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation **OR**
 - b. Was the loss prior to onset of labor or after rupture of membranes without labor **AND** after 37 0/7 weeks gestation **OR**
 - c. Was the loss during labor **AND** between 20 0/7 weeks gestation and 36 6/7 weeks gestation **OR**
 - d. Was the loss during labor **AND** after 37 0/7 weeks gestation
 - D. Was the loss greater than 20 0/7 weeks gestation **AND** diagnosed by a physician **AND** by maternal request, subsequently delivered OOH by you? (no)
 - i. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (no)
 - a. Was the loss prior to onset of labor or after rupture of membranes without labor, **AND** between 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation **OR**

- b. Was the loss prior to onset of labor or after rupture of membranes without labor **AND** after 37 0/7 weeks gestation **OR**
 - c. Was the loss during labor **AND** between 20 0/7 weeks gestation and 36 6/7 weeks gestation **OR**
 - d. Was the loss during labor **AND** after 37 0/7 weeks gestation
2. Did the death occur after transfer to another provider or facility? (if yes continue if no return to (1) above)
- i. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (If yes continue, if no skip to (ii) below)
 - a. Was the loss prior to onset of labor or after rupture of membranes without labor, **AND** between 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation **OR**
 - b. Was the loss prior to onset of labor or after rupture of membranes without labor **AND** after 37 0/7 weeks gestation **OR**
 - c. Was the loss during labor **AND** between 20 0/7 weeks gestation and 36 6/7 weeks gestation **OR**
 - d. Was the loss during labor **AND** after 37 0/7 weeks gestation
 - ii. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (no)
 - a. Was the loss prior to onset of labor or after rupture of membranes without labor, **AND** between 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation *we could include a question asking the exact number of gestational weeks* **OR**
 - b. Was the loss prior to onset of labor or after rupture of membranes without labor **AND** after 37 0/7 weeks gestation **OR**
 - c. Was the loss during labor **AND** between 20 0/7 weeks gestation and 36 6/7 weeks gestation *we could include a question asking the exact number of gestational weeks* **OR**
 - d. Was the loss during labor **AND** after 37 0/7 weeks gestation *we could include a question asking the exact number of gestational weeks*
 - e. Complication contributing to or causing death, mark all that apply. (this has not been collected prior to this but we believe it should be collected)
 - i. Infection
 - ii. Meconium aspirations, other respiratory
 - iii. Neurological issues/seizures
 - iv. As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - v. As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vi. Other medical issue
 - vii. Unknown
 - viii. Information not obtainable
 - ix. Other

Neonatal deaths (live born infant who died prior to the 7th day of life)

1. Did the death occur OOH (if yes continue, if no skip to (2) below)

A. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if yes continue, if no skip to (b) below)

a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, mark all that apply

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

B. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if no continue, if yes revert to (A) above)

a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries

- As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)
 Complication contributing to or causing death, choose **ONE** from the following list
- Infection
 - Meconium aspiration, other respiratory
 - Neurological issues/seizures
 - As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
2. Did the death occur after transfer to another provider or facility? (if yes continue, if no revert to (1) above)
- A. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if yes continue, if no skip to (b) below)
- a. Was neonate born of a gestation between 20 0/7 and 36 6/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*
 Complication contributing to or causing death, choose **ONE** from the following list
- Infection
 - Meconium aspiration, other respiratory
 - Neurological issues/seizures
 - As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)
 Complication contributing to or causing death, choose **ONE** from the following list
- Infection
 - Meconium aspiration, other respiratory
 - Neurological issues/seizures

- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
- B. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if no continue, if yes revert to (A) above)
- a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*
- Complication contributing to or causing death, choose **ONE** from the following list
- Infection
 - Meconium aspiration, other respiratory
 - Neurological issues/seizures
 - As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)
- Complication contributing to or causing death, choose **ONE** from the following list
- Infection
 - Meconium aspiration, other respiratory
 - Neurological issues/seizures
 - As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other

Neonatal Deaths (live born infant who died between day 7 and day 28 of extra-uterine life)

1. Did the death occur OOH (if yes continue, if no skip to (2) below)

A. County in which death diagnosed

B. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if yes continue, if no skip to (b) below)

a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a pregnancy or trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a pregnancy or trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

C. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if no continue, if yes revert to (A) above)

a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures

- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - Other medical issue
 - Unknown
 - Information not available
 - Other
- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

2. Did the death occur after transfer to another provider or facility? (if yes continue, if no revert to (1) above)

B. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if yes continue, if no skip to (b) below)

- a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

C. Was the death due to a diagnosed (either before or after delivery) anomaly deemed incompatible with life? (if no continue, if yes revert to (A) above)

- a. Was neonate born of a gestation between 20 0/7 and 36 0/7 weeks? (if yes continue, if no skip to (ii) below) *we could include a question asking the exact number of gestational weeks*

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

- b. Was neonate born of a gestation greater than 36 0/7 weeks? *we could include a question asking the exact number of gestational weeks* (if yes continue, if no revert to (a) above)

Complication contributing to or causing death, choose **ONE** from the following list

- Infection
- Meconium aspiration, other respiratory
- Neurological issues/seizures
- As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
- As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
- Other medical issue
- Unknown
- Information not available
- Other

Maternal Deaths

1. Did the death occur OOH? (if yes continue, if no skip to (2) below)
 - A. County where death was diagnosed
 - B. Did the death occur prior to labor? (if yes continue, if no skip to (C) below)
 - a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation greater than 37 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - C. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis
 - iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other
 - D. Did death occur during labor? (if yes continue, if no skip to (D) below)
 - a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation greater than 37 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - d. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis
 - iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other
 - E. Did death occur after delivery and prior to the 42nd day post-partum? (if yes continue, if no revert to (B or C) above)
 - a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation 20 0/7 to 3 6/7 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - d. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis

- iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other
2. Did the death occur after transfer to another provider or facility? (if yes continue, if no revert to (1) above)
- A. County where death was diagnosed
 - B. Did the death occur prior to labor? (if yes continue, if no skip to (C) below)
 - a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation greater than 37 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - d. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis
 - iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other
 - F. Did death occur during labor? (if yes continue, if no skip to (D) below)
 - a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation greater than 37 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - d. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis
 - iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other

- G. Did death occur after delivery and prior to the 42nd day post-partum? (if yes continue, if no revert to (B or C) above)
- a. Was gestation greater than 20 weeks (if yes skip to (D) below, if no continue)
 - b. Was gestation greater than 37 weeks (if yes skip to (D) below, if no continue)
 - c. Was gestation greater than 42 weeks (if yes skip to (D) below, if no revert to (a or b) above)
 - d. Complication contributing to or resulting in death. Mark all that apply:
 - i. Blood loss
 - ii. Sepsis
 - iii. Eclampsia/toxemia/HELLP syndrome
 - iv. Embolism (pulmonary or amniotic fluid)
 - v. As a direct result of a trial of labor in a woman with a history of 1 or 2 prior cesarean deliveries
 - vi. As a direct result of a trial of labor in a woman with a history of more than 2 prior cesarean deliveries
 - vii. Unknown
 - viii. Information not available
 - ix. Other

MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 14/15	Q1	Q2	Q3	Q4
Applications Received	45	3	20	16	6
Applications Withdrawn	1	0	1	0	0
Licenses Issued	42	5	14	13	10
Applications Pending	N/A	2	7	10	6
Licenses Renewed	153	43	39	29	42
Licenses Cancelled	3	3	0	0	0

Licensed Midwives	FY 13/14	Q1	Q2	Q3	Q4
Applications Received	30	2	15	4	9
Applications Pending	3	7	5	4	3
Licenses Issued	28	1	12	5	10
Licenses Renewed	141	36	25	46	34
Licenses Cancelled	2	0	1	0	1

Licensed Midwives	FY 12/13	Q1	Q2	Q3	Q4
Applications Received	31	8	12	8	3
Applications Pending	2	5	6	8	2
Licenses Issued	31	5	12	5	9
Licenses Renewed	126	31	32	28	35
Licenses Cancelled	0	0	0	0	0

Licensed Midwives	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	31	9	5	8	9
Applications Pending	0	6	3	3	0
Licenses Issued	31	4	8	10	9
Licenses Renewed	123	24	31	31	37
Licenses Cancelled	1	0	0	1	0

LM License Status as of 6/30/2015	
Renewed / Current	361
Current Inactive	1
Delinquent	43
Cancelled	39
Revoked	4
Surrendered	6
Deceased	5

MIDWIFERY PROGRAM ENFORCEMENT STATISTICS	FY	FY	FY	FY	FY	FY
	13/14 Total	14/15 Qtr 1	14/15 Qtr 2	14/15 Qtr 3	14/15 Qtr 4	14/15 Total
Hospital Reporting Forms Received	N/A	53	22	31	31	137
COMPLAINTS						
Total number of complaints received	26	4	3	4	3	14
Licensed midwives	20	3	3	3	1	10
Unlicensed midwives	6	1	0	1	2	4
Total number of closed complaints	21	2	4	3	3	12
Licensed midwives	17	1	4	2	2	9
Unlicensed midwives	4	1	0	1	1	3
INVESTIGATIONS						
Total number of open investigations	2	1	0	0	2	3
Licensed midwives	1	1	0	0	2	3
Unlicensed midwives	1	0	0	0	0	0
Total number of closed investigations	2	1	2	0	2	5
Licensed midwives	2	1	2	0	2	5
Unlicensed midwives	0	0	0	0	0	0
Total number of cases referred to the Attorney General (AG)	1	1	1	0	0	2
Licensed midwives	2	1	1	0	0	2
Unlicensed midwives	0	0	0	0	0	0
Total number of cases referred for criminal action	0	0	0	0	0	0
Licensed midwives	0	0	0	0	0	0
Unlicensed midwives	0	0	0	0	0	0
The number of probation violation reports referred to the AG	0	0	0	0	0	0

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

Summary

as of 7/20/2015 9:19:02 AM

SECTION A - Submission Summary

Number of Midwives Expected to Report	363
Number Reported	316
Number Unreported	47
Note: Report Field Numbers 1 through 10 are specific to each midwife report submitted and are not included in this aggregation.	

SECTION B - REPORTING PERIOD

Line No.	Report Year
11	2014

SECTION C - SERVICES PROVIDED IN CALIFORNIA - This report should reflect services provided in California only.

Line No.		Total # Yes	Total # No
12	Did you or a student midwife supervised by you perform midwife services in the State of California during the year when the intended place of birth at the onset of your care was an out-of-hospital setting?	220	96

SECTION D - CLIENT SERVICES

Line No.		Total #
13	Total number of clients served as primary caregiver during this calendar year.	5386
14	Number of clients who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	256
15	Total number of clients served whose births were still pending on the last day of this reporting year.	1282
16	Enter the number of clients served who also received collaborative care. IMPORTANT: SEE DEFINITION OF COLLABORATIVE CARE!	2763
17	Enter the number of clients served under the supervision of a licensed physician and surgeon. IMPORTANT: SEE DEFINITION OF SUPERVISION!	161

SECTION E - OUTCOMES PER COUNTY IN WHICH BIRTH, FETAL DEMISE, OR INFANT OR MATERNAL DEATH OCCURRED

(A1) County Code	(A2) County Name	(B) # of Live Births	(C) # of Cases Fetal Demise	(D) # of Infant Deaths	(E) # of Maternal Deaths	(A1) County Code	(A2) County Name	(B) # of Live Births	(C) # of Cases Fetal Demise	(D) # of Infant Deaths	(E) # of Maternal Deaths
01	ALAMEDA	324	2	1	0	30	ORANGE	119	0	0	0
02	ALPINE	1	0	0	0	31	PLACER	39	0	0	0
03	AMADOR	3	0	0	0	32	PLUMAS	1	0	0	0
04	BUTTE	25	0	0	0	33	RIVERSIDE	124	0	0	0
05	CALAVERAS	3	0	0	0	34	SACRAMENTO	110	0	0	0
06	COLUSA	1	0	0	0	35	SAN BENITO	6	0	0	0
07	CONTRA COSTA	39	1	0	0	36	SAN BERNARDINO	124	1	0	0
08	DEL NORTE	1	0	0	0	37	SAN DIEGO	251	0	0	0
09	EL DORADO	27	1	0	0	38	SAN FRANCISCO	240	1	0	0
10	FRESNO	21	0	0	0	39	SAN JOAQUIN	17	0	0	0
11	GLENN	0	0	0	0	40	SAN LUIS OBISPO	74	1	0	0
12	HUMBOLDT	57	0	0	0	41	SAN MATEO	40	0	0	0
13	IMPERIAL	0	0	0	0	42	SANTA BARBARA	108	1	0	0
14	INYO	0	0	0	0	43	SANTA CLARA	116	0	1	0
15	KERN	59	0	0	0	44	SANTA CRUZ	58	1	0	0
16	KINGS	1	0	0	0	45	SHASTA	107	0	0	0
17	LAKE	5	0	0	0	46	SIERRA	0	0	0	0
18	LASSEN	6	0	0	0	47	SISKIYOU	12	0	0	0
19	LOS ANGELES	550	2	0	0	48	SOLANO	14	0	0	0
20	MADERA	6	0	0	0	49	SONOMA	125	1	0	0
21	MARIN	55	1	0	0	50	STANISLAUS	23	0	0	0
22	MARIPOSA	5	0	0	0	51	SUTTER	2	0	0	0
23	MENDOCINO	21	1	0	0	52	TEHAMA	4	0	0	0
24	MERCED	6	0	0	0	53	TRINITY	5	0	0	0
25	MODOC	1	0	0	0	54	TULARE	9	0	0	0
26	MONO	0	0	0	0	55	TUOLUMNE	30	0	0	0
27	MONTEREY	70	0	0	0	56	VENTURA	109	0	0	0
28	NAPA	13	0	0	0	57	YOLO	28	0	0	0
29	NEVADA	84	0	0	0	58	YUBA	6	0	0	0

SECTION F - OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Line No.		Total #
19	Number of planned out-of-hospital births at the onset of labor	3397
20	Number of completed births in an out-of-hospital setting	2833
21	Breech deliveries	12
22	Successful VBAC's	150
23	Twins both delivered out-of-hospital	1
24	Higher Order Multiples - all delivered out-of-hospital	1

SECTION G - ANTEPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions <i>unrelated</i> to pregnancy	12
26	G2	Hypertension developed in pregnancy	40
27	G3	Blood coagulation disorders, including phlebitis	5
28	G4	Anemia	6
29	G5	Persistent vomiting with dehydration	3
30	G6	Nutritional & weight loss issues, failure to gain weight	1
31	G7	Gestational diabetes	10
32	G8	Vaginal bleeding	4
33	G9	Suspected or known placental anomalies or implantation abnormalities	10
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	67
35	G11	HIV test positive	1
36	G12	Suspected intrauterine growth restriction, suspected macrosomia	12
37	G12.1	Fetal anomalies	5
38	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	15
39	G14	Fetal heart irregularities	2
40	G15	Non vertex lie at term	43
41	G16	Multiple gestation	8
42	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	35
43	G18	Client request	48
44	G19	Other	74

SECTION H - ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
45	H1	Non pregnancy-related medical condition	21
46	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	16
47	H3	Isoimmunization, severe anemia, or other blood related issues	2
48	H4	Significant infection	0
49	H5	Significant vaginal bleeding	2
50	H6	Preterm labor or preterm rupture of membranes	47
51	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	12
52	H8	Fetal demise	7
53	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	1
54	H10	Other	5

SECTION I - INTRAPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY

Line No.	Code	Reason	Total #
55	I1	Persistent hypertension; severe or persistent headache	11
56	I2	Active herpes lesion	0
57	I3	Abnormal bleeding	5
58	I4	Signs of infection	5
59	I5	Prolonged rupture of membranes	41
60	I6	Lack of progress; maternal exhaustion; dehydration	260
61	I7	Thick meconium in the absence of fetal distress	22
62	I8	Non-vertex presentation	16
63	I9	Unstable lie or mal-position of the vertex	6
64	I10	Multiple gestation (NO BABIES DELIVERED PRIOR TO TRANSFER)	0
65	I11	Clinical judgment of the midwife (where a single other condition above does not apply)	41
66	I12	Client request; request for medical methods of pain relief	70
67	I13	Other	15

SECTION J - INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
68	J1	Suspected preeclampsia, eclampsia, seizures	4
69	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	5
70	J3	Suspected uterine rupture	2
71	J4	Maternal shock, loss of consciousness	0
72	J5	Prolapsed umbilical cord	1
73	J6	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress	45
74	J7	Clinical judgment of the midwife (where a single other condition above does not apply)	10
75	J8	Other life threatening conditions or symptoms	2
76	J9	Multiple gestation (AT LEAST ONE BABY HAS BEEN DELIVERED OUT-OF-HOSPITAL)	0

SECTION K - POSTPARTUM TRANSFER OF CARE - MOTHER, ELECTIVE/NON-EMERGENCY

Line No.	Code	Reason	Total #
77	K1	Adherent or retained placenta without significant bleeding	14
78	K2	Repair of laceration beyond level of midwife's expertise	20
79	K3	Postpartum depression	1
80	K4	Social, emotional or physical conditions outside of scope of practice	1
81	K5	Excessive or prolonged bleeding in later postpartum period	5
82	K6	Signs of infection	7
83	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	3
84	K8	Client request	1
85	K9	Other	5

SECTION L - POSTPARTUM TRANSFER OF CARE - MOTHER, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
86	L1	Abnormal or unstable vital signs	4
87	L2	Uterine inversion, rupture or prolapse	1
88	L3	Uncontrolled hemorrhage	8
89	L4	Seizures or unconsciousness, shock	2
90	L5	Adherent or retained placenta with significant bleeding	17
91	L6	Suspected postpartum psychosis	1
92	L7	Signs of significant infection	2
93	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	2
94	L9	Other	0

SECTION M - TRANSFER OF CARE - INFANT, ELECTIVE/NON-EMERGENCY

Line No.	Code	Reason	Total #
95	M1	Low birth weight	1
96	M2	Congenital anomalies	4
97	M2.1	Birth injury	0
98	M3	Poor transition to extrauterine life	13
99	M4	Insufficient passage of urine or meconium	0
100	M5	Parental request	2
101	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	7
102	M7	Other	4

SECTION N - TRANSFER OF CARE - INFANT, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
103	N1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	11
104	N2	Signs or symptoms of infection	8
105	N3	Abnormal cry, seizures or loss of consciousness	2
106	N4	Significant jaundice at birth or within 30 hours	2
107	N5	Evidence of clinically significant prematurity	0
108	N6	Congenital anomalies	2
109	N6.1	Birth injury	0
110	N7	Significant dehydration or depression of fontanelles	0
111	N8	Significant cardiac or respiratory issues	9
112	N9	Ten minute APGAR score of six (6) or less	3
113	N10	Abnormal bulging of fontanelles	0
114	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	0
115	N12	Other	2

SECTION O - BIRTH OUTCOMES AFTER TRANSFER OF CARE

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarean Deliveries	
		Code		Code	
MOTHER					
116	Without complication	O1	592	O8	267
117	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2	15	O9	8
118	With serious pregnancy/birth related medical complications not resolved by 6 weeks	O3	2	O10	0
119	Death of mother	O4	0	O11	0
120	Unknown	O5	3	O12	0
121	Information not obtainable	O6	4	O13	0
122	Other	O7	3	O14	0
INFANT					
123	Healthy live born infant	O15	611	O24	231
124	With serious pregnancy/birth related medical complications resolved by 4 weeks	O16	19	O25	2
125	With serious pregnancy/birth related medical complications not resolved by 4 weeks	O17	4	O26	4
126	Fetal demise diagnosed prior to labor	O18	5	O27	0
127	Fetal demise diagnosed during labor or at delivery	O19	2	O28	3
128	Live born infant who subsequently died	O20	1	O29	1
129	Unknown	O21	4	O30	0
130	Information not obtainable	O22	2	O31	0
131	Other	O23	5	O32	0

SECTION P - COMPLICATIONS LEADING TO MATERNAL AND/OR INFANT MORTALITY

Line No.	Complication	Out-of-Hospital (A)		After Transfer (B)		Total # from (A) and (B) (C)	
		Code		Code		Code	
MOTHER							
132	Blood loss	P8	0	P15	0	P1	0
133	Sepsis	P9	0	P16	0	P2	0
134	Eclampsia/toxemia or HELLP syndrome	P10	0	P17	0	P3	0
135	Embolism (pulmonary or amniotic fluid)	P11	0	P18	0	P4	0
136	Unknown	P12	0	P19	0	P5	0
137	Information not obtainable	P13	0	P20	0	P6	0
138	Other	P14	0	P21	0	P7	0
INFANT							
139	Anomaly incompatible with life	P30	1	P38	1	P22	2
140	Infection	P31	0	P39	0	P23	0
141	Meconium aspiration, other respiratory	P32	0	P40	1	P24	1
142	Neurological issues/seizures	P33	0	P41	0	P25	0
143	Other medical issue	P34	1	P42	0	P26	1
144	Unknown	P35	0	P43	0	P27	0
145		P36	0	P44	0	P28	0

	Information not obtainable						
146	Other	P37	0	P45	0	P29	0

California Licensed Midwife Annual Report Optional Feedback

Total Number of Comments: 21

Reporting Year: 2014

As of: 7/20/2015 9:28:54 AM

Section/Category	Comments/Explanation
Miscellaneous	I am currently licensed to practice in another state, but occasionally I come to California to attend to family and close friends. Please call if you need any further clarification. Thank you.
G-Other	The newborn in section O, line 125, with serious medical complication has Trisomy18 and is currently still alive at 7 months old. He is in and out of the hospital due to respiratory issues and infections.
G-Other	there is no way to change my address on this form.
Miscellaneous	need to add intrapartum category for non-progressive prodromal labor (signs and symptoms of very early labor that last longer than 24-48 hrs without change or progress
L-Other	need category for discovery of complicated vertex presentation such as face presentation or compound presentation, etc
G-Other	Please change my address: ...
G-Other	Mom developed cholestasis prior to 37 weeks gestation
G-Other	I just submitted my report and immediately after detected an error in Section G where I report the 4 who left care in Section D for non medical reasons. And it states not to report them anywhere else. So I just removed them from line items 43 and 44 and now I am completely accurate. I apologize for my confusion.
P-Infant-Other	The only fetal demise we had was detected once we transported to the hospital for pre-eclampsia. The placenta had abrupted and the baby was stillborn.
N-Other	One baby suspected of possible UTI at 3 weeks of age. Admitted to hospital and treated for UTI. One baby admitted to hospital at 15 days and treated for late onset GBS infection.
G-Other	I included a birth as an out-of-hospital birth that happened with me catching in the back of an ambulance. The reason for the transfer was a prolapsed cord on a breech baby. The delivery went well and mom and baby were both healthy and ready to go home before we arrived at the hospital. They were forced to stay in the hospital for 24 hours.
G-Other	Please change my mailing address to: ...
G-Other	My address isn't current on this form but I couldn't figure out how to change it here. MBC has the accurate address.
G-Other	Midwifery care was provided as secondary midwife in 2014
G-Other	My address has changed and the field did not allow me to change it. Please note that my current address is: ...
Miscellaneous	My address was changed with the board last year and is correct online, but doesn't appear correct here. The correct address is ...
G-Other	I have a new address. This form reflects my old address, and I am unable to change my address here. My new address is: ... I would like to request an option for confirming, then changing our addresses on the form each year. Thank you!
Miscellaneous	I'm currently living and working in Madagascar, East Africa where we have a maternity center for impoverished women.
Miscellaneous	I am a new midwife, my first year in practice. I offer Hybrid Midwifery for those women wanting home midwifery care prenatally and postpartum, but would like to birth in the hospital. I found my first Annual Reporting to be challenging to describe my role, in terms of Primary Provider, etc. I had 1 client with an

California Licensed Midwife Annual Report Optional Feedback

Total Number of Comments: 21

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As of: 7/20/2015 9:28:54 AM

	infant death, who was under collaborative care with a pediatrician. How do I report?
Miscellaneous	To note, I live in Belize 75% of the year and attend most of my clients there. As I understand it this form is only to report births in the state of California, so for that reason it appears that I only attended 2 births last year. I am also licensed in Belize and report as needed under their Nurses & Midwives Act. Please do let me know is it is necessary to report to The Medical Board of California births that I attend elsewhere, & if so how I go about doing that. Thank you so much.
G-Other	Client lives 2 hours away and started care with Primary Care Physician. Continues concurrent care until she delivers.

Home Birth Summit



The Future of Home Birth in the United States: Addressing Shared Responsibility

Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

"We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits."

The statement above from the Home Birth Consensus Summit serves as the foundation for the following guidelines on transfer from planned home birth to hospital. These guidelines were developed by a multidisciplinary group of home and hospital based providers and stakeholders who were delegates at the national Home Birth Consensus Summits in 2011 and 2013. These guidelines are informed by the best available evidence on risk reduction and quality improvement and by existing regional policy and practice documents addressing transfer from home to hospital.²⁻¹⁹

The purpose of these guidelines is twofold:

1. To highlight core elements to be included when developing documents and policies related to transfer from home to hospital.
2. To promote the highest quality of care for women and families across birth settings via respectful inter-professional collaboration, ongoing communication, and the provision of compassionate family-centered care.

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting. Coordination of care and communication of expectations during transfer of care between settings improve health outcomes and consumer satisfaction.²⁰⁻³⁴

State-specific hospital regulations and the Emergency Medical Treatment and Labor Act (EMTALA)³⁵ establish the legal framework for requiring access to hospital care in the United States. The legal recognition of providers of maternity care services varies between states. However, each woman seeking care at any point during the maternity cycle has the right to optimal and respectful care regardless of her planned birth setting, the persons she selects to be part of the process, or state provider regulations.

These guidelines are appropriate for births planned at home or in a freestanding birth center. Furthermore, we recognize not all providers of home birth or birth center services are midwives. However, we use the term midwife herein because the vast majority of providers of home birth or birth center services identify as midwives.

Model practices for the midwife

- In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise.¹⁵
- The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.
- The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.^{11,13-16,19}
- The midwife continues to provide routine or urgent care en route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.
- Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records.^{11,12,15,16,19}
- The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider.¹³
- The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the woman's need for information regarding care options.
- If the woman chooses, the midwife may remain to provide continuity and support.

Model practices for the hospital provider and staff

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting.¹¹
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.¹²
- Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.¹¹⁻¹⁵
- Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.
- Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
- If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.
- The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.
- Relevant medical records, such as a discharge summary, are sent to the referring midwife.¹⁴

Quality improvement and policy development

All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process. Policies and quality improvement processes should incorporate the model practices above and delineate at a minimum the following:

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the woman prior to hospital discharge.
- Documentation of the woman's perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery.¹²
- Opportunities for education regarding home birth practice, shared continuing medical education, and relationship building that are incorporated into medical, midwifery and nursing education programs. Multi-disciplinary sessions to address system issues may enhance relationship building and the work culture.

Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital.²⁻¹⁰

Home Birth Summit, Collaboration Task Force

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Home Birth Summit

*The Future of Home Birth in United States:
Addressing Shared Responsibility*

Best Practice Transfer Guidelines

*Home Birth Summit Collaboration Task Force
2014*



Home Birth Consensus Summit

Organizational Representation for Planning





Home Birth Consensus Summit

- October 20-22, 2011
- Warrenton, VA

National leaders from all stakeholder perspectives in maternity services met to address shared responsibility for care across birth settings in the United States.





Home Birth Consensus Summit

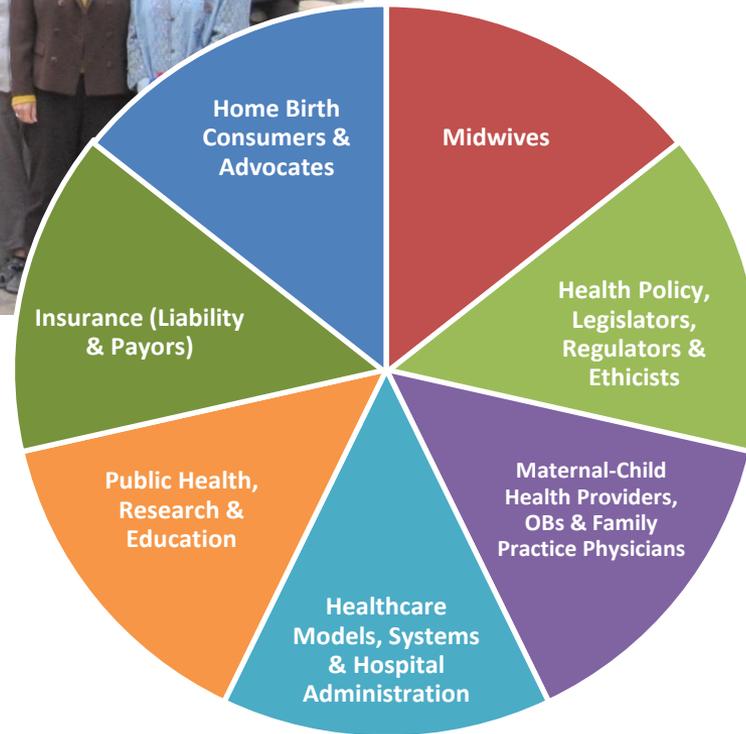
Improved integration of services across birth sites for all women and families in the U.S.



- *A cross-section of the maternity care system in one room*
- *A shared passion for quality in maternity care*
- *A commitment to work together to improve safety for women and babies across birth sites*
- *All perspectives and viewpoints considered*
- *Purposeful dialogue*



Stakeholder groups representing the complete spectrum of maternity care:



What did we do?

- The Future Search Model, known for achieving cooperative action in highly polarized issues, facilitated the group in discovering common ground





Visioning in Mixed Groups



The “Elephant”



Did not debate home
birth as:

-Right or Wrong

-Safety or Harm

-Agree or Disagree

All participants agreed
on the need to improve
care.





Summit Outcomes



Our 3 days of labor resulted in the birth of:

- *9 Common Ground Statements*
- *Task Force Groups*



Outcomes





Outcomes

Areas for Action
for each of the
vision
statements

**Personal
Commitments**
to work to
address barriers

Task Forces
formed



Interprofessional Collaboration & Communication



“We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes.”

All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary.

When ongoing inter-professional dialogue and cooperation occur, everyone benefits.”



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*a unique collaboration among physicians, midwives,
nurses and consumers*



Home Birth Summit



The Future of Home Birth in the United States: Addressing Shared Responsibility

Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

"We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits."¹

The statement above from the Home Birth Consensus Summit serves as the foundation for the following guidelines on transfer from planned home birth to hospital. These guidelines were developed by a multidisciplinary group of home and hospital based providers and stakeholders who were delegates at the national Home Birth Consensus Summits in 2011 and 2013. These guidelines are informed by the best available evidence on risk reduction and quality improvement and by existing regional policy and practice documents addressing transfer from home to hospital.²⁻¹⁹

The purpose of these guidelines is twofold:

1. To highlight core elements to be included when developing documents and policies related to transfer from home to hospital.
2. To promote the highest quality of care for women and families across birth settings via respectful inter-professional collaboration, ongoing communication, and the provision of compassionate family-centered care.

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting. Coordination of care and communication of expectations during transfer of care between settings improve health outcomes and consumer satisfaction.²⁰⁻³⁴

State-specific hospital regulations and the Emergency Medical Treatment and Labor Act (EMTALA)³⁵ established the legal framework for requiring access to hospital care in the United States. The legal recognition of providers of maternity care services varies between states. However, each woman seeking care at any point during the maternity cycle has the right to optimal and respectful care regardless of her planned birth setting, the persons she selects to be part of the process, or state provider regulations.

These guidelines are appropriate for births planned at home or in a freestanding birth center. Furthermore, we recognize not all providers of home birth or birth center services are midwives. However, we use the term midwife herein because the vast majority of providers of home birth or birth center services identify as midwives.

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Why is this needed?



Key Findings from CDC

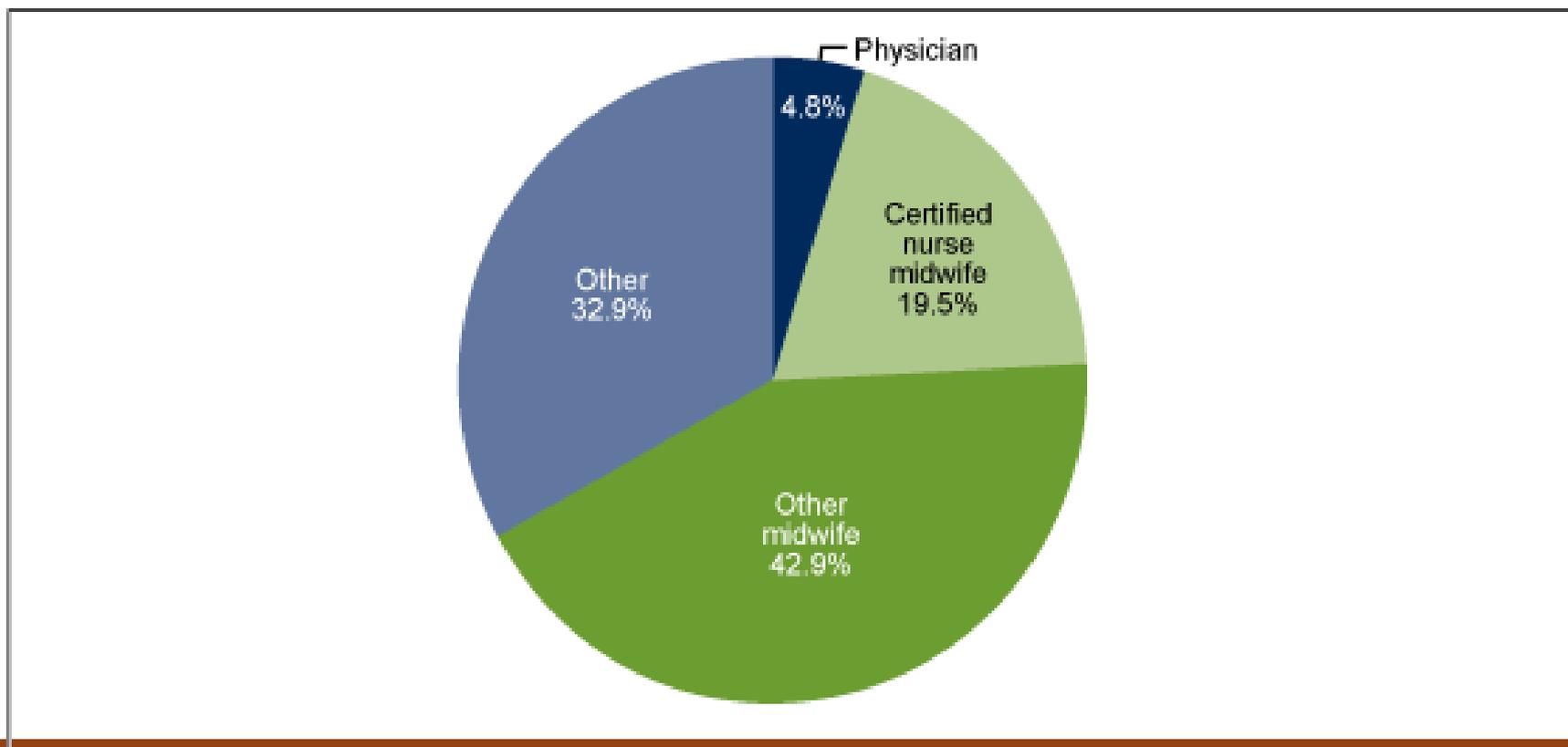
- *For non-Hispanic white women, **home births increased by 36%**, from 2004-2009, and 29% overall.*
- *About **1 in every 90 births** for non-Hispanic white women is **now a home birth**.*
- *In 2009, there were **29,650 home births** in the United States*



MOST HOMEBIRTHS ARE ATTENDED BY MIDWIVES:

*-62% of home births were attended by midwives: 19% by CNM and 43% by other midwives.
-33% were reported as delivered by "other" (a family member or emergency medical technician)*

Figure 4. Percent distribution of home births, by type of birth attendant: United States, 2009



- SOURCE: CDC/NCHS, birth certificate data from the National Vital Statistics System.



Research shows...

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting.

Physicians & Midwives in North America Report:

- Feelings of discomfort & friction during interprofessional consultations related to planned home birth

Health Outcomes & Satisfaction Improved by:

- Coordinating care & communication of expectations during transfer of care between birth settings

Sources: Guise J, Segel S. *Teamwork in obstetric critical care*. Best Pract Res Cl Ob (2008); The Joint Commission *Preventing Maternal Death* (2010); Nieuwenhuijze N, Kane Low L. *Facilitating Women's Choice in Maternity Care*. J of Clinical Ethics (2013); Cheyney M, Everson C, Burcher P. *Homebirth transfers in the United States: narratives of risk, fear, and mutual accommodation*. Qual Health Res (2014).



*Best Practice Guidelines:
Transfer from Planned Home
Birth to Hospital*



Development Process

**Collaboration Task
Force – physicians,
midwives, nurses
& consumers**

**Reviewed existing
regional exemplars**

**Critical elements
outlined,
evidence-reviewed**

**Vetted with all
Home Birth
Summit delegates**



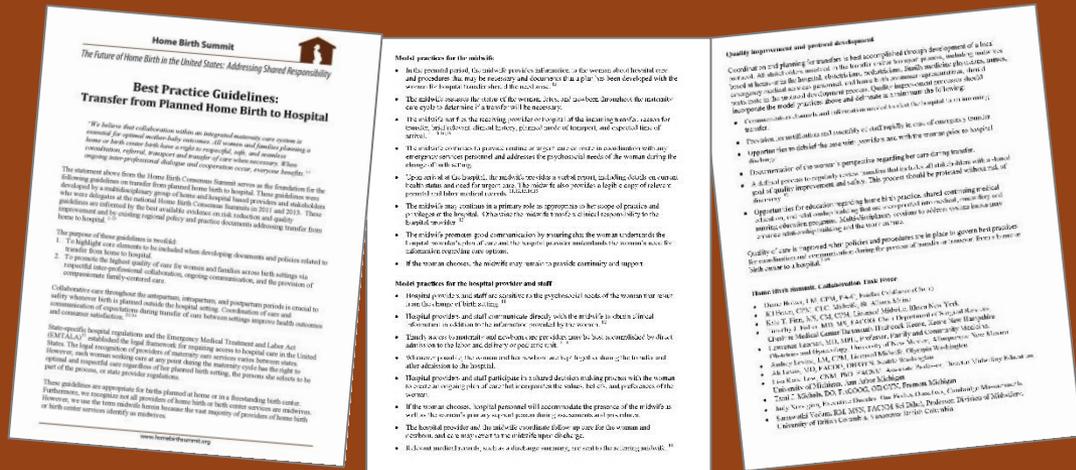
The Guidelines

• Appropriate for births planned for home or birth center

• Focus on the consumer

• Provided as open source to encourage widespread adoption

• Best Practice Guidelines: Transfer from Planned Home Birth to Hospital





Best Practice Guidelines: Transfer from Planned Home Birth to Hospital

Promote the highest quality of care for women and families across birth settings via respectful inter-professional collaboration, ongoing communication, and the provision of compassionate family-centered care.

Model practices for the midwife

Model practices for hospital-based care provider and staff

Quality improvement and policy development



In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise.

The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.

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The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.

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The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider.

Model practices for the midwife

The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the woman's need for information regarding care options.

If the woman chooses, the midwife may remain to provide continuity and support.



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Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.

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Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.



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If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.

The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.

Relevant medical records, such as a discharge summary, are sent to the referring midwife.



Quality improvement & policy development

All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process.

Policies and quality improvement processes should incorporate the model practices ...



Dissemination

Publication

- Journal of Midwifery & Women's Health. *Transfer from Planned Home Birth to Hospital: Improving Interprofessional Collaboration*. Nov. 2014

Poster Presentations

- Lamaze & DONA – September 2014
- AAFP - *Family Centered Maternity Care* – July 2014

Conferences

- MANA – October 2014
- ACOOG – Spring 2015
- ACNM – June 2015
- ACOG – *abstract submitted* – Annual Meeting 2015

Webinar

- NACPM

Hospital Presentations

- Smooth Transitions – Washington State
- Michigan State



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Outcomes

Common Ground
Context and Scope

History

Why Necessary
What Was the Process
Who were the organizers?
Who Were the Stakeholders
Who Were the Delegates?
Why Future Search

Action Groups

Site of Birth Decision Making
Collaboration
Health Disparities & Equity
Regulation & Licensure
Consumer Engagement
Interprofessional Education
Liability
Research & Data Collection
Physiologic Birth

News & Events

Online News Stories
Blogs
Upcoming Events

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