MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 9, 2018
ATTENTION: Members, Medical Board of California
SUBJECT: Licensed Midwife Annual Report
STAFF CONTACT: April Alameda, Chief of Licensing

REQUESTED ACTION:
After review and discussion, approve the revisions to the Licensed Midwife Annual Report (LMAR), direct staff to update the data system with conforming changes, and work with the Office of Statewide Health Planning (OSHPD) to establish the new reporting requirements for the 2018 reporting period and ongoing.

BACKGROUND AND ANALYSIS:
Pursuant to Business and Professions Code (BPC) section 2516, a licensed midwife who assists or supervises a childbirth that occurs in an out-of-hospital setting, must report to OSHPD by March 30 of each calendar year specific data elements. OSHPD is required to maintain the confidentiality of the licensed midwife and report only aggregate information to the Medical Board of California (Board) by July 30 of each year. Assembly Bill 1308 amended BPC section 2516 to allow the Board, along with input from the Midwifery Advisory Committee (MAC), to revise the data elements to better coordinate with other reporting systems and to collect data that fits the needs of the midwifery community.

A task force was created to research the current reporting requirements and to work with Board staff to determine the data elements needed to revise the LMAR reporting tool. Several meetings were held, which provided open discussion on the current data and the needs of licensed midwives and other interested parties on how the future statistics would be collected and what data elements would be included. In addition, the Board provided a survey to licensed midwives for obtaining feedback on how they would prefer that the data be reported.

At the MAC's December 7, 2017 meeting, the MAC discussed the proposed changes to the LMAR and approved the recommendations. Board staff created a new form to incorporate the changes to present to the full Board for review and approval (Attachment 1). Attached is a copy of the current version of the LMAR for your reference (Attachment 2).

RECOMMENDATION:
Staff recommends the Board approve the proposed changes to the LMAR, authorize staff to make non substantive changes, and direct staff to update the data system and work with OSHPD to begin the new data reporting for the 2018 reporting period.

ATTACHMENTS:

Attachment 1 – Proposed Licensed Midwife Annual Report form

Attachment 2 – Current Licensed Midwife Annual Report form

California Licensed Midwife Annual Report

FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX

MAILING ADDRESS (Including Suite or Apartment Number):	CITY:	STATE	ZIP:

TELEPHONE NUMBER:	ALTERNATE NUMBER:	EMAIL ADDRESS:

CALIFORNIA LICENSE MIDWIFE NUMBER:	REPORTING YEAR:

Part I Services Provided in California

1 Did you or a student midwife supervised by you perform **birth related midwifery 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? ☐ Yes ☐ No

Birth related midwifery services: includes antepartum, intrapartum, and postpartum. This does not include clients seen for family planning during the inter-conceptional years.

If "YES", continue with the completion of the report. If "NO", proceed to page 3, sign and date the report, and mail to:

Office of Statewide Health Planning and Development
Information Services Division, Patient Data Section
Licensed Midwife Annual Report
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833

Part II Client Services

Client Services include all clients for whom you provided birth related midwifery services in this reporting year, whose intended place of birth at the onset of **YOUR** care was an out-of-hospital setting. Include **all** clients regardless of year initially booked.

1 Total number of clients served as primary caregiver, for **birth related midwifery services**, during this calendar year: ______

2 Total number of clients who were either **lost to care** or who left care for non-medical reasons. ______

Lost to care: includes clients who never returned for appointments despite efforts to contact them and you do not know if they left for medical or non-medical reasons. Lost to care **SHOULD NOT** include clients that refused a transfer of care, as this should be reported as a transfer of care on form LMAR-2.

NOTE: DO NOT include these clients in any further categories on this report.

3 Total number of clients whose pregnancies ended for any reason prior to 20 weeks gestation. ______

NOTE: DO NOT include these clients in any further categories on this report.

4 Total number of clients served whose deliveries were still pending on the first day of the new year. ______

NOTE: DO NOT include these clients in any further categories on this report.

5 Total number of clients covered in this report = 1-2-3-4=5 ______

Part III Client Outcomes

Include all **deliveries** that occurred during this reporting year, regardless of year client was initially booked.

Delivery: an episode of a client giving birth, regardless of number of babies born alive or dead.

1 Of the clients served during the year specific to birthing needs, how many deliveries occurred in an out-of-hospital setting, which did not result in a transfer, multiple infants, or a maternal, fetal, or infant death prior to six (6) weeks postpartum? ______

Maternal death: death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Fetal death: lack of fetal heart tones after 20 weeks gestation.

Infant death: death occurring between live birth and up to and including day 28 of extra-uterine life.

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Part III Client Outcomes (continued)

2 Of the clients served during the year specific to birthing needs, how many clients transferred to another healthcare provider and did not return to your care during the client's pregnancy? ______

NOTE: For each client that was transferred, or whom you recommended a transfer of care that was refused, complete form LMAR-2

3 Of the clients served during the year specific to birthing needs, how many clients delivered multiples? ______

NOTE: For each client that delivered more than one infant, complete form LMAR-3

4 Of the clients served during the year specific to birthing needs, how many maternal, fetal, or infant deaths occurred? ______

Maternal death: death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Fetal death: lack of fetal heart tones after 20 weeks gestation.

Infant death: death occurring between live birth and up to and including day 28 of extra-uterine life.

NOTE: For each maternal, fetal, or infant death, complete form LMAR-4.

Part IV Out-of-Hospital Deliveries

Data reported below should not include clients that were transferred to another healthcare provider or delivered more than one infant; or, in which there was a maternal, fetal, or infant death.

1 Of those births attended out-of-hospital, provide the number of non-VBAC completed singleton **breech** live born deliveries. ______

1a Of the non-VBAC completed singleton **breech** live born deliveries, provide the number of precipitous deliveries. ______

2 Of those births attended out-of-hospital, provide the number of **planned** VBACs at onset of term labor or term rupture of membranes. ______

3 Of those births attended out-of-hospital, provide the number of **completed** VBACs. ______

NOTE: For each completed VBAC answer questions 4 through 6 below. If no VBACs were completed, continue to Part V.

4 VBAC CLIENT 1

For this delivery:

Gestational age at time of delivery: ______

If gestational age at the time of delivery < 36 6/7 weeks, was delivery precipitous? ☐ Yes ☐ No

Fetal position: ☐ Vertex ☐ Breech ☐ Other ______

Prior to this delivery:

How many prior vaginal deliveries has the client had? ______

How many caesarean deliveries has the client had? ______

How many VBACs has the client had? ______

5 VBAC CLIENT 2

For this delivery:

Gestational age at time of delivery: ______

If gestational age at the time of delivery < 36 6/7 weeks, was delivery precipitous? ☐ Yes ☐ No

Fetal position: ☐ Vertex ☐ Breech ☐ Other ______

Prior to this delivery:

How many prior vaginal deliveries has the client had? ______

How many caesarean deliveries has the client had? ______

How many VBACs has the client had? ______

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Part IV Out-of-Hospital Deliveries (continued)

6 VBAC CLIENT 3

For this delivery:

Gestational age at time of delivery: ________

If gestational age at the time of delivery < 36 6/7 weeks, was delivery precipitous? ☐ Yes ☐ No

Fetal position: ☐ Vertex ☐ Breech ☐ Other ________

Prior to this delivery:

How many prior vaginal deliveries has the client had? ________

How many caesarean deliveries has the client had? ________

How many VBACs has the client had? ________

Part V Outcomes per County in which a Live Birth Occurred – Out-of-Hospital Only

Include all births that occurred during this reporting year, regardless of year client was initially booked.

NOTE: DO NOT include clients who were transferred, delivered multiples, or in which a maternal, fetal, or infant death occurred.

	(A) List each county in which a live birth occurred, where you attended as the primary caregiver.	(B) Number of clients in each county whose pregnancies resulted in a live birth, where you attended as the primary caregiver.	(C) Number of live pre-term births (before 37 0/7 weeks gestation)	(D) Number of live term births (between 37 1/7 and 41 6/7 weeks)	(E) Number of live post-term births after 42 0/7 weeks	(F) Number of low birth weight, term, infants (under 2500 grams)
1						
2						
3						
4						
5						
6						
7						

Part VI Declaration

I,____________________________________, hereby attest to the fact that I am the person whose signature appears below. I certify under penalty of perjury, under the laws of the State of California, that I have full knowledge of the content of this report and declare that all information contained herein and all attachments in support of this report are true and correct to the best of my knowledge.

________________________________ SIGNATURE

________________ DATE

Send completed report to:

Office of Statewide Health Planning and Development
Information Services Division, Patient Data Section
Licensed Midwife Annual Report
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833

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California Licensed Midwife Annual Report
Supplemental Data Transfer of Client/Infant

FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX

MAILING ADDRESS (Including Suite or Apartment Number):	CITY:	STATE	ZIP:

TELEPHONE NUMBER:	ALTERNATE NUMBER:	EMAIL ADDRESS:

CALIFORNIA LICENSE MIDWIFE NUMBER:	REPORTING YEAR:

Complete this form in its entirety **for each client/infant that required a transfer of care to another healthcare provider**, regardless of whether the transfer of care was refused.

DO NOT complete this form for clients who delivered multiple infants, or in which a maternal, fetal, or infant death occurred; information regarding these clients will be completed on forms LMAR 3 and LMAR 4 respectively.

Upon completion of this form, submit with the California Licensed Midwife Annual Report - Initial (LMAR 1) to OSHPD.

Part I General Transfer Information

1 Who was transferred: ☐ Client (Complete Part 1) ☐ Infant (Complete Part 2) ☐ Client and Infant (Complete Parts 1 & 2)

2 Did the client accept transfer of care to another healthcare provider? ☐ Yes ☐ No

Part II Client Transfer Information

1 When did the transfer occur: ☐ Antepartum ☐ Intrapartum ☐ Postpartum

2 If antepartum or intrapartum, gestational age at time of transfer: ______

3 If postpartum, number of days since delivery (1-42): ______

Note: Day 1 = day of delivery or first day of infant life

4 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

5 Primary reason for transfer: (Refer to **Appendix A – Reason for Transfer of Client)** TC - ______

Part III Infant Transfer Information

1 Gestational age at birth: ______

2 Number of days of age at transfer: (1-42): ______

Note: Day 1 = day of delivery or first day of infant life

3 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

4 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ______

Part IV Client Outcome Information

For any client who transferred care as reported in Part II above, from the licensed midwife to another healthcare provider, provide the outcome information regarding the client.

1 Gestational age at delivery: ______

2 Outcome after transfer: (Refer to **Appendix C – Outcome of Client after Transfer of Care)** OC - ______

Part V Infant Outcome Information

For any infant who transferred care as reported in Part III above, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

1 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI - ______

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Part VI Client Delivery Information

1 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other ____________

2 Infant birth weight: ☐ < 2500 Grams ☐ Breech >2500 Grams and < 4000 Grams ☐ > 4000 Grams

3 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC (if VBAC please answer questions 3a – 3e)

3a Was VBAC planned at the onset of term labor or term rupture of membranes? ☐ Yes ☐ No

3b Was there a diagnosed uterine rupture? ☐ Yes ☐ No

Prior to this delivery:

3c How many prior vaginal deliveries has the client had? ____________

3d How many caesarean deliveries has the client had? ____________

3e How many VBACs has the client had? ____________

Part VII Declaration

I,___________________________________, hereby attest to the fact that I am the person whose signature appears below. I certify under penalty of perjury, under the laws of the State of California, that I have full knowledge of the content of this report and declare that all information contained herein and all attachments in support of this report are true and correct to the best of my knowledge.

____ _______________________________

SIGNATURE DATE

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California Licensed Midwife Annual Report
Supplemental Data Multiple Infants

FIRST NAME:	MIDDLE NAME:	LAST NAME:		SUFFIX
MAILING ADDRESS (Including Suite or Apartment Number):		CITY:	STATE	ZIP:
TELEPHONE NUMBER:	ALTERNATE NUMBER:	EMAIL ADDRESS:		
CALIFORNIA LICENSE MIDWIFE NUMBER:		REPORTING YEAR:		

Complete this form in its entirety **for each client that delivered multiple infants**, regardless of where the delivery occurred.

DO NOT complete this form for clients who had a singleton delivery, or in which a maternal, fetal, or infant death occurred; information regarding these clients will be completed on forms LMAR 1, LMAR 2, and LMAR 4 respectively.

Upon completion of this form, submit with the California Licensed Midwife Annual Report - Initial (LMAR 1) to OSHPD.

Part I General Information

1 Gestational age at time multiple fetuses discovered: ________

2 Number of fetuses: ________

Part II Client Information

1 Has the client ever had a prior caesarean delivery? ☐ Yes ☐ No

If yes answer questions 2 – 5

2 Was VBAC planned (either out of hospital or in hospital) at the onset of term labor or term rupture of membranes? ☐ Yes ☐ No

Prior to this delivery:

3 How many non-VBAC vaginal deliveries has the client had? ________

4 How many caesarean deliveries has the client had? ________

5 How many VBACs has the client had ________

Transfer Information

For any client who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the client.

6 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No

7 Did the client accept transfer of care to another healthcare provider? ☐ Yes ☐ No

8 When did the transfer occur: ☐ Antepartum ☐ Intrapartum ☐ Postpartum

9 If antepartum or intrapartum, gestational age at time of transfer: ________

10 If postpartum, number of days from delivery (1-42): ________
Note: Day 1 = day of delivery or first day of infant life

11 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

12 Primary reason for transfer: (Refer to **Appendix A – Reason for Transfer of Client)** TC - ______

Outcome Information

For any client who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the client.

13 Gestational age at delivery: ________

14 Outcome after transfer: (Refer to **Appendix C – Outcome of Client after Transfer of Care)** OC - ______

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Part III Infant Information

1 During the delivery of the infants, was there a diagnosed uterine rupture? ☐ Yes ☐ No

Infant 1

2 Gestational age at birth: ______

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

3 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No

If yes answer questions 4 - 8

4 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

5 Number of days of age at transfer: (1-42): ______

Note: Day 1 = day of delivery or first day of infant life

6 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

7 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ______

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

8 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI - ______

Delivery Information

9 Was infant delivered out-of-hospital? ☐ Yes ☐ No

If yes answer questions 10 - 11

10 Was delivery precipitous? ☐ Yes ☐ No

11 County in which live-birth occurred: ______

12 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

13 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other ______

14 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

Infant 2

15 Gestational age at birth: ______

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

16 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No

If yes answer questions 17 - 21

17 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

18 Number of days of age at transfer: (1-42): ______

Note: Day 1 = day of delivery or first day of infant life

19 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

20 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ______

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Part III **Infant Information (continued)**

Infant 2 (continued)

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

21 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI -

Delivery Information

22 Was infant delivered out-of-hospital? ☐ Yes ☐ No

If yes answer questions 23 - 24

23 Was delivery precipitous? ☐ Yes ☐ No

24 County in which live-birth occurred:

25 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

26 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other

27 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

Infant 3 ☐ N/A (if N/A skip to Part IV)

28 Gestational age at birth:

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

29 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No

If yes answer questions 30 - 34

30 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

31 Number of days of age at transfer: (1-42):

Note: Day 1 = day of delivery or first day of infant life

32 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

33 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI -

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

34 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI -

Delivery Information

35 Was infant delivered out-of-hospital? ☐ Yes ☐ No

If yes answer questions 36 - 37

36 Was delivery precipitous? ☐ Yes ☐ No

37 County in which live-birth occurred:

38 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

39 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other

40 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

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Part VII Declaration

I,___________________________________, hereby attest to the fact that I am the person whose signature appears below. I certify under penalty of perjury, under the laws of the State of California, that I have full knowledge of the content of this report and declare that all information contained herein and all attachments in support of this report are true and correct to the best of my knowledge.

SIGNATURE DATE

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California Licensed Midwife Annual Report
Supplemental Data Maternal, Fetal, Infant Death

FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX

MAILING ADDRESS (Including Suite or Apartment Number):	CITY:	STATE	ZIP:

TELEPHONE NUMBER:	ALTERNATE NUMBER:	EMAIL ADDRESS:

CALIFORNIA LICENSE MIDWIFE NUMBER:	REPORTING YEAR:

Complete this form in its entirety for each client served during the year specific to birthing needs **that resulted in a maternal, fetal, or infant death.**

Upon completion of this form, submit with the California Licensed Midwife Annual Report - Initial (LMAR 1) to OSHPD.

Part I **Client Information**

1 Maternal death? ☐ Yes ☐ No

2 Has the client ever had a prior caesarean delivery? ☐ Yes ☐ No

If yes answer questions 3 – 6

3 Was VBAC planned (either out of hospital or in hospital) at the onset of term labor or term rupture of membranes? ☐ Yes ☐ No

Prior to this delivery:

4 How many non-VBAC vaginal deliveries has the client had? ______

5 How many caesarean deliveries has the client had? ______

6 How many VBACs has the client had ______

Transfer Information

For any client who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the client.

7 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No

8 Did the client accept transfer of care to another healthcare provider? ☐ Yes ☐ No

9 When did the transfer occur: ☐ Antepartum ☐ Intrapartum ☐ Postpartum

10 If antepartum or intrapartum, gestational age at time of transfer: ______

11 If postpartum, number of days from delivery (1-42): ______

Note: Day 1 = day of delivery or first day of infant life

12 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

13 Primary reason for transfer: (Refer to **Appendix A – Reason for Transfer of Client)** TC - ______

Outcome Information

For any client who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the client.

14 Gestational age at delivery: ______

15 Outcome after transfer: (Refer to **Appendix C – Outcome of Client after Transfer of Care)** OC - ______

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Part II Infant Information

1 During this pregnancy were multiple fetuses identified? ☐ Yes ☐ No
If yes answer questions 2 - 3

2 Gestational age at time multiple fetuses discovered: ______

3 Number of fetuses: ______

4 During the delivery of the infant(s), was there a diagnosed uterine rupture? ☐ Yes ☐ No

Infant 1

1 Infant 1 death? ☐ Yes ☐ No

2 Gestational age at birth: ______

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

3 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No
If no skip to Infant 1 Delivery Information Section

4 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

5 Number of days of age at transfer: (1-42): ______
Note: Day 1 = day of delivery or first day of infant life

6 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

7 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ______

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

8 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI - ______

Delivery Information

9 Was infant delivered out-of-hospital? ☐ Yes ☐ No
If yes answer questions 10 - 11

10 Was delivery precipitous? ☐ Yes ☐ No

11 County in which live-birth occurred: ______

12 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

13 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other ______

14 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

Infant 2 ☐ N/A (if N/A skip to Part III)

1 Infant 2 death? ☐ Yes ☐ No

2 Gestational age at birth: ______

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

3 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No
If no skip to Infant 2 Delivery Information Section

4 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

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Part II **Infant Information (continued)**

Infant 2 (continued)

5 Number of days of age at transfer: (1-42): ____________
Note: Day 1 = day of delivery or first day of infant life

6 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

7 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ________

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

8 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI - ________

Delivery Information

9 Was infant delivered out-of-hospital? ☐ Yes ☐ No
If yes answer questions 10 - 11

10 Was delivery precipitous? ☐ Yes ☐ No

11 County in which live-birth occurred: ____________________________

12 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

13 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other ____________________

14 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

Infant 3 ☐ N/A (if N/A skip to Part III)

1 Infant 3 death? ☐ Yes ☐ No

2 Gestational age at birth: ____________

Transfer Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the transfer information regarding the infant.

3 Was a transfer of care to another healthcare provider recommended? ☐ Yes ☐ No
If no skip to Infant 3 Delivery Information Section

4 Did the client accept transfer of care of the infant to another healthcare provider? ☐ Yes ☐ No

5 Number of days of age at transfer: (1-42): ____________
Note: Day 1 = day of delivery or first day of infant life

6 Type of transfer: ☐ Elective/Non-Emergency ☐ Urgent/Emergency

7 Primary reason for transfer: (Refer to **Appendix B – Reason for Transfer of Infant)** TI - ________

Outcome Information

For any infant who transferred care, from the licensed midwife to another healthcare provider, provide the outcome information regarding the infant.

8 Outcome after transfer: (Refer to **Appendix D – Outcome of Infant after Transfer of Care)** OI - ________

Delivery Information

9 Was infant delivered out-of-hospital? ☐ Yes ☐ No
If yes answer questions 10 - 11

10 Was delivery precipitous? ☐ Yes ☐ No

11 County in which live-birth occurred:

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Part II **Infant Information (continued)**

Infant 3 (continued)

12 Mode of delivery: ☐ Vaginal ☐ C-Section ☐ VBAC

13 Fetal position at delivery: ☐ Vertex ☐ Breech ☐ Other ______

14 Infant birth weight: ☐ < 2500 Grams ☐ >2500 Grams and < 4000 Grams ☐ > 4000 Grams

Part III **Maternal, Fetal or Infant Death**

Definitions

Maternal death: death of a woman while pregnant or within forty-two (42) days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Fetal death: lack of fetal heart tones after twenty (20) weeks gestation; out-of-hospital by midwife constitutes fetal death out-of-hospital if confirmed after transfer or delivery; lack of heart tones discovered only after transfer, constitutes fetal death after transfer.

Infant death: death of infant from live birth to day twenty-eight (28) of extra-uterine life.

1 Death being reported: (check all that apply) ☐ Maternal ☐ Fetal ☐ Infant

Part IV **Maternal Death**

1 When did the death occur: ☐ While pregnant

Gestational age at time of death: ______

☐ Within forty-two (42) days of ending a pregnancy

Number of days after end of pregnancy at time of death: ______

2 Maternal age at death: ______

3 Place of death: ☐ Out-of-Hospital ☐ After transfer ☐ In hospital distant to immediate post-partum period (i.e., uncomplicated delivery either out-of-hospital or in hospital, with death occurring after this period)

4 County death occurred: ______

5 Primary complication leading to maternal death:
(Refer to **Appendix E – Complications Leading to Maternal Death)** MD - ______

Part V **Fetal Death**

1 When did the death occur:

☐ Prior to onset of labor or after rupture of membranes without labor

☐ Prior to onset of labor or rupture of membranes without labor

☐ After the onset of labor, from 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation

☐ After the onset of labor, between 37 0/7 weeks gestation up to and including 41 6/7 weeks gestation

☐ After the onset of labor, after 42 0/7 weeks gestation

☐ During labor after 37 0/7 weeks gestation

2 Gestational age at death: ______

3 Was death diagnosed prior to labor by a physician and later delivered out-of-hospital by you at the request of the client? ☐ Yes ☐ No

4 Place of death: ☐ Out-of-Hospital ☐ After transfer

5 County death occurred: ______

6 Primary complication leading to fetal death:
(Refer to **Appendix F – Complications Leading to Fetal Death)** FD - ______

DRAFT

Part VI Infant Death

1 When did the death occur:
- ☐ Early Infant – birth through the end of the seventh (7th) day of extra-uterine life
- ☐ Late Infant – eighth (8th) day of extra-uterine life through the end of day twenty-seven (27) of extra-uterine life

2 Number of days of life: ____________

3 Was death diagnosed prior to labor by a physician and later delivered out-of-hospital by you at the request of the client? ☐ Yes ☐ No

4 Place of death: ☐ Out-of-Hospital ☐ After transfer ☐ In hospital distant to immediate post-partum period (i.e., uncomplicated delivery either out-of-hospital or in hospital, with death occurring after this period)

5 County death occurred: ______________________________

6 Primary complication leading to infant death:
(Refer to **Appendix G – Complications Leading to Infant Death)** ID - ______

Part VII Declaration

I,___________________________________, hereby attest to the fact that I am the person whose signature appears below. I certify under penalty of perjury, under the laws of the State of California, that I have full knowledge of the content of this report and declare that all information contained herein and all attachments in support of this report are true and correct to the best of my knowledge.

SIGNATURE DATE

DRAFT

Appendix A – Reason for Transfer of Client

Antepartum – Elective/Non-Emergency	
Transfer Code	Reason
TC-01	Medical or mental health conditions *unrelated* to pregnancy
TC-02	Hypertension developed in pregnancy
TC-03	Blood coagulation disorders, including phlebitis
TC-04	Anemia
TC-05	Persistent vomiting with dehydration
TC-06	Nutritional and weight loss issues, failure to gain weight
TC-07	Gestational diabetes
TC-08	Vaginal bleeding
TC-09	Suspected or known placental anomalies or implantation abnormalities
TC-10	Loss of pregnancy (includes spontaneous and elective abortion) (should only be used when completing form LMAR 4)
TC-11	HIV test positive
TC-12	Suspected intrauterine growth restriction, suspected macrosomia
TC-13	Fetal anomalies
TC-14	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios
TC-15	Fetal heart irregularities
TC-16	Non vertex lie at term
TC-17	Greater than 42 weeks and less than 37 weeks gestation
TC-18	Multiple gestation (should only be used when completing form LMAR 3)
TC-19	Clinical judgment of the midwife (where a single other condition above does not apply)
TC-20	Client request
TC-21	Other

Antepartum – Urgent/Emergency	
Transfer Code	Reason
TC-22	Non pregnancy-related medical condition
TC-23	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia
TC-24	Isoimmunization, severe anemia, or other blood related issues
TC-25	Significant infection
TC-26	Significant vaginal bleeding
TC-27	Preterm labor or preterm rupture of membranes
TC-28	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)
TC-29	Less than 37 0/7 weeks gestation with rupture of membranes
TC-30	Clinical judgment of the midwife (where a single other condition above does not apply
TC-31	Fetal demise (should only be used when completing form LMAR 4)
TC-32	Other

Intrapartum – Elective/Non-Emergency	
Transfer Code	Reason
TC-33	Persistent hypertension; severe or persistent headache
TC-34	Active herpes lesion
TC-35	Abnormal bleeding
TC-36	Signs of infection
TC-37	Prolonged rupture of membranes
TC-38	Lack of progress; maternal exhaustion; dehydration
TC-39	Thick meconium in the absence of fetal distress
TC-40	Non-vertex presentation
TC-41	Unstable lie or mal-position of the vertex

TC-42	Less than 37 weeks gestation in labor
TC-43	Greater than 42 weeks gestation in labor
TC-44	Multiple gestation (should only be used when completing form LMAR 3)
TC-45	Clinical judgment of the midwife (where a single other condition above does not apply)
TC-46	Client request; request for medical methods of pain relief
TC-47	Other

Intrapartum – Urgent/Emergency	
Transfer Code	Reason
TC-48	Suspected preeclampsia, eclampsia, seizures
TC-49	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor
TC-50	Suspected uterine rupture
TC-51	Maternal shock, loss of consciousness
TC-52	Prolapsed umbilical cord
TC-53	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress
TC-54	Less than 37 weeks gestation in labor
TC-55	Greater than 42 weeks gestation in labor
TC-56	Clinical judgment of the midwife (where a single other condition above does not apply)
TC-57	Other
TC-58	Multiple gestation (should only be used when completing form LMAR 3)

Postpartum – Elective/Non-Emergency	
Transfer Code	Reason
TC-59	Adherent or retained placenta without significant bleeding
TC-60	Repair of laceration beyond level of midwife's expertise
TC-61	Postpartum depression
TC-62	Social, emotional or physical conditions outside of scope of practice
TC-63	Excessive or prolonged bleeding in later postpartum period
TC-64	Signs of infection
TC-65	Clinical judgment of the midwife (where a single other condition above does not apply)
TC-66	Client request
TC-67	Other

Postpartum – Urgent/Emergency	
Transfer Code	Reason
TC-68	Abnormal or unstable vital signs
TC-69	Uterine inversion, rupture or prolapse
TC-70	Uncontrolled hemorrhage
TC-71	Seizures or unconsciousness, shock
TC-72	Adherent or retained placenta with significant bleeding
TC-73	Suspected postpartum psychosis
TC-74	Signs of significant infection
TC-75	Clinical judgment of the midwife (where a single other condition above does not apply)
TC-76	Other

Appendix B – Reason for Transfer of Infant

Infant - Elective/Non-Emergency	
Transfer Code	Reason
TI-01	Low birth weight
TI-02	Congenital anomalies
TI-03	Birth injury
TI-04	Poor transition to extrauterine life
TI-05	Insufficient passage of urine or meconium
TI-06	Parental request
TI-07	Clinical judgment of the midwife (where a single other condition above does not apply)
TI-08	Other

Infant – Urgent/Emergency	
Transfer Code	Reason
TI-09	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing
TI-10	Signs or symptoms of infection
TI-11	Abnormal cry, seizures or loss of consciousness
TI-12	Significant jaundice at birth or within thirty (30) hours
TI-13	Evidence of clinically significant prematurity
TI-14	Congenital anomalies
TI-15	Birth injury
TI-16	Significant dehydration or depression of fontanelles
TI-17	Significant cardiac or respiratory issues
TI-18	Ten (10) minute APGAR score of six (6) or less
TI-19	Abnormal bulging of fontanelles
TI-20	Clinical judgment of the midwife (where a single other condition above does not apply)
TI-21	Other

Appendix C – Outcome of Client after Transfer of Care

Client - Outcome	
Outcome Code	Outcome
OC-01	Without complication
OC-02	With serious pregnancy/birth related medical complications resolved by six (6) weeks
OC-03	With serious pregnancy/birth related medical complications **not** resolved by six (6) weeks
OC-04	Death of client (should only be used when completing form LMAR 4)
OC-05	Information not obtainable
OC-06	Other

Appendix D – Outcome of Infant after Transfer of Care

Infant - Outcome	
Outcome Code	Outcome
OI-01	Healthy live born infant
OI-02	With serious pregnancy/birth related medical complications resolved by four (4) weeks
OI-03	With serious pregnancy/birth related medical complications **not** resolved by four (4) weeks
OI-04	Fetal demise diagnosed prior to labor (should only be used when completing form LMAR 4)
OI-05	Fetal demise diagnosed during labor or at delivery (should only be used when completing form LMAR 4)
OI-06	Live born infant who subsequently died (should only be used when completing form LMAR 4)
OI-07	Information not obtainable
OI-08	Other

Appendix E – Complications Leading to Maternal Death

Complication Leading to Death Code	Reason
MD-01	Blood loss
MD-02	Sepsis
MD-03	Eclampsia/toxemia or HELLP syndrome
MD-04	Embolism (pulmonary or amniotic fluid)
MD-05	Uterine rupture
MD-06	Information not obtainable
MD-07	Other

Appendix F – Complications Leading to Fetal Death

Complication Leading to Death Code	Reason
FD-01	Anomaly incompatible with life
FD-02	Infection
FD-03	Uterine rupture
FD-04	Cord accident
FD-05	Information not obtainable
FD-06	Other
FD-07	Other Maternal complication
FD-08	Maternal death

Appendix G – Complications Leading to Infant Death

Complication Leading to Death Code	Reason
ID-01	Anomaly incompatible with life
ID-02	Infection
ID-03	Meconium aspiration, other respiratory
ID-04	Neurological issues/seizures
ID-05	Uterine rupture
ID-06	Other medical issue
ID-07	Information not obtainable
ID-08	Other

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

Attachment 2

SECTION A - LICENSEE DATA

1a. First:		1b. Middle:		1c. Last:	
2. License Number:					
Numbers 3-10 are voluntary, but will assist OSHPD in contacting you if questions arise relating to your report					
3. Street Address 1:					
4. Street Address 2:					
5. City:		6. State:		7. ZIP Code:	
8. Phone 1:			9. Phone 2:		
10. E-mail Address:					

SECTION B - REPORTING PERIOD

Line No.	Report Year
11	2017

SECTION C - SERVICES PROVIDED IN CALIFORNIA

Line No.		Yes	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?		

If "yes," continue with completion of the report. If "no," go to the last page, sign and date the report and mail to:

Office of Statewide Health Planning and Development
Information Services Division, Patient Data Section
Licensed Midwife Annual Report
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833

SECTION D - CLIENT SERVICES

Lines 13 to 17: Client Services include all clients for whom you provided midwifery services in this reporting year, whose intended place of birth at the onset of **YOUR** care was an out-of-hospital setting. Include **all** clients regardless of year initially booked.

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

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

Lines 18a to 18g: Include all births, cases of fetal demise, and infant and maternal deaths that occurred during this reporting year, regardless of year client was initially booked.

Column A: Enter each county - use the county codes provided from the dropdown list - where you attended a birth as the primary caregiver or had a client whose pregnancy resulted in a fetal demise discovered while under your care.

Column B: Enter the number of clients in that county whose pregnancies resulted in a live birth while under your care.

Column C: Enter the number of clients in that county whose pregnancies resulted in a fetal demise discovered while under your care.

Column D: Enter the number of clients in that county whose pregnancies resulted in an infant death while under your care.

Column E: Enter the number of clients in that county whose pregnancies resulted in a maternal death while under your care.

Line No.	(A) County in which the Birth Occurred, or Fetal Demise or Death was discovered (see county code list)	(B) # of Live Births	(C) # of Cases Fetal Demise Discovered while Client was Under Your Care	(D) # of Cases of Infant Death While Under Your Care	(E) # of Cases of Maternal Death While Client was Under Your Care
18a					
18b					
18c					
18d					
18e					
18f					
18g					

SECTION F - OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Lines 19 to 24: Include all births that occurred during this reporting year, regardless of year client was initially booked. It is understood that for this section each birth experience or infant born may be included on more than one line.

DELIVERY: episode of a mother giving birth regardless of number of babies born alive or dead.

Line 19: Enter total number of out-of-hospital deliveries you planned on attending as the primary caregiver at the onset of labor

Line 20: Out of the total number of out-of-hospital births you planned on attending as the primary caregiver **at the onset of labor** (as indicated in line 19), enter the number of those deliveries that **actually did occur** in an out-of-hospital setting

Line 21: Enter the number of planned deliveries you attended in an out-of-hospital as the primary caregiver that were delivered **breech.**

Line 22: Enter the number of planned deliveries you attended in an out-of-hospital setting as the primary caregiver who delivered vaginally after having a prior cesarean section (VBAC).

Lines 23: Enter the number of planned deliveries you attended in an out-of-hospital as the primary caregiver that involved twins. Each mother giving birth counts as one delivery, regardless of number of babies born. **Record only if all babies delivered out-of-hospital.**

Lines 24: Enter the number of planned deliveries you attended in an out-of-hospital setting as the primary caregiver that involved a high number of multiples. Each mother giving birth counts as one delivery, regardless of number of babies born. **Record only if all babies delivered out-of-hospital.**

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

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

Lines 25-44: For each reason listed, enter the number of clients who, during the antepartum period electively (no emergency existed) transferred to the care of another healthcare provider. Report the primary reason for each client.

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

SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 45-54: For each reason listed, enter the number of clients who, during the antepartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

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

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

Lines 55-67: For each reason listed, enter the number of clients who, during the intrapartum period, electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

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

SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 68-76: For each reason listed, enter the number of clients who, during the intrapartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

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

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

Lines 77-85: For each reason listed, enter the number of clients who, during the postpartum period, electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

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

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

Lines 86-94: For each reason listed, enter the number of clients who, during the postpartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

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

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

Lines 95-102: For each reason listed, enter the number of infants who electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each infant.

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

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

Lines 103-115: For each reason listed, enter the number of infants who were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each infant.

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

SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Lines 116-131: For any mother or infant with transfer of care Reported in section I, J, K, L, M and N, from the licensed midwife to another healthcare provider, please provide the outcome information regarding both the mother and for the infant in the spaces provided.

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

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

Only complete this section if you reported instances of fetal demise or infant or maternal deaths in previous sections!

Lines 132-138: For each complication listed, in Column A, enter the total number of mothers who died during the pregnancy or within six (6) weeks after the end of a pregnancy as a result of that complication. Indicate in Columns A or B the numbers that were out-of-hospital births or transfers. Report only one primary complication for each client.

Lines 139-146: Indicate in Columns A or B the numbers that were out-of-hospital births or transfers. Report only one primary complication for each client.

Line No.	Complication	Out-of-Hospital (A)		After Transfer (B)		Total # from (A) and (B) (C)	
MOTHER		Code		Code		Code	
132	Blood loss	P8		P15		P1	
133	Sepsis	P9		P16		P2	
134	Eclampsia/toxemia or HELLP syndrome	P10		P17		P3	
135	Embolism (pulmonary or amniotic fluid)	P11		P18		P4	
136	Unknown	P12		P19		P5	
137	Information not obtainable	P13		P20		P6	
138	Other	P14		P21		P7	
P12 Explanation							
P13 Explanation							
P14 Explanation							
P19 Explanation							
P20 Explanation							
P21 Explanation							
INFANT							
139	Anomaly incompatible with life	P30		P38		P22	
140	Infection	P31		P39		P23	
141	Meconium aspiration, other respiratory	P32		P40		P24	
142	Neurological issues/seizures	P33		P41		P25	
143	Other medical issue	P34		P42		P26	
144	Unknown	P35		P43		P27	
145	Information not obtainable	P36		P44		P28	
146	Other	P37		P45		P29	
P35 Explanation							
P36 Explanation							
P37 Explanation							
P43 Explanation							
P44 Explanation							

P45 Explanation	

The information contained herein is accurate and complete to the best of my knowledge.	
Signature:	Date:
Please send the completed report to:	
Office of Statewide Health Planning and Development Information Services Division, Patient Data Section Licensed Midwife Annual Report 2020 West El Camino Avenue, Suite 1100 Sacramento, CA 95833	