Arizona Department of Health Services

Public Health Licensing Services
Bureau of Special Licensing

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DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST MD, DIRECTOR

November 15, 2015

Dear Dr. Christ:

The Licensed Midwife Advisory Committee (Committee) would like to submit this inaugural report on midwifery and home births in the state of Arizona. In an advisory role to the Arizona Department of Health Services (Department), the Committee was established in July 2013 and consists of seven voting members and one ex-officio member. The Bureau of Special Licensing, within the Department, has provided facilitation and coordination of six Committee open meetings in 2015.

The fiscal year 2015 report includes the sections established in R9-16-117(E)(4), including recommendations for the Department in review of aggregate data from reports of midwifery services submitted by licensed midwives, evidence-based research pertaining to the practice of midwifery and recommendations for changes to the rules for licensing of midwifery. All recommendations provided in this report reflect views of Committee members for the Department's assessment.

The Committee appreciates the opportunity to submit this report for consideration by the Department.

Sincerely,

Carla Berg, MHS
Chief, Bureau of Special Licensing

Annual Report

Licensed Midwife Advisory Committee

July 2014 - June 2015

PHOTO CREDIT DIANA PETERSON, 2015

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Facts at a Glance

- 1,142 Deliveries; 11 VBAC, 3 Breech
- 73 Licensed Midwives (LM)
- 51 of LMs are Certified Professional Midwives
- 7 Initial Licenses Issued
- 25 Renewal Licenses Issued
- 2 Complaints filed regarding midwives' care or conduct
- 18 Enforcements Actions for reports submitted beyond 30 days ($4320 fines)
- 4 Enforcement Actions for other scope of practice violations ($150 fines)
- 1 License Suspension resulting in reinstatement with probationary restrictions
- 1 Notification of Fetal Demise

Introduction

Committee Structure and Meetings:

The Licensed Midwife Advisory Committee (LMAC or referred to as the Committee) was established under the Bureau of Special Licensing (referred to as the Bureau) as a part of rulemaking effective July 1, 2013 for advisory purposes to make recommendations to the Arizona Department of Health Services (referred to as the Department) addressing specific issues. LMAC appointments allow for members to have an opportunity to make a contribution by lending their experience and expertise. Committee members voluntarily serve and offer their time during their regular schedules.

Applications were accepted and appointments were made by the Director by August 30, 2013. The initial work of the Committee was to develop the informed consent for midwifery services according to R9-16-109 and assertion to decline required tests according to R9-16-110. These documents were developed by October 1, 2013 and are available for all licensed midwives to access on the Department's Provider Information website.

In Fiscal Year 2015 (FY15), the Committee met six times. Meeting agenda, minutes and related presentations are available on the Department's Committee website.

Committee Functions:

The functions of LMAC are defined by the Arizona Administrative Code Department of Health Services, Occupational Licensing, and Article 1 Licensing of Midwifery. A copy of the Arizona Revised Statutes Title 36, Article 7 for Licensing and Regulation of Midwifery and the Arizona Administrative Code Title 9, Chapter 16, Article 1 for Licensing of Midwifery are included in Appendix A. Specifically, R9-16-117 indicates the Midwifery Advisory Committee shall:

- Examine aggregate data from the midwife reports required in R9-16-114;
- Examine any notifications received by the Department required in R9-16-104(B);
- Examine evidence-based research pertaining to the practice of midwifery;
- Develop an annual report on midwifery and home births in this state during the previous fiscal year, including:
    - a. An analysis of the information from subsections (E)(1) and (2),
    - b. A summary of the information from subsection (E)(3), and
    - c. Recommendations for changes to the rules in this Article;
- Submit a copy of the report required in subsection (E)(4) to the Department on or before November 15 of each year, beginning in 2015;
- Assist in the development of the informed consent for midwifery services according to R9-16-109 by October 1, 2013; and
- Assist in the development of the assertion to decline required tests according to R9-16-110 by October 1, 2013.

Year in Review:

This Annual Report is the first opportunity for the Committee to provide an account of the information reviewed during the last year. Based on the rule requirements established for the Report, the Committee has identified goals to inform the Department and establish a baseline with data analysis and reevaluate these for future reports. In creating the document, the Committee completed a search of similar reports published in other states as well as international midwifery and homebirth reports.

The Committee would like to note certain limitations with the development of the Report. These include limitations in meeting availability for members to develop the report, resources, scope, and the data limitations noted in the Midwifery Report Review section. The Committee plans to improve on the report each year and will complete the FY2016 report by November 15, 2016.

Committee Members

Carol Denny, CPM, Licensed Midwife
Carol Denny has been a Licensed Midwife in the state of Arizona since 1997. She is a graduate of Ancient Art Midwifery Institute. She is the founder of Global Health Training, a non-profit organization devoted to teaching healthcare with the purpose of improving maternal and neonatal outcomes. She has traveled to Mexico, Honduras, Haiti, Uganda, and India.

Paula Matthew, CPM, Licensed Midwife
Paula Matthews is a homebirth midwife serving Yavapai County. Paula has been a Licensed Midwife in the state of Arizona since 1982.

Jude Melton, CPM, Licensed Midwife
Jude Melton is a homebirth midwife in Mesa, Arizona. Jude received her midwifery training from Maternidad La Luz, a free-standing birth center in El Paso Texas. She successfully completed the advanced three year program in 2003 and became an Arizona Licensed Midwife in October 2004. Jude is the owner and primary midwife at Sunrise Midwifery. Jude is active in the midwifery community and enjoys serving women who choose alternative birthing options including homebirth.

Jenny Schultz, MPA, CPM, Licensed Midwife
Jenny Schultz is a native of Arizona, committed to families throughout the Valley, and believes in the empowerment and safety of homebirths for low-risk women, newborns and their families. She completed her studies at the Midwives College of Utah, and has been working directly in providing midwifery care since 2010. Jenny also has a Masters in Public Administration from Arizona State University.

Elizabeth Morton, MSW, Member of the Public
Elizabeth Morton is a native of Phoenix, AZ. Elizabeth is the mother of 3, 1 born via cesarean and 2 born with the care of homebirth midwives. Elizabeth has a background in social services, family welfare, and has a Masters of Social Work from Arizona State University. Elizabeth is an active volunteer for International Cesarean Awareness Network of Phoenix and Babywearing International of Phoenix.

Francisco Garcia, MD, MPH, Physician - OB/GYN
Dr. Francisco García is the Director and Chief Medical Officer of the Pima County Department of Health in Tucson, Arizona. He is a fellow of the American Congress of Obstetricians and Gynecologists and a diplomat of the American Board of Obstetrics and Gynecology. Dr. Garcia is also the Distinguished Outreach Professor of Public Health at the University of Arizona. Dr. García is a member of the U.S. Preventive Services Task Force which produces national evidence-based clinical guidelines, as well as the Institute of Medicine Roundtable on Health Equity and the Elimination of Health Disparities. Prior to joining Pima County Department of Health, Dr. García served in a variety of roles at the University of Arizona including director of the Arizona Center of Excellence in Women's Health, the Arizona Hispanic Center of Excellence, and the Cancer Disparities Institute of the Arizona Cancer Center. He retains an academic title as the Distinguished Outreach Professor of Public Health.

Roy Teramoto, MD, MPH, Ex-Officio
Roy Teramoto is a pediatrician who retired from the U.S. Public Health Service after a thirty year career with the Indian Health Service. He served as a pediatrician at the Phoenix Indian Medical Center and later as the Maternal Child Health consultant for the Phoenix Area. He continues to work part time for the Phoenix Area Indian Health Service. He is a member of the American Academy of Pediatrics and the Arizona Chapter of the American Academy of Pediatrics and is a member of the American Public Health Association.

Members who also contributed to this Report as members during the year include Mary Henderson (Licensed Midwife) and Jeanne Stagner (Certified Nurse Midwife).

Midwife Report Review

Data Sources and Limitations

The data source used in this report includes electronic reports submitted to the Department by licensed midwives in fiscal year 2015 (July 1, 2014 – June 30, 2015). The report is a requirement for licensed midwives under A.A.C. R9-16-114(B) within 30 calendar days after the termination of midwifery services to the client. Midwives must complete the midwifery report for each client that includes the variables identified in A.A.C. R9-16-114(A). This analysis and report includes midwife reports based on the date the midwife submitted the report.

From July 1, 2014 to December 14, 2014, the format provided by the Department for the required reporting was via a SurveyMonkey® report. From December 15, 2014 to June 30, 2015, the format changed to a Department Midwife Reporting Portal. All data from the SurveyMonkey® reports were imported into the Portal when the transition to the Portal occurred. Therefore, data analysis was completed using Portal data extracts. Data elements are reported by the midwife. Variables such as Apgar score are both designated and reported by the midwife.

Table 1: Overview of Reports and Licensed Midwives

Reporting Timeframe	July 1, 2014—June 30, 2015
Number of Licensed Midwives (LM)	73
Number of Certified Professional Midwives (CPM)	51
Number of Initial Licenses Issued	7
Number of Renewal Licenses Issued	25
Number of Licensed Midwives submitting at least 1 report	53
Total number of reports submitted	1,399
Total number of deliveries reported	1,142 (82%)

Table 2: Client Report Identified Vaginal Birth after Cesarean or Complete/Frank Breech

Delivery Type	Reports	Transfer of Care	Outcome
VBAC	11	No	Normal/No Complications
Complete / Frank Breech	3	No	Normal/No Complications

Table 3: Gravida and Para Reported by Midwife n=1,398 for Gravida, n=1,399 for Para

	Mean	Minimum	Maximum
Gravida	3.01	1	16
Para	1.59	0	13

Figure 1: Delivery Completed by Midwife

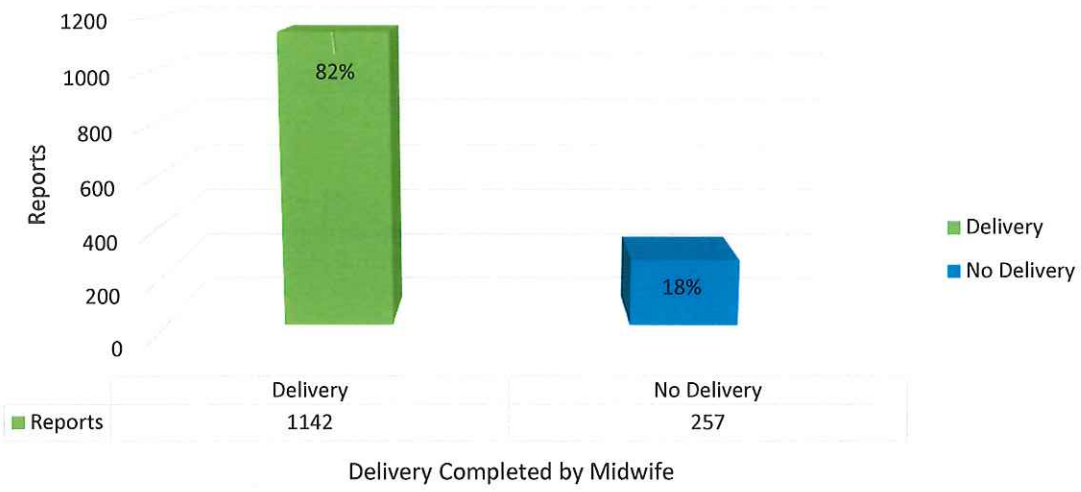


Figure 2: Apgar at 1minute Reported by Midwives who Completed Delivery
n=1,139

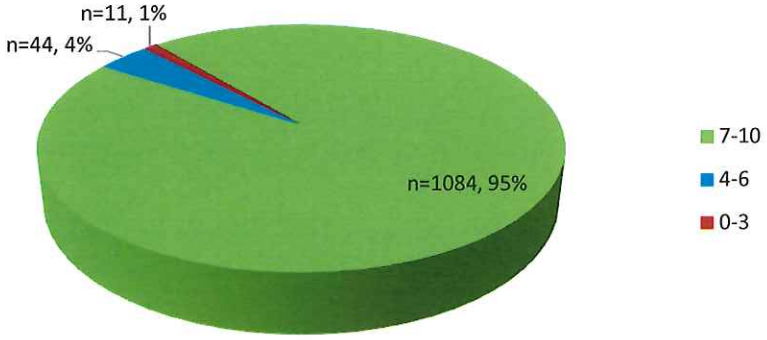


Figure 3: Apgar at 5 minutes Reported by Midwives who Completed Delivery
n=1,139

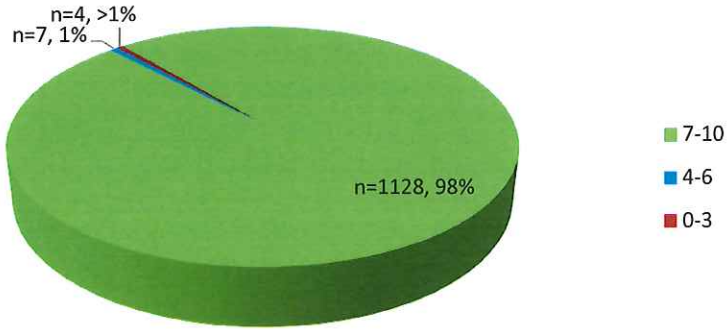
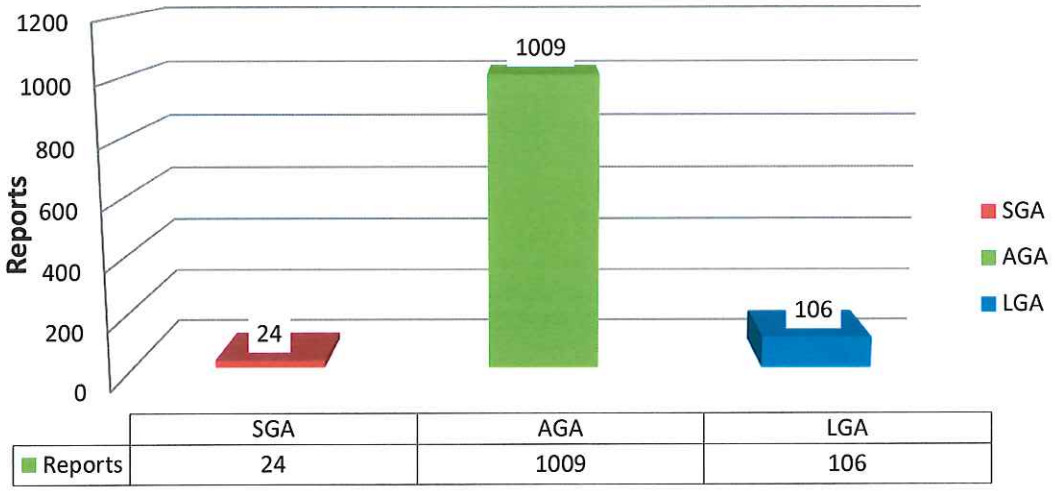


Table 4: Newborn Weight at Birth Reported by Midwife
n=1,084

	Mean (g)	Minimum (g)	Maximum (g)
Infant Weight	**3579**	**2183**	**5380**

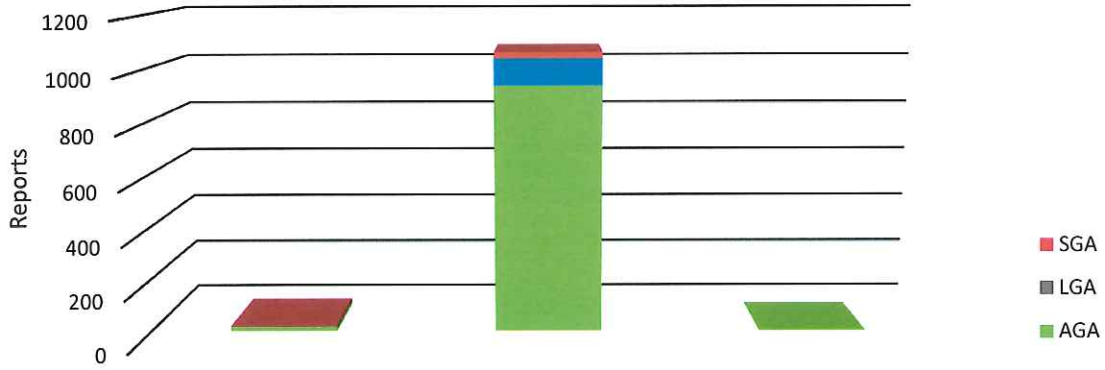
Figure 4: Weight for Gestational Age Reported by Midwife
n=1,139



	SGA	AGA	LGA
Reports	24	1009	106

Weight for Gestational Age

Figure 5: Infant Outcome by Gestational Age Designation Reported by Midwife
n=1,086



	Abnormal/Complications	Normal (>37 weeks)	Preterm (<36 weeks)
SGA	2	20	
LGA	1	101	
AGA	16	944	2

Infant Outcomes

Table 5: Newborn Head Circumference and Length at Birth Reported by Midwife
n=1,142

	Mean (cm)	Minimum (cm)	Maximum (cm)
Length	51.7	33.0	59.0
Head Circumference	34.6	5.6	39.6

Figure 6: Transfer of Care Reported by Midwife

Per R9-16-102, "Transfer of care" means that a midwife refers the care of the client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.
n=1,397

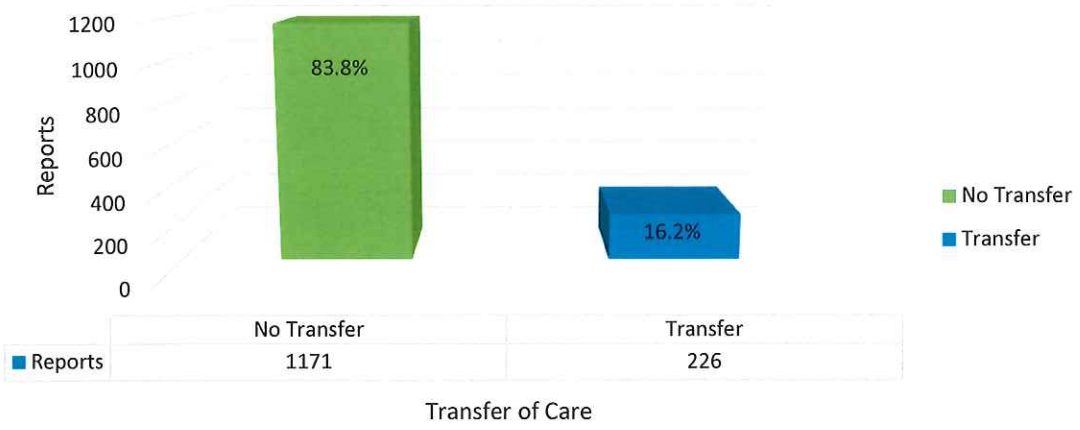
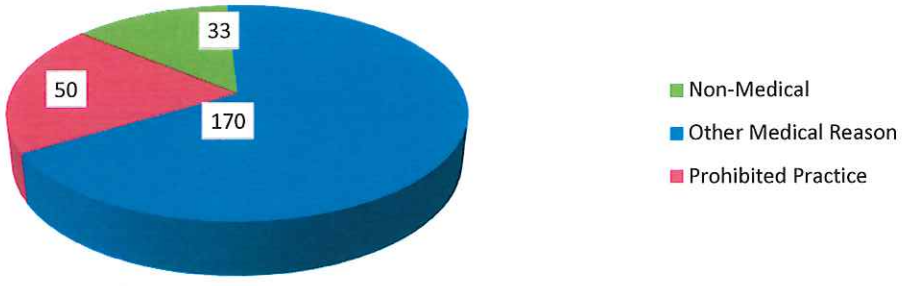


Figure 7: Reason for Transfer of Care Reported by Midwife

253 reasons noted for the 226 Yes responses to Transfer of Care as multiple responses allowed.



	Prohibited Practice	Other Medical Reason	Non-Medical Reason
Reports	50	170	33

Figure 8: Transport Destination

For reports where a Transfer of Care was reported, the options for the Transport Destination include hospital, physician's office, certified nurse midwife or emergency medical services.

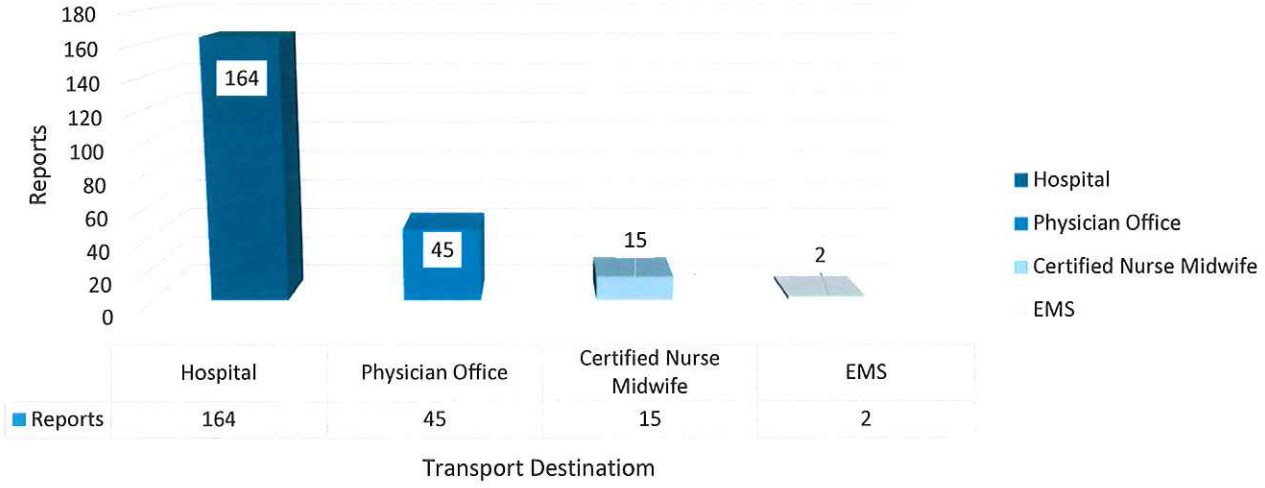


Table 6: Prohibited Practice Detail

	Reports
Gestation beyond 42 weeks	11
Labor beginning before the beginning of 36 weeks gestation	7
A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy	6
Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute	5
Multiple Fetuses	3
Preeclampsia or eclampsia	3
Breech does not meet requirements for home birth	3
A progression of labor that does not meet the requirement of R9-16-108(J)(4), if applicable	3
A non-bleeding placenta retained more than 60 minutes	2
Respiratory distress	2
A blood pressure of 140/190 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart	2
Placenta Previa or placenta Accreta	1
Uncontrolled gestational diabetic, insulin-dependent diabetes, hypertension, Rh disease with positive titers, active tuberculosis, or active syphilis	1
Presence of ruptured membrane without onset of labor within 24 hours	1
Total	**50**

Data Limitations

Limitations of this data include incorrect data entry and data missing across certain fields. These limitations are more evident for reports submitted via the Survey Monkey as data validation was not available but was later included for reports submitted via the Portal.

In November 2014, licensed midwives were notified of reports not previously submitted and were provided with a timeframe of December 31, 2014 to submit these reports. The data include reports received by the Department in FY2015 where services were provided in 2013. For example, 293 of the reports where a delivery was reported by the licensed midwife include a delivery date in calendar year 2013.

Demise Notifications

One notification received by the Department, as required in R9-16-104(B), was reviewed by the Committee. The report was for a stillborn infant delivered by a Licensed Midwife. The Committee plans to develop a standard form and procedure for review of any future notifications received by the Department.

Complaints & Enforcement Actions

Source of Complaint	Complaints	Outcome
Consumers	2	1 complaint did not meet criteria for investigation 1 complaint resulted in enforcement action
Source of Violation	**Violations**	**Outcome**
Midwife Report	21	Enforcement Action
Complaint	1	Enforcement Action

Enforcement Violations	Violations	Action
Midwife report submitted beyond 30 days	18	$4320 collected in fines
Failure to obtain consultation for parity greater than 5	2	$50 fine
Accepting a client with a history of prior cesarean section (violation occurred prior to July 1, 2013).	1	$100 fine
A suspected postpartum hemorrhage of greater than 500 milliliters in the current pregnancy	1	6 month license suspension 40 hours continuing education 2 years probation

Data Limitations

The Bureau was unable to provide data on how many midwife patient records were requested or viewed. This data is reflective of final enforcement dates during FY2015 and does include violations that occurred prior to July 1, 2014. Enforcement action records can be found at http://hsapps.azdhs.gov/ls/sod/SearchProv.aspx?type=MW

Consumer Voice

Arizona has a strong tradition of good outcomes and responsible practices among its Licensed Midwives (LMs). This is evident in the increasing number of consumers seeking to birth at home or at a birth center under the care of Arizona LMs, low incidence of scope of practice violations, and even lower incidence of consumer complaints filed against LMs. Since July 2013, when the new scope took effect, consumers looked forward to seeing positive changes that would result in an environment of appropriate licensing oversight, departmental transparency, midwife support, and an even greater focus on safety of mothers and infants. This would allow consumers to make an educated decision when seeking a care provider for an out-of-hospital birth.

While consumers have experienced a positive increase in their care provider options with the LM scope inclusion of VBAC and breech pregnancies, consumers do have a few concerns. These concerns include access to their private medical records, mandatory prenatal screenings and vaginal exams, the narrow parameters of midwifery services as defined by rule, and loss of postpartum care due to transfer.

Consumers have serious concerns about their private medical information being reviewed without any indication of risk to mother or infant warranting such investigation. When pressed for this information to be included in this report, the Bureau was unable to provide data on how many records had been requested or reviewed, or why the records were requested. Consumers see this as a violation of HIPPA and Arizona statute. Consumers would like to see transparency regarding requests and reviews of private medical records.

Consumers feel coerced to consent to mandatory prenatal screenings and vaginal exams. These feelings of coercion are especially strong when it comes to consenting to vaginal exams. Vaginal exams are an invasive and unreliable indicator of labor progression. Consumers would like to see the department address this area of scope and allow for consumers to decline unnecessary screenings and exams.

Consumers are most concerned about the complete loss of postpartum care, or the precarious challenge of securing postpartum care, following a transfer of care. Transfers of care, for emergency and non-emergency needs, often results in consumers being released from the hospital with instructions to resume care with their midwife but, due to current interpretations of scope, midwives are being instructed not to resume care following such transfers of care Postpartum visits are part of the standard of care, and are important for establishing breastfeeding, screening for postpartum depression, and monitoring the health of the mother for potential complications. By making postpartum care more difficult to obtain, or withdrawing care altogether, these new rules and their current interpretation present a real risk to the health and safety of mothers and infants.

Consumers want continuity of care addressed to help ensure mothers and infants do not find themselves without postpartum care or care erroneously limited to 6 weeks. Consumers want the definition of "midwifery services" to fully encompass a midwife's ability to meet the needs of consumers beyond the current definition's narrow prenatal and postpartum parameters. Doing so increases safety to mothers and infants.

The LMAC Member of the Public gathered these consumer concerns from groups and individuals through the Rights for Homebirth Facebook group and direct communication.

Scope Recommendations

The AZDHS Licensed Midwife Advisory Committee recommends the following rule changes to the current AZDHS Midwifery RulesandRegulations.

As stated by the Clinical Practice Guidelines for Midwifery and Women's Health, Midwifery is a discipline that melds science with art; it is a humanistic approach to providing quality health care to women and newborns and their families (Thrope et. al., 2014). The Committee believes in the value of formal education, lifelong learning and the development and application of evidenced based care for competent midwifery practice. With these recommendations, the goal of these recommendations is to provide a brief but succinct referenced synthesis of current midwifery practice. And in doing so, provide these proposed rule changes, to ensure the AZDHS reviews and determines the need for rule changes to comply with current evidence based standards and health care policy.

The Committee received written proposals presented by the Arizona Association of Midwives. The Committee reviewed these and, in consensus, presents three of these proposals in this report as recommendations to the Department. These recommendations were created in partnership with the AZ AssociationofMidwives. Each proposed rule change is listed along with current reference for justification of the proposed rule changes.

Recommendation for Rule Change:
Definition of Midwifery Services

CURRENT RULE A.A.C. R9-16-101(30)

"Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery, and postpartum care.

PROPOSED RULE CHANGE:

"Midwifery services" defined as health care, provided by a midwife, related to pregnancy, labor, delivery, and postpartum care. This care includes preconception counseling, well-woman care, preventative care, the promotion of normal birth, the detection of complications in pregnancy and the newborn, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

JUSTIFICATION

Midwifery practice as stated in the official policy statement from the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) is the "...independent management of women's healthcare, focusing on pregnancy, childbirth, the postpartum period, care of the newborn and the family planning and gynecological care. The core of midwifery practice contains health promotion, management of normal birth, assessment and detection of complications, and referral as needed," (AWHONN, 2015).

The certified and licensed midwife in Arizona has demonstrated competency via a national certification and state exam. Licensed midwives historically and currently work in partnership with women to give the necessary support, clinical care and recommendations pertaining to health promotion, reproductive health and wellness, care of the newborn and the carrying out of emergency measures if needed. Arizona enacted regulations for licensed midwives in the 1970s and should continue to be a state considering evidence based regulation of certified midwives. National and international standards for education, training, competency and credentialing of midwives include the expanded definition of midwifery services as outlined above. Midwives are recognized as experts in normal birth and wellness care globally and are held to a set of professional standards and ethics that require the midwife to consult or refer to another healthcare provider when the needs for care exceed the competency of the midwife (AWHONN, 2015).

REFERENCE LIST

Association of Women's Health, Obstetric and Neonatal Nursing. (2012). *Midwifery Position Statement.* Accessed online 5/16/15 at https://www.awhonn.org/awhonn/content.do?name=07_PressRoom/07_PositionStatements.htm

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New Mexico Midwives Association. (2008). *Practice Guidelines for New Mexico Midwives.* Accessed online 04/16/15 at http://www.newmexicomidwifery.org/images/uploads/NMMA_2008_practice_guidelines.pdf

State of Vermont. (2015). *The Vermont Statutes Online. Title 26: Professions And Occupations. Chapter 85: Midwives* . Accessed online 05/16/15 at http://legislature.vermont.gov/statutes/fullchapter/26/085

Recommendation for Rule Change:
Continuity of Care

CURRENT RULE A.A.C. R9-16-111(B)

PROPOSED RULE CHANGE:
A midwife shall not knowingly accept for midwifery services or continue midwifery services without documentation of condition treated and resolved, following which midwifery services may resume; for a client who has or develops any of the following:

1. A previous surgery that involved:
    a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
    b. A previous uterine surgery that enters the myometrium;
2. Multiple fetuses
3. Placenta previa or placenta accreta;
4. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
5. Deep vein thrombosis or pulmonary embolism;
6. Uncontrolled gestational diabetes;
7. Insulin-dependent diabetes;
8. Hypertension;
9. Rh disease with positive titers;
10. Active:
    a. Tuberculosis;
    b. Syphilis;
    c. Genital herpes at the onset of labor;
    d. Hepatitis until treated and recovered, following which midwifery services may resume; or
    e. Gonorrhea until treated and recovered, following which midwifery services may resume;
11. Preeclampsia or eclampsia persisting after the second trimester;
12. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
13. A persistent hemoglobin level below 10 grams or a persistent hematocrit below 30 during the third trimester;
14. A pelvis that will not safely allow a baby to pass through during labor;
15. A serious mental illness;
16. Evidence of substance abuse, including six months prior to pregnancy, to one of the following, evident during an assessment of a client;
    a. Alcohol
    b. Narcotics
    c. Other drugs
17. Except as provided in R9-16-108(B)(2), a fetus with an abnormal presentation;
18. Labor beginning before the beginning of 36 weeks gestation;
19. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
20. Gestational age greater than 34 weeks with no prior prenatal care;
21. A gestation beyond 42 weeks;
22. Presence of ruptured membranes without onset of labor within 24 hours;

23. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
24. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
25. A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy; or 52. A non--bleeding placenta retained for more than 60 minutes

JUSTIFICATION - Midwife led continuity of care is provided in a multidisciplinary network of consultation and referral with other care providers. This contrasts with medical- models of care where an obstetrician or family physician is primarily responsible for care (Cochrane.org). A shared-care model, is one in which responsibility is shared between different healthcare professionals to provide optimal outcomes for mother and baby.

Organizations worldwide and in the United States, such as the Homebirth Summit, have concentrated on shared care in the midwifery led model of care and most specifically during a medical transport. This design recognizes that midwives have proven competency in medical assessment for conditions which would require a transfer of care or consultation. Once consulted or transferred the optimal care for the woman would be the ability to maintain continuity of care by her midwife once the condition necessitating transfer of care or consultation is resolved.

The midwifery prohibited practice section states that "[a] midwife shall not accept for midwifery services or continue midwifery services for a client who has or develops any of the following and lists twenty-six different health conditions. (A.A.C. R9-16-111(B)).

Historically, this provision was interpreted by the Department to allow a midwife to resume care once the health condition had been treated or ceased to exist. After the revision of the Midwifery rules, the Department has taken action against midwives and had opined in a training session that this "Prohibited Practice" section does not allow a midwife to resume care.

This new position is problematic.

First, interpreting the rules in this way arbitrarily excludes healthy, low-risk women from midwifery services. Many of the health conditions within section 111(B) are not permanent conditions and can be resolved. By interpreting these rules to not allow midwives to resume care, the Department is excluding healthy women from the care providers of their choice.

Second, this interpretation is not consistent with the plain language of the rules. When the Department revisited the midwifery rules in 2013, the Department chose to use the words "has or develops." The Department chose to use these words in the present perfect tense, indicating that a midwife cannot accept or continue care when a client presently has one of the twenty-six different conditions. Therefore, the logical leap that the Department has made is that this section also prohibits care when a client has had any of these conditions.

Third, midwives are mandated in A.A.C. R9-108-K to provide postpartum care for the mother and the newborn. The interpretation of this rule offered by the Department to immediately terminate all midwifery services when the midwifery client experiences any of the conditions within 111(B) ignores that there are two people the midwife is legally tasked with caring for in the days following birth.

Last, as currently interpreted, these rules do not provide guidance on a midwife's responsibilities in the event that her patient does not consent to a transfer of care. Both the Arizona Supreme Court and the United States Supreme Court have held that patients have a right to refuse medical treatment, even when that treatment is lifesaving. (Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 277 (1990); Rasmussen by Mitchell v. Fleming, 1 54 Ariz. 207, 215, 741 P.2d 674, 682 (1987)).

The Department has been aware for years the way in which the current rules are interpreted place the midwife in an impossible situation if her client exercises her constitutionally protected right to decline treatment: the midwife must choose between keeping her license and her ethical responsibility to not abandon her patient. This rule change would provide the midwife with the guidance she needs while still protecting public health and safety.

R9-16-101. 30 Definition of 'midwifery services' : " Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery or postpartum care.

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Recommendation for Rule Change:
Care for the Woman with Postpartum Hemorrhage

CURRENT RULE A.A.C. R9-16-111(B)(25)

PROPOSED RULE CHANGE:
A midwife may continue care for a midwifery client with a postpartum hemorrhage in the current pregnancy as stated in R9-16-111 (B) (25) if all of the following criteria are met in the postpartum period:

1 The hemorrhage responds to treatments available in the out of hospital setting and is well controlled
   a The client is alert and oriented
   b The client's blood pressure remains within normal limits of between 90/60 and 140/90
2 The client has been discharged from physician care following a transfer of care for hemorrhage

JUSTIFICATION
Currently available prevention and treatment options for postpartum hemorrhage have been found to be effective at improving maternal outcomes (Barbieri, 2007).

Midwives undergo rigorous training in assessing risk factors for postpartum hemorrhage (CMQCC Hemorrhage Task Force, 2010).

Midwives regularly implement prenatal care plans that reduce identified risks. Under current guidelines, rules and regulations, Arizona Midwives in out of hospital birth practices do not provide care to clients with known risk factors for postpartum hemorrhage such as those with: multiple gestation, preeclampsia, chorioamnionitis, and polyhydramnios. Similarly, patients planning an out of hospital birth do not undergo procedures known to increase rates of hemorrhage such as: medical labor augmentation, assisted delivery techniques (vacuum or forceps), and cesarean delivery. Postpartum hemorrhage is regularly defined as a blood loss of greater than 500 mL; it affects 1-3% of postpartum patients (Gregory, Main & Lyndon, 2009). The most common cause of postpartum hemorrhage is uterine atony, a situation of which responds well to current standards of practice for a licensed midwife (McCormick, Sanghvi, &McIntosh, 2002).

There is no single accepted definition of postpartum hemorrhage in the United States. A blood loss of 500mL following vaginal birth and 1000mL following cesarean birth are commonly used for diagnosis even though current research suggests average blood loss may be greater (Beer, Duvvi, 2005).

Visual estimation of blood loss can be inaccurate, often over-estimating total blood loss, and has been found to be of little clinical use. It is important to note that a blood loss volume of 500mL is somewhat arbitrary and fails to take into consideration the individual's starting blood volume and may be irrelevant to the client's hemodynamic state. Likewise, a decrease in hematocrit levels by 10% has also been used for diagnosis, but similarly may not represent the current hematological state of the client and some individuals may suffer effects of a postpartum hemorrhage with lower blood losses.

Two health and safety advantages of the proposed rule changes include: supporting continuity of care for the client and expanding the definition of postpartum hemorrhage to allow for assessment and treatment of signs and symptoms of postpartum hemorrhage rather than basing transfer of care upon an arbitrary and often inaccurate numerical estimated measurement. Midwives are trained and capable of assessing signs and symptoms that would indicate impending hypovolemic shock or a hemorrhage that is not responding well to treatment. Midwifery clients exhibiting concerning symptoms or presenting with a poorly controlled hemorrhage would appropriately be transferred to the hospital while those midwifery clients who have a postpartum blood loss greater than an estimated 500mL yet remain stable would be permitted to remain home under the care of their midwife.

Supporting continuity of care for clients through treatment of postpartum hemorrhage is of great value to the client, as continuity of care has been shown to decrease maternal morbidity and mortality. In a shared-care, midwife-led model, continuity of care is provided in a multidisciplinary network of consultation and referral with other care providers. In shared-care models, responsibility is shared between different healthcare professionals. Organizations worldwide and in the United States, such as the Homebirth Summit, have concentrated on shared care during a medical transport, which recognizes that midwives have proven competency at medical assessment for conditions, which would require a transfer of care or consultation. Once consulted or transferred the optimal care for the woman would be the ability to maintain continuity of care by her midwife.

Therefore even if a transfer is necessitated for treatment of postpartum hemorrhage once the condition is resolved the client should be given the opportunity return to her midwife for postpartum care (Home Birth Summit, 2014).

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Appendix

Arizona Licensing of Midwifery Program Governing Documents

Midwives in the State of Arizona are authorized by Arizona Revised Statutes 36-751-760 et seq. and Arizona Administrative Code R9-16-191 et seq.

Arizona Revised Statutes (A.R.S.)

The Arizona Revised Statutes (A.R.S.) represent the statutory laws of the state of Arizona. The A.R.S. and the Arizona Administrative Code (A.A.C.) Licensing of Midwifery (Rules) each contain requirements applicable to the Arizona Bureau of Special Licensing. Accordingly, to fully understand all the requirements applicable to the Arizona Licensing of Midwifery, the A.R.S. and the Arizona Midwifery Rules should be read in conjunction with each other.

A.R.S. Title 36

CHAPTER	Licensing and Regulation of Midwifery
36-751	Definitions
36-752	Licensure; exceptions
36-753	Application for license as midwife
36-754	Licensing of midwives; renewal of license
36-755	Powers and duties of the director
36-756	Grounds for denial of license and disciplinary action; hearing; appeal; civil penalties; injunctions
36-756.01	Investigations; right to examine evidence; subpoenas; confidentiality
36-757	Violations; classification
36-758	Fees
36-759	Use of title; prohibitions
36-760	Persons and acts not affected by this article

Arizona Licensing of Midwifery Administrative Code (Rules)

A.A.C R9-16-191 et seq.

Evidence Based Research

*The following publications have not been reviewed and verified by the Department.

Intrapartum care for healthy women and babies. NICE guidelines [CG190] Published date: December 2014 https://www.nice.org.uk/guidance/cg190

Intrapartum care: care of healthy women and their babies during childbirth. NICE guidelines [CG190] Published date: December 2014 http://www.nice.org.uk/guidance/cg190/evidence

Midwifery: Evidence-Based Practice A Summary of Research on Midwifery Practice in the United States American College of Nurse-Midwives. Revised April 2012 http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000002128/midwifery%20evidence-based%20practice%20issue%20brief%20finalmay%202012.pdf

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Definitions

ArizonaAssociationofMidwives (AAM): a professional organization with a mission to advance the quality and accessibility of midwifery in Arizona.

Committee on Legal and Regulatory Concerns (CLaRC): a committee within AAM, whose purpose is to address legal concerns for AAM midwives and to take actions to encourage improved midwifery regulatory climate in Arizona.

Department: The Arizona Department of Health Services

Bureau: The Bureau of Special Licensing within Public Health Licensing Services, a division of the Arizona Department of Health Services