Wisconsin Department of Safety and Professional Services
Division of Policy Development
4822 Madison Yards Way
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**Tony Evers, Governor**
**Dan Hereth, Secretary**

**VIRTUAL/TELECONFERENCE**
**MIDWIFE ADVISORY COMMITTEE**
**Virtual, 4822 Madison Yards Way, Madison**
**Contact: Tom Ryan (608) 266-2112**
**January 20, 2026**

*The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee.*

**AGENDA**

**9:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A. Adoption of Agenda (1-2)**

**B. Approval of Minutes of November 18, 2025 (3)**

**C. Administrative Matters – Discussion and Consideration**
1. Department, Staff and Committee Updates
2. **2026 Meeting Dates (4)**
3. **Annual Policy Review (5-7)**
4. **Election of Officers (8)**
5. Committee Members
   a. Abitz, Leslie C.
   b. Bauer, Korina M.
   c. Guzzardo, Angela L.
   d. Scherer, Kelsey A.
   e. Stevenson, Kaycie Marie

**D. Administrative Rule Matters – Discussion and Consideration (9-47)**
1. Public Comment Process Reminder
2. Drafting Proposals: SPS 180 to 183, Relating to Licensed Midwives Comprehensive Review
   a. SPS 182.02 – Informed Consent
   b. SPS 182.03 (4) – Consultation and Referral
   c. SPS 182.03 (5) – Transfer
   d. Proposed Changes from the Members of the Wisconsin Guild of Midwives
   e. Other Proposals from the Department or Committee Members
3. Pending and Possible Rulemaking Projects

E. Legislative and Policy Matters – Discussion and Consideration

F. Discussion and Consideration of Items Added After Preparation of Agenda:

1. Introductions, Announcements and Recognition
2. Administrative Matters
3. Election of Officers
4. Education and Examination Matters
5. Credentialing Matters
6. Legislative and Policy Matters
7. Administrative Rule Matters
8. Committee Liaison Training and Appointment of Mentors
9. Informational Items

**G. Public Comments**

**ADJOURNMENT**

**NEXT MEETING: APRIL 7, 2026**

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held virtually unless otherwise indicated. In-person meetings are typically conducted at 4822 Madison Yards Way, Madison, Wisconsin, unless an alternative location is listed on the meeting notice. In order to confirm a meeting or to request a complete copy of the board's agenda, please visit the Department website at https:\\dsps.wi.gov. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of any agenda item may be changed by the board for the convenience of the parties. The person credentialed by the board has the right to demand that the meeting at which final action may be taken against the credential be held in open session. Requests for interpreters for the hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer or reach the Meeting Staff by calling 608-267-7213.

# VIRTUAL/TELECONFERENCE
# MIDWIFE ADVISORY COMMITTEE
# MEETING MINUTES
# NOVEMBER 18, 2025

**PRESENT:** Leslie Abitz, Korina Bauer, Kelsey Scherer, Kayci Marie Stevenson

**ABSENT:** Angela Guzzardo

**STAFF:** Will Johnson, Executive Director; Renee Parton, Assistant Deputy Chief Legal Counsel; Gretchen Mrozinski, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Tracy Drinkwater, Board Administration Specialist; and other DSPS Staff

## CALL TO ORDER

Korina Bauer, Chairperson, called the meeting to order at 12:01 p.m. A quorum of four (4) members was confirmed.

## ADOPTION OF AGENDA

**MOTION:** Korina Bauer moved, seconded by Abitz, to adopt the agenda as published. Motion carried unanimously.

## APPROVAL OF MINUTES FROM SEPTEMBER 23, 2025

**MOTION:** Korina Bauer moved, seconded by Leslie Abitz, to approve the minutes of September 23, 2025, as published. Motion carried unanimously.

## ADJOURNMENT

**MOTION:** Korina Bauer moved, seconded by Leslie Abitz, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 1:25 p.m.

**MIDWIFE ADVISORY COMMITTEE**
**2026 MEETING DATES**

| Meeting Date | Start time | Location | Agenda Item Deadline |
|---|---|---|---|
| Tuesday, January 20, 2026 | 9:00 AM | Virtual | 1/7/2026 |
| Tuesday, April 7, 2026 | 9:00 AM | Virtual | 3/26/2026 |
| Tuesday, July 14, 2026 | 9:00 AM | Virtual | 7/2/2026 |
| Tuesday, October 20, 2026 | 9:00 AM | Virtual | 10/8/2026 |

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

1) Name and title of person submitting the request: Audra Cohen-Plata, DPD Division Administrator
2) Date When Request Submitted: 12/11/2025
3) Name of Board, Committee, Council, Section**: All Boards**
4) Meeting Date: **First Meeting of 2026**

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5) Attachments: **Yes**
6) How should the item be titled on the agenda page? **Administrative Matters: Annual Policy Review**
7) Place Item in: **Open Session**
8) Is an appearance before the Board being scheduled? No
9) Name of Case Advisor(s), if applicable: N/A

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10) Describe the issue and action that should be addressed:

**Please be advised of the following policy item attachments:**

1) 2026 Annual Policy Review Memo
2) Timeline of a Meeting
3) Sample Per Diem Report

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**DATE: January 1, 2026**
**TO: DSPS Board, Council, and Committee Members**
**FROM: Division of Policy Development**
**SUBJECT: 2026 Administrative Policy Reminders**

**Please be advised of the following policy items:**

1. In-Person and Virtual Meetings: Depending on the frequency of scheduled meetings, discussion topics, and member availability, DSPS may host one or more in-person meetings. Virtual connection options are available for all board meetings. If you are traveling internationally, please see item 9 below.

2. Attendance/Quorum: Thank you for your service and commitment to meeting attendance. If you cannot attend a meeting or have scheduling conflicts impacting your attendance, please let us know as soon as possible. A quorum is required for Boards, Sections, and Councils to meet pursuant to Open Meetings Law. Connect to / arrive at meetings 10 minutes before posted start time to allow for audio/connection testing, and timely Call to Order and Roll Call. Virtual meetings include viewable onscreen materials and A/V (speaker/microphone/video) connections.

3. Walking Quorum: Board/Section/Council members must not collectively discuss the body's business outside a properly noticed meeting. If several members of a body do so, they could be violating the open meetings law.

4. Mandatory Training: All Board Members must complete Public Records and Ethics Training, annually. Register to set up an account in the Cornerstone LearnCenter online portal or Log in to an existing account.

5. Agenda Deadlines: Please communicate agenda topics to your Executive Director before the agenda submission deadline at 12:00 p.m., eight business days before a meeting. (Attachment: Timeline of a Meeting)

6. Travel Voucher and Per Diem Submissions: Please submit all Per Diem and Reimbursement claims to DSPS within 30 days of the close of each month in which expenses are incurred. (Attachment: Per Diem Form) Travel Vouchers are distributed on travel approval.

7. Lodging Accommodations/Hotel Cancellation Policy: Lodging accommodations are available to eligible members for in-person meetings. Standard eligibility: the member must leave home before 6:00 a.m. to attend an in-person meeting by the scheduled start time.

a. If a member cannot attend a meeting, they must cancel their reservation with the hotel within the applicable cancellation timeframe.
b. If a meeting is changed to occur remotely, is canceled, or rescheduled, DSPS staff will cancel or modify reservations as appropriate.

8. Inclement Weather Policy: In inclement weather, the DSPS may change a meeting from an in-person venue to a virtual/teleconference only.

9. International Travel: Use of State-managed IT resources and access of State data outside the United States are strictly prohibited, as they cause an unacceptable level of cybersecurity risk. This prohibition includes all State-provided or State-managed IT resources housed on personal devices. Please advise your Executive Director of any planned international travel commitments that may coincide with board meetings or other board business in advance of your departure.

# Timeline of a Meeting

**At least 2 weeks (10 business days) prior to the meeting**
Submit Agenda Item suggestions to the Board's Executive Director. Include background materials. Copyright-protected materials must be accompanied by written permission from the publisher to share documents.

**8 business days prior to the meeting**
The Agenda is drafted. (All agenda materials are due to the Department by 12:00 p.m.)

**7 business days prior to the meeting**
The draft agenda is submitted to the Executive Director; the Executive Director transmits it to the Chair for review and approval.

**5 business days prior to the meeting**
The approved agenda is returned to the Board Administration Specialist (BA) for agenda packet production and compilation.

**4 business days prior to the meeting**
Agenda packets are posted on the DSPS Board SharePoint site and on the Board webpage.

**Agenda Item Examples:**

- Open Session Items
  - Public Hearings and Administrative Rules Matters
  - Administrative Matters
  - Legislation and Policy Matters
  - Credentialing Matters
  - Education and Exam Issues
  - Public Agenda Requests
  - Current Issues Affecting the Profession
- Closed Session items
  - Deliberations on Proposed Disciplinary Actions
  - Monitoring Matters
  - Professional Assistance Procedure (PAP) Issues
  - Proposed Final Decisions and Orders
  - Orders Fixing Costs/Matters Relating to Costs
  - Credentialing Matters
  - Education and Exam Issues

**Thursday of the Week Prior to the Meeting**
Agendas are published for public notice on the Wisconsin Public Notices and Meeting Minutes website: **publicmeetings.wi.gov**.

**1 business day after the Meeting**
"Action" lists are distributed to Department staff detailing board actions on closed session business.

**5 business days after the Meeting**
"To Do" lists are distributed to staff to ensure that board open session decisions are acted on and/or implemented within the appropriate divisions in the Department. Minutes approved by the board are published on the Wisconsin Public Notices and Meeting Minutes website: **publicmeetings.wi.gov**.

**MIDWIFE ADVISORY COMMITTEE**

**2024 Officers**

| **2024 OFFICERS** | |
|---|---|
| **Chairperson** | Korina Bauer |
| **Vice Chairperson** | Leslie Abitz |
| **Secretary** | Kelsey Scherer |

# State of Wisconsin
# Department of Safety & Professional Services

## AGENDA REQUEST FORM

| 1) Name and title of person submitting the request: | 2) Date when request submitted: |
|---|---|
| **Nilajah Hardin**<br>**Administrative Rules Coordinator** | **1/7/26**<br>**Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting** |

**3) Name of Board, Committee, Council, Sections:**

Midwife Advisory Committee

| 4) Meeting Date: | 5) Attachments: | 6) How should the item be titled on the agenda page? |
|---|---|---|
| **1/20/26** | ☒ Yes<br>☐ No | **Administrative Rule Matters – Discussion and Consideration**<br>**1. Public Comment Process Reminder**<br>**2. Drafting Proposals: SPS 180 to 183, Relating to Licensed Midwives Comprehensive Review**<br>**a. SPS 182.02 – Informed Consent**<br>**b. SPS 182.03 (4) – Consultation and Referral**<br>**c. SPS 182.03 (5) – Transfer**<br>**d. Proposed Changes from the Members of the Wisconsin Guild of Midwives**<br>**e. Other Proposals from the Department of Committee Members**<br>**3. Pending or Possible Rulemaking Projects** |

| 7) Place Item in: | 8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)* | 9) Name of Case Advisor(s), if required: |
|---|---|---|
| ☒ Open Session<br>☐ Closed Session | ☐ Yes<br>☒ No | **N/A** |

**10) Describe the issue and action that should be addressed:**

Attachments:

1. SPS 180 to 183 Redlined Code Text
2. Information Regarding Planned Out-of-Hospital Birth of Twins
3. In the Beginning Midwives Vaginal Breech Birth Informed Choice and Consent Agreement
4. Emailed Statement from WI Physician Assistant Affiliated Credentialing Board Member Regarding Referrals
5. Proposed Changes from the Members of the Wisconsin Guild of Midwives

**11) Authorization**

Nilajah D. Hardin — 1/7/26

**Signature of person making this request** — **Date**

**Supervisor (if required)** — **Date**

**Executive Director signature (indicates approval to add post agenda deadline item to agenda)** **Date**

**Directions for including supporting documents:**

**1. This form should be attached to any documents submitted to the agenda.**
**2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.**
**3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.**

# Chapter SPS 180

## AUTHORITY AND DEFINITIONS



Note: Chapter RL 180 was renumbered chapter SPS 180 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

**SPS 180.01 Authority.** The rules in chs. SPS 180 to 183 are adopted under the authority of ss. 227.11 (2) and 440.08 (3), Stats., and subch. XIII of ch. 440, Stats.

**SPS 180.02 Definitions.** As used in chs. SPS 180 to 183 and in subch. XIII of ch. 440, Stats.:

**(1)** "Administer" means the direct provision of a prescription drug or device, whether by injection, ingestion or any other means, to the body of a client.

**(1m)** "Automated external defibrillator" has the meaning given in s. 440.01 (1) (ad), Stats.

**(2)** "Client" means a woman who obtains maternity care provided by a licensed midwife.

**(3)** "Consultation" means discussing the aspects of an individual client's circumstance with other professionals to assure comprehensive and quality care for the client, consistent with the objectives in the client's treatment plan or for purposes of making adjustments to the client's treatment plan. Consultation may include history-taking, examination of the client, rendering an opinion concerning diagnosis or treatment, or offering service, assistance or advice.

**(3m)** "Defibrillation" has the meaning given in s. 440.01 (1) (ag), Stats.

**(4)** "Department" means the department of safety and professional services.

**(5)** "Direct supervision" means immediate on-premises availability to continually coordinate, direct and inspect at first hand the practice of another.

**(7)** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq.

**(8)** "Licensed midwife" means a person who has been granted a license under subch. XIII of ch. 440, Stats., to engage in the practice of midwifery.

**(9)** "Practice of midwifery" means providing maternity care during the antepartum, intrapartum, and postpartum periods consistent with the standards of practice set forth in ch. SPS 182.

**(10)** "Temporary permit" means a credential granted under s. SPS 181.01 (4), to an individual to practice midwifery under the direct supervision of a licensed midwife pending successful completion of the requirements for a license under s. SPS 181.01 (1).

**(11)** "Ventricular fibrillation" has the meaning given in s.440.01 (1) (i), Stats.

Chapter SPS 181

APPLICATIONS FOR LICENSURE, RENEWAL OF LICENSES AND TEMPORARY PERMITS

SPS 181.01 Applications.

Note: Chapter RL 181 was renumbered chapter SPS 181 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

**SPS 181.01 Applications. (1)** LICENSES. An individual who applies for a license as a midwife shall apply on a form provided by the department. An applicant who fails to comply with a request for information related to the application, or fails to meet all requirements for the license within 120 calendar days from the date of filing shall file a new application and fee if licensure is sought at a later date. The application shall include all of the following:

**(a)** The fee specified in s. 440.03 (9), Stats.

**(b)** Evidence satisfactory to the department of one of the following:

1. That the applicant holds a valid certified professional midwife credential granted by the North American Registry of Midwives or a successor organization.
2. That the applicant holds a valid certified nurse-midwife credential granted by the American College of Nurse Midwives or a successor organization.
3. That the applicant holds a valid certified nurse-midwife or midwife credential granted by the American Midwifery Certification Board or a successor organization.

**(c)** That the applicant, subject to ss. 111.321, 111.322 and 111.335, Stats., does not have an arrest or conviction record. An applicant who has a pending criminal charge or has been convicted of any crime or ordinance violation shall provide the department with all information requested relating to the applicant's pending criminal charge, conviction or other offense, as applicable. The department may not grant a midwife license to a person convicted of an offense under s. 940.22, 940.225, 944.06, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.06, 948.07, 948.075, 948.08, 948.09, 948.095, 948.10, 948.11 or 948.12, Stats.

**(d)** Evidence satisfactory to the department that the applicant has current proficiency in the use of an automated external defibrillator achieved through instruction provided by an individual, organization, or institution of higher education approved under s. 46.03 (38), Stats., to provide the instruction.

**Note:** Instructions for applications for licensure as a midwife are available on the department's website at: http://dsps.wi.gov.

**(1m)** RECIPROCITY FOR SERVICE MEMBERS, FORMER SER- VICE MEMBERS, AND SPOUSES OF SERVICE MEMBERS OR FORMER SERVICE MEMBERS. A reciprocal midwife license shall be granted to an applicant who is a service member, former service member, or the spouse of a service member or former service member as defined in s.

440.09 (1), Stats., if the department determines that the applicant meets all of the requirements under s. 440.09 (2), Stats. Subject to s. 440.09 (2m), Stats., the department may request verification necessary to make a determination under this subsection.

**Note:** Instructions for applications are available on the department's website at http://dsps.wi.gov .

**(2)** RENEWAL OF LICENSES. **(a)** Except for temporary permits granted under sub. (4), the renewal date for licenses granted un- der subch. XIII of ch. 440, Stats., is July 1 of each even-numbered year.

**(b)** Renewal applications shall be submitted to the department on a form provided by the department and shall include the renewal fee specified in s. 440.08 (2) (a) 46w., Stats.

**(c)** At the time of renewal of a license under par. (b), a li- censed midwife shall submit proof satisfactory to the department of all of the following:

1. The licensee holds a valid certified professional midwife credential from the North American Registry of Midwives or a successor organization, or a valid certified nurse-midwife credential from the American College of Nurse Midwives or a successor organization.
2. The licensee has current proficiency in the use of an auto- mated external defibrillator achieved through instruction pro- vided by an individual, organization, or institution of higher education approved under s. 46.03 (38), Stats., to provide the instruction.

**(3)** LATE RENEWAL OF LICENSES. A licensed midwife who fails to renew a license by the renewal date may renew the license by submitting an application on a form provided by the department and satisfying the following requirements:

**(a)** If applying less than 5 years after the renewal date, satisfy the requirements under sub. (2), and pay the late renewal fee specified in s. 440.08 (3), Stats.

**(b)** If applying 5 years or more after the renewal date, satisfy the requirements under sub. (2); pay the late renewal fee specified in s. 440.08 (3), Stats., and submit proof of one or more of the following, as determined by the department to ensure protection of the public health, safety and welfare:

1. Successful completion of educational course work.
2. Successful completion of the national examination required by the North American Registry of Midwives for certification as a certified professional midwife or successful completion of the national examination required by the American College of Nurse Midwives for certification as a certified nurse-midwife.

**(4)** TEMPORARY PERMITS. **(a)** Application. An applicant seeking a temporary permit shall apply on a form provided by the department. An applicant who fails to comply with a request for information related to the application, or fails to meet all requirements for a permit within 120 calendar days from the date of filing shall submit a new application

and fee if a permit is sought at a later date. The application shall include all of the following:

1. The fee specified in s. 440.05 (6), Stats.
2. Evidence satisfactory to the department of all of the following:
   a. The applicant is actively engaged as a candidate for certification with the North American Registry of Midwives or a successor organization; or is currently enrolled in the portfolio evaluation process program through the North American Registry of Midwives or a successor organization, or a certified professional midwife educational program accredited by the Midwifery Education Accreditation Council.
   b. The applicant has received a written commitment from a licensed midwife to directly supervise the applicant's practice of midwifery during the duration of the temporary permit.
   c. The applicant is currently certified by the American Red Cross or American Heart Association in neonatal resuscitation.
   d. The applicant is currently certified by the American Red Cross or American Heart Association in adult cardiopulmonary resuscitation.
   e. The applicant has attended at least 5 births as an observer.
   f. The applicant, subject to ss. 111.321, 111.322 and 111.335, Stats., does not have an arrest or conviction record. An applicant who has a pending criminal charge or has been convicted of any crime or ordinance violation shall provide the department with all information requested relating to the applicant's pending criminal charge, conviction or other offense, as applicable. The department may not grant a temporary permit to a per- son convicted of an offense under s. 940.22, 940.225, 944.06, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.06, 948.07, 948.075, 948.08, 948.09, 948.095, 948.10, 948.11 or 948.12, Stats.

**Note:** Instructions for applications are available on the department's website at: http://dsps.wi.gov.

**(b)** Duration of permit. 1. The duration of a temporary permit is for a period of 3 years or until the permit holder ceases to be currently registered or actively engaged as a candidate for certification as specified in par. (a) 2., whichever is shorter.

2. A licensed midwife with a written commitment to supervise the holder of a temporary permit shall notify the department immediately of a termination of the supervisory relationship.
3. Upon termination of a supervisory relationship, the temporary permit shall be automatically suspended until the permit holder obtains another written supervisory commitment that complies with par. (a) 2. b.
4. The department may in its discretion grant renewal of a temporary permit. Renewal shall be granted only once and for a period of no more than 3 years. A permit holder

seeking renewal of a temporary permit shall submit documentation that satisfies the requirements for an initial permit under par. (a).

**Note:** The North American Registry of Midwives may be contacted at P.O. Box 420, Summertown, TN 38483, 1−888−842−4784, https://narm.org/. The American College of Nurse−Midwives may be contacted at 409 12th Street SW, Suite 600, Washington, DC 20024-2188, (240) 485−1800, https://www.midwife.org/.

Chapter SPS 182

# STANDARDS OF PRACTICE



**Note:** Chapter RL 182 was renumbered chapter SPS 182 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

**SPS 182.01 Standards.** Licensed midwives shall comply with the standards of practice of midwifery established by the National Association of Certified Professional Midwives.

**Note:** The standards of the National Association of Certified Professional Midwives are set forth in ch. SPS 183 Appendix I. The National Association of Certified Professional Midwives may be contacted at 234 Banning Road, Putney, VT 05346, (866) 704-9844, https://www.nacpm.org/.

**SPS 182.02 Informed consent. (1)** DISCLOSURE OF INFORMATION TO CLIENT. A licensed midwife shall, at an initial consultation with a client, provide a copy of the rules promulgated by the department under subch. XIII of ch. 440, Stats., and disclose to the client orally and in writing on a form provided by the department all of the following:

**(a)** The licensed midwife's experience and training.

**(b)** Whether the licensed midwife has malpractice liability insurance coverage and the policy limits of the coverage.

**(c)** A protocol for medical emergencies, including transportation to a hospital, particular to each client.

**(d)** A protocol for and disclosure of risks associated with vaginal birth after a cesarean section. The protocol shall include all of the following:

1. A summary of the current statement on vaginal birth after cesarean section by the american college of obstetricians and gynecologists.
2. A description of the risks and benefits associated with vaginal birth after cesarean section.
3. A description of the licensed midwife's clinical experience and training with vaginal birth after cesarean section.
4. Documentation of the client's agreement to:
   a. Provide a copy of the operative report on any prior cesarean section.
   b. Allow increased monitoring before and during labor.
   c. Transfer to a hospital at any time if requested by the licensed midwife.
5. Notification to the client that if a complication occurs, the risk to the client will be higher due to the delay in obtaining access to hospital care.
6. Notification to the client that if a uterine rupture occurs it will likely result in the loss of the fetus.

**(de)** A protocol for and disclosure of risks associated with breech presentation. The protocol shall include all of the following:

1. A description of the risks associated with breech presentation.

2. A description of the licensed midwife's clinical experience and training with breech presentation.
3. A description of the outcome for any birth with breech presentation that the licensed midwife has attended.
4. A list that includes the number of breech births attended and indicates how many of those births were in a home setting.
5. A list of the number of continuing education hours the licensed midwife has completed in breech birth.
6. Notification to the client that vaginal delivery of a breech baby may increase the risk of fetal death and short-term serious neonatal morbidity.
7. Notification to the client that the committee on obstetric practice of the american college of obstetricians and gynecologist considers malpresentation, including breech presentation to be an absolute contraindication to planned home birth. In the United States planned home birth of a breech presenting fetus is associated with an in-labor fetal mortality rate of 13.5 per 1000 and a neonatal mortality rate of 9.2 per 1000. This is significantly higher than planned hospital breech birth which is driven by strict protocols for candidate selection. Risks include but are not limited to cord prolapse and failure to deliver the aftercoming head. Successful vaginal breech birth is also highly dependent on the experience of the provider; most fully trained obstetricians do not have sufficient experience to manage planned hospital vaginal breech births

**(dm)** A protocol for and disclosure of risks associated with birth with two or more fetuses. The protocol shall include all of the following:

1. A description of the risks associated with vaginal birth of two or more fetuses.
2. A description of the licensed midwife's clinical experience and training with births with two or more fetuses.
3. A list of the number of births of two or more fetuses attended that includes a description of the outcome for each birth
4. Notification to the client that the committee on obstetric practice of the american college of obstetricians and gynecologists considers multiple birth to be an absolute contraindication to planned home birth. Vaginal delivery complications of second twins are unpredictable and risk for malpresentation, cord prolapse, fetal distress and postpartum hemorrhage are very high. Vaginal twin birth should only occur in facilities with immediate cesarean section available.

**(e)** The number of babies delivered and the number of clients transferred to a hospital since the time the licensed midwife commenced practice of midwifery.

**(f)** A statement that the licensed midwife does not have the equipment, drugs or personnel available to perform neonatal resuscitations that would normally be available in a hospital setting.

**Note:** Forms are available on the department's website at: http://dsps.wi.gov.

**(1m)** DISCLOSURE OF INFORMATION BY TEMPORARY PERMIT HOLDER. A temporary permit holder shall inform a client orally and in writing that the temporary permit holder may not engage in the practice of midwifery unless the temporary permit holder practices under the direct supervision of a licensed midwife.

**(2)** ACKNOWLEDGEMENT BY CLIENT. A licensed midwife shall, at an initial consultation with a client, provide a copy of the written disclosures required under sub. (1), to the client and

obtain the client's signature acknowledging that she has been in- formed, orally and in writing, of the disclosures required under sub. (1).

**SPS 182.03 Practice. (1)** TESTING, CARE AND SCREENING. A licensed midwife shall:

**(a)** Offer each client routine prenatal care and testing in accordance with current American College of Obstetricians and Gynecologists guidelines.

**(b)** Provide all clients with a plan for 24 hour on-call availability by a licensed midwife, certified nurse-midwife or licensed physician throughout pregnancy, intrapartum, and 6 weeks postpartum.

**(c)** Provide clients with labor support, fetal monitoring and routine assessment of vital signs once active labor is established.

**(d)** Supervise delivery of infant and placenta, assess newborn and maternal well being in immediate postpartum, and perform Apgar scores.

**(e)** Perform routine cord management and inspect for appropriate number of vessels.

**(f)** Inspect the placenta and membranes for completeness.

**(g)** Inspect the perineum and vagina postpartum for lacerations and stabilize.

**(h)** Observe mother and newborn postpartum until stable condition is achieved, but in no event for less than 2 hours.

**(i)** Instruct the mother, father and other support persons, both verbally and in writing, of the special care and precautions for both mother and newborn in the immediate postpartum period.

**(j)** Reevaluate maternal and newborn well being within 36 hours of delivery.

**(k)** Use universal precautions with all biohazard materials.

**(L)** Ensure that a birth certificate is accurately completed and filed in accordance with state law.

**(m)**Offer to obtain and submit a blood sample in accordance with the recommendations for metabolic screening of the newborn.

**(n)** Offer an injection of vitamin K for the newborn in accordance with the indication, dose and administration route set forth in sub. (3).

**(o)** Within one week of delivery, offer a newborn hearing screening to every newborn or refer the parents to a facility with a newborn hearing screening program.

**(p)** Within 2 hours of the birth offer the administration of antibiotic ointment into the eyes of the newborn, in accordance with state law on the prevention of infant blindness.

**(q)** Maintain adequate antenatal and perinatal records of each client and provide records to consulting licensed physicians and licensed certified nurse-midwives, in accordance with HIPAA regulations.

**(2)** PRESCRIPTION DRUGS, DEVICES AND PROCEDURES. A licensed midwife may administer the following during the practice of midwifery:

**(a)** Oxygen for the treatment of fetal distress.

**(b)** Eye prophylactics – 0.5% erythromycin ophthalmic ointment or 1% tetracycline ophthalmic ointment for the prevention of neonatal ophthalmia.

**(c)** Oxytocin, or pitocin, as a postpartum antihemorrhagic agent.

**(d)** Methyl-ergonovine, or methergine, for the treatment of postpartum hemorrhage.

(dm) Misoprostol, or cytotec, for the prevention and treatment of postpartum hemorrhage.

**(e)** Vitamin K for the prophylaxis of hemorrhagic disease of the newborn.

**(f)** RHo (D) immune globulin for the prevention of RHo (D) sensitization in RHo (D) negative women.

**(g)** Intravenous fluids for maternal stabilization –Lactated Ringer's solution, unless unavailable or impractical in which case 0.9% sodium chloride may be administered.

**(h)** In addition to the drugs, devices and procedures that are identified in pars. (a) to (g), a licensed midwife may administer any other prescription drug, use any other device or perform any other procedure as an authorized agent of a licensed practitioner with prescriptive authority.

**Note:** Licensed midwives do not possess prescriptive authority. A licensed midwife may legally administer prescription drugs or devices only as an authorized agent of a practitioner with prescriptive authority. For physicians, physician assistants, and advanced practice nurse prescribers, an agent may administer prescription drugs or devices pursuant to written standing orders and protocols.

**Note:** Medical oxygen, 0.5% erythromycin ophthalmic ointment, tetracycline ophthalmic ointment, oxytocin (pitocin), methyl-ergonovine (methergine), misoprostol (cytotec), injectable vitamin K and RHo (D) immune globulin are prescription drugs. See s. SPS 180.02 (1).

**(3)** INDICATIONS, DOSE, ADMINISTRATION AND DURATION OF TREATMENT. The indications, dose, route of administration and duration of treatment relating to the administration of drugs and procedures identified under sub. (2) are as follows:

| Medication | Indication | Dose | Route of Administration | Duration of Treatment |
|---|---|---|---|---|
| Oxygen | Fetal distress | Maternal:<br>6-8 L/minute<br>Infant: 10-12 L/minute 2-4 L/minute | Mask<br><br>Bag and mask<br>Mask | Until delivery or transfer to a hospital is complete 20 minutes or until transfer to a hospital is complete |
| 0.5% Erythromycin Ophthalmic Ointment Or 1% Tetracycline Ophthalmic Ointment | Prophylaxis of Neonatal Ophthalmia | 1 cm ribbon in each eye from unit dose package<br><br>1 cm ribbon in each eye from unit dose package | Topical<br><br>Topical | 1 dose |
| Oxytocin (Pitocin) 10 units/ml | Prevention and Treatment of Postpartum hemorrhage only | 10-20 units, 1-2 ml | Intramuscularly or Intravenously | 1-2 doses |
| Methyl-ergonovine (Methergine) 0.2 mg/ml or 0.2 mg tabs | Postpartum hemorrhage only | 0.2 mg | Intramuscularly<br>Orally | Single dose Every 6 hours, may repeat 3 times<br>Contraindicated in hypertension and Raynaud's Disease |
| Misoprostol, (Cytotec) 800 mcg or 400-600 mcg | Prevention and Treatment of Postpartum hemorrhage only | 800 mcg for treatment or 400-600 mcg for prevention | Sublingually, orally, or rectally | 1 dose |
| Vitamin K 1.0 mg/0.5 ml | Prophylaxis of Hemorrhagic Disease of the Newborn | 0.5-1.0 mg, 0.25-0.5 ml | Intramuscularly | Single dose |
| RHo (D) Immune Globulin | Prevention of RHo (D) sensitization in RHo (D) negative women | Unit dose | Intramuscularly only | Single dose at any gestation for RHo (D) negative, antibody negative women within 72 hours of spontaneous bleeding.<br>Single dose at 26-28 weeks gestation for RHo (D) negative, antibody negative women and Single dose for RHo (D) negative, antibody negative women within 72 hours of delivery of RHo (D) positive infant, or infant with unknown blood type |
| Lactated Ringer's solution , unless unavailable or impractical in which case 0.9% sodium chloride may be administered | To achieve maternal stabilization during uncontrolled post-partum hemorrhage or anytime blood loss is accompanied by tachycardia, hypotension, de-creased level of consciousness, pallor or diaphoresis | 125 mL/h or 250 mL/hr | Intravenously | Until maternal stabilization is achieved or transfer to a hospital is complete |

**(4)** CONSULTATION AND REFERRAL. **(a)** A licensed midwife shall consult with a licensed physician, licensed physician assistant, certified advanced practice nurse prescriber, or a licensed nurse-midwife who has current working knowledge and experience in providing obstetrical care, whenever there are significant deviations, including abnormal laboratory results, relative to a client's pregnancy or to a neonate. If a referral to a physician is needed, the licensed midwife shall refer the client to a physician and, if possible, remain in consultation with the physician until resolution of the concern.

**Note:** Consultation does not preclude the possibility of an out-of-hospital birth. It is appropriate for the licensed midwife to maintain care of the client to the greatest degree possible, in accordance with the client's wishes, during the pregnancy and, if possible, during labor, birth and the postpartum period.

**(b)** A licensed midwife shall consult with a licensed physician, licensed physician assistant, certified advanced practice nurse prescriber, or licensed nurse-midwife who has current working knowledge and experience in providing obstetrical care, with regard to any mother who presents with or develops the following risk factors or presents with or develops other risk factors that in the judgment of the licensed midwife warrant consultation:

1. Antepartum.
   a. Pregnancy induced hypertension, as evidenced by a blood pressure of 140/90 on 2 occasions greater than 6 hours apart.
   b. Persistent, severe headaches, epigastric pain or visual disturbances.
   c. Persistent symptoms of urinary tract infection.
   d. Significant vaginal bleeding before the onset of labor not associated with uncomplicated spontaneous abortion.
   e. Rupture of membranes prior to the 37th week gestation.
   f. Noted abnormal decrease in or cessation of fetal movement.
   g. Anemia resistant to supplemental therapy.
   h. Fever of 102° F or 39° C or greater for more than 24 hours.
   i. Non-vertex presentation after 38 weeks gestation.
   j. Hyperemisis or significant dehydration.
   k. Isoimmunization, Rh-negative sensitized, positive titers, or any other positive antibody titer, which may have a detrimental effect on mother or fetus.
   L. Elevated blood glucose levels unresponsive to dietary management.
   m. Positive HIV antibody test.
   n. Primary genital herpes infection in pregnancy.
   o. Symptoms of malnutrition or anorexia or protracted weight loss or failure to gain weight.
   p. Suspected deep vein thrombosis.
   q. Documented placental anomaly or previa.
   r. Documented low lying placenta in woman with history of previous cesarean delivery.

s. Labor prior to the 37th week of gestation.
t. History of prior uterine incision.
u. Lie other than vertex at term.
v. Multiple gestation.
w. Known fetal anomalies that may be affected by the site of birth.
x. Marked abnormal fetal heart tones.
y. Abnormal non-stress test or abnormal biophysical profile.
z. Marked or severe poly- or oligo-dydramnios.
za. Evidence of intrauterine growth restriction.
zb. Significant abnormal ultrasound findings.
zc. Gestation beyond 42 weeks by reliable confirmed dates.

2. Intrapartum.
a. Rise in blood pressure above baseline, more than 30/15 points or greater than 140/90.
b. Persistent, severe headaches, epigastric pain or visual disturbances.
c. Significant proteinuria or ketonuria.
d. Fever over 100.6° F or 38° C in absence of environmental factors.
e. Ruptured membranes without onset of established labor after 18 hours.
f. Significant bleeding prior to delivery or any abnormal bleeding, with or without abdominal pain; or evidence of placental abruption.
g. Lie not compatible with spontaneous vaginal delivery or unstable fetal lie.
h. Failure to progress after 5 hours of active labor or following 2 hours of active second stage labor.
i. Signs or symptoms of maternal infection.
j. Active genital herpes at onset of labor.
k. Fetal heart tones with non-reassuring patterns.
L. Signs or symptoms of fetal distress.
m. Thick meconium or frank bleeding with birth not imminent.
n. Client or licensed midwife desires physician consultation or transfer.

3. Postpartum.
a. Failure to void within 6 hours of birth.
b. Signs or symptoms of maternal shock.
c. Febrile: 102° F or 39° C and unresponsive to therapy for 12 hours.
d. Abnormal lochia or signs or symptoms of uterine sepsis.
e. Suspected deep vein thrombosis.
f. Signs of clinically significant depression.

**(c)** A licensed midwife shall consult with a licensed physician or licensed certified nurse-midwife with regard to any neonate who is born with or develops the following risk factors:

1. Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.
2. Persistent grunting respirations or retractions.
3. Persistent cardiac irregularities.
4. Persistent central cyanosis or pallor.

5. Persistent lethargy or poor muscle tone.
6. Abnormal cry.
7. Birth weight less than 2300 grams.
8. Jitteriness or seizures.
9. Jaundice occurring before 24 hours or outside of normal range.
10. Failure to urinate within 24 hours of birth.
11. Failure to pass meconium within 48 hours of birth.
12. Edema.
13. Prolonged temperature instability.
14. Significant signs or symptoms of infection.
15. Significant clinical evidence of glycemic instability.
16. Abnormal, bulging, or depressed fontanel.
17. Significant clinical evidence of prematurity.
18. Medically significant congenital anomalies.
19. Significant or suspected birth injury.
20. Persistent inability to suck.
21. Diminished consciousness.
22. Clinically significant abnormalities in vital signs, muscle tone or behavior.
23. Clinically significant color abnormality, cyanotic, or pale or abnormal perfusion.
24. Abdominal distension or projectile vomiting.
25. Signs of clinically significant dehydration or failure to thrive.

**(5)** TRANSFER. **(a)** All transfers, whether emergent in nature or not, shall include a verbal or face-to-face hand-off between the licensed midwife and an appropriate provider of the receiving facility whenever possible. Transport via private vehicle is an acceptable method of transport if it is the most expedient and safest method for accessing medical services. The licensed midwife shall initiate immediate transport according to the licensed midwife's emergency plan; provide emergency stabilization until emergency medical services arrive or transfer is completed; accompany the client or follow the client to a hospital in a timely fashion; provide pertinent information to the receiving facility and complete an emergency transport record. The following conditions shall require immediate physician notification and emergency transfer to a hospital:

1. Seizures or unconsciousness.
2. Respiratory distress or arrest.
3. Evidence of shock.
4. Psychosis.
5. Symptomatic chest pain or cardiac arrhythmias.
6. Prolapsed umbilical cord.
7. Shoulder dystocia not resolved by Advanced Life Support in Obstetrics (ALSO) protocol.
8. Symptoms of uterine rupture.
9. Preeclampsia or eclampsia.
10. Severe abdominal pain inconsistent with normal labor.

11. Chorioamnionitis.
12. Clinically significant fetal heart rate patterns or other manifestation of fetal distress.
13. Presentation not compatible with spontaneous vaginal delivery.
14. Laceration greater than second degree perineal or any cervical.
15. Hemorrhage non-responsive to therapy.
16. Uterine prolapse or inversion.
17. Persistent uterine atony.
18. Anaphylaxis.
19. Failure to deliver placenta after one hour if there is no bleeding and fundus is firm.
20. Sustained instability or persistent abnormal vital signs.
21. Other conditions or symptoms that could threaten the life of the mother, fetus or neonate.

**(b)** A licensed midwife may deliver a client with any of the complications or conditions set forth in par. (a), if no physician or other equivalent medical services are available and the situation presents immediate harm to the health and safety of the client; if the complication or condition entails extraordinary and unnecessary human suffering; or if delivery occurs during transport.

**(c)** The licensed midwife's emergency plan required under par (a) shall at a minimum include all of the following:

1. Be in writing, dated, and updated on a yearly basis.
2. Private vehicles used for transport shall be identified and insured. Documentation of insurance for transport vehicles shall be included in the emergency plan.
3. A first aid kit shall be included in each private vehicle used for transport.
4. Detailed information on the appropriate provider receiving the transfer and their associated facility.
5. A detailed summary of circumstances when a private transport vehicle may be used in lieu of an ambulance or other emergency medical transport.
6. Each patient shall acknowledge receipt of a copy of the emergency plan.

**(d)** The licensed midwife shall transfer all relevant client records in a timely manner.

**(e)** The pertinent information required to be given under par (a) upon transfer shall include all of the following:

1. Full name and date of birth of the client.
2. A list of any current medications the client is taking.
3. Details about labor history including date and time when active onset labor commenced if applicable.
4. A detailed description of any pregnancy complications.
5. A list of any known drug allergies that the client has.
6. A detailed description of any medications or fluids administered by the midwife prior to transport.

**(6)** PROHIBITED PRACTICES. A licensed midwife may not do any of the following:

**(a)** Administer prescription pharmacological agents intended to induce or augment labor.

**(b)** Administer prescription pharmacological agents to provide pain management.

**(c)** Use vacuum extractors or forceps.

**(d)** Prescribe medications.

**(e)** Provide out-of-hospital care to a woman who has had a vertical incision cesarean section.

**(f)** Perform surgical procedures including, but not limited to, cesarean sections and circumcisions.

**(g)** Knowingly accept responsibility for prenatal or intrapartum care of a client with any of the following risk factors:

1. Chronic significant maternal cardiac, pulmonary, renal or hepatic disease.
2. Malignant disease in an active phase.
3. Significant hematological disorders or coagulopathies, or pulmonary embolism.
4. Insulin requiring diabetes mellitus or uncontrolled gestational diabetes or type 2 diabetes mellitus.
5. Known maternal congenital conditions affecting childbirth.
6. Confirmed isoimmunization, Rh disease with positive titer.
7. Active tuberculosis.
8. Active syphilis or gonorrhea.
9. Active genital herpes infection 2 weeks prior to labor or in labor.
10. Pelvic or uterine conditions affecting normal vaginal births, including tumors and malformations.
11. Alcohol use disorder.
12. Substance use disorder.
13. Uncontrolled current serious psychological or behavioral condition or disorder.
14. Conditions considered by the licensed midwife to be unsafe for the client, the fetus, or the midwife.
15. Fetus with suspected or diagnosed congenital conditions that may require immediate medical intervention.

Chapter SPS 183
GROUNDS FOR DISCIPLINE



Note: Chapter RL 183 was renumbered chapter SPS 183 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

**SPS 183.01 Disciplinary proceedings and actions**.

**(1)** Subject to the rules promulgated under s. 440.03 (1), Stats., the department may reprimand a licensed midwife or deny, limit, suspend, or revoke a license or temporary permit granted under subch. XIII of ch. 440, Stats., if the department finds that the applicant, temporary permit holder, or licensed midwife has engaged in misconduct. Misconduct comprises any practice or behavior that violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a client or the public. Misconduct includes the following:

**(a)** Submitting fraudulent, deceptive or misleading information in conjunction with an application for a credential.

**(b)** Violating, or aiding and abetting a violation, of any law or rule substantially related to practice as a midwife. A certified copy of a judgment of conviction is prima facie evidence of a violation.

Note: Pursuant to s. SPS 4.09, all credential holders licensed by the department need to report a criminal conviction within 48 hours after entry of a judgment against them. The department form for reporting convictions is available on the department's website at http://dsps.wi.gov.

**(c)** Having a license, certificate, permit, registration, or other practice credential granted by another state or by any agency of the federal government to practice as a midwife, which the granting jurisdiction limits, restricts, suspends, or revokes, or having been subject to other adverse action by a licensing authority, any state agency or an agency of the federal government including the denial or limitation of an original credential, or the surrender of a credential, whether or not accompanied by findings of negligence or unprofessional conduct. A certified copy of a state or federal final agency decision is prima facie evidence of a violation of this provision.

**(d)** Failing to notify the department that a license, certificate, or registration for the practice of any profession issued to the mid- wife has been revoked, suspended, limited or denied, or subject to any other disciplinary action by the authorities of any jurisdiction.

**(e)** Violating or attempting to violate any term, provision, or condition of any order of the department.

**(f)** Performing or offering to perform services for which the midwife is not qualified by education, training or experience.

**(g)** Practicing or attempting to practice while the midwife is impaired as a result of any

condition that impairs the midwife's ability to appropriately carry out professional functions in a manner consistent with the safety of clients or the public.

**(h)** Using alcohol or any drug to an extent that such use im- pairs the ability of the midwife to safely or reliably practice, or practicing or attempting to practice while the midwife is impaired due to the utilization of alcohol or other drugs.

**(i)** Engaging in false, fraudulent, misleading, or deceptive behavior associated with the practice as a midwife including advertising, billing practices, or reporting, falsifying, or inappropriately altering patient records.

**(j)** Discriminating in practice on the basis of age, race, color, sex, religion, creed, national origin, ancestry, disability or sexual orientation.

**(k)** Revealing to other personnel not engaged in the care of a client or to members of the public information which concerns a client's condition unless release of the information is authorized by the client or required or authorized by law. This provision shall not be construed to prevent a credential holder from cooperating with the department in the investigation of complaints.

**(L)** Abusing a client by any single or repeated act of force, violence, harassment, deprivation, neglect, or mental pressure which reasonably could cause physical pain or injury, or mental anguish or fear.

**(m)** Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a client. For the purposes of this paragraph, an adult shall continue to be a client for 2 years after the termination of professional services. If the person receiving services is a minor, the person shall continue to be a client for the purposes of this paragraph for 2 years after termination of services, or for one year after the client reaches age 18, whichever is later.

**(n)** Obtaining or attempting to obtain anything of value from a client without the client's consent.

**(o)** Obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of practice.

**(p)** Offering, giving or receiving commissions, rebates or any other forms of remuneration for a client referral.

**(q)** Failing to provide the client or client's authorized representative a description of what may be expected in the way of tests, consultation, reports, fees, billing, therapeutic regimen, or schedule, or failing to inform a client of financial interests which might accrue to the midwife for referral to or for any use of ser- vice, product, or publication.

**(r)** Failing to maintain adequate records relating to services provided a client in the course of a professional relationship.

**(s)** Engaging in a single act of gross negligence or in a pattern of negligence as a midwife, or in other conduct that evidences an inability to apply the principles or skills of midwifery.

**(t)** Failing to respond honestly and in a timely manner to a request for information from the department. Taking longer than 30 days to respond creates a rebuttable presumption that the response is not timely.

**(u)** Failing to report to the department or to institutional supervisory personnel any violation of the rules of this chapter by a midwife.

**(v)** Allowing another person to use a license granted under subch. XIII of ch. 440, Stats.

**(w)** Failing to provide direct supervision over a temporary permit holder while the permit holder is engaging in the practice of midwifery.

**(2)** Subject to the rules promulgated under s. 440.03 (1), Stats., the department shall revoke a license granted under subch. XIII of ch. 440, Stats., if the licensed midwife is convicted of any of the offenses specified in s. 440.982 (2), Stats.

**(3)** Subject to s. 440.982, Stats., no person may engage in the practice of midwifery the person has been granted a license or a temporary permit to practice midwifery under subch. XIII of ch. 440, Stats., or granted a license to practice as a nurse-midwife under s. 441.15, Stats.

**(4)** Subject to s. 440.981, Stats., no person may use the title "licensed midwife" unless the person has been granted a license to practice midwifery under subch. XIII of ch. 440, Stats., or granted a license to practice as a nurse-midwife under s. 441.15, Stats.

Chapter SPS 183
APPENDIX I
ESSENTIAL DOCUMENTS OF THE NATIONAL ASSOCIATION OF CERTIFIED PROFESSIONAL MIDWIVES

**Contents**



Gender references: To date, most NACPM members are women. For simplicity, this document uses female pronouns to refer to the NACPM member, with the understanding that men may also be NACPM members.

## I. Introduction

The Essential Documents of the NACPM consist of the NACPM Philosophy, the NACPM Scope of Practice, and the Standards for NACPM Practice. They are written for Certified Professional Midwives (CPMs) who are members of the National Association of Certified Professional Midwives.

- They outline the understandings that NACPM members hold about midwifery.
- They identify the nature of responsible midwifery practice.

## II. Philosophy and Principles of Practice

NACPM members respect the mystery, sanctity and potential for growth inherent in the experience of pregnancy and birth. NACPM members understand birth to be a pivotal life event for mother, baby, and family. It is the goal of midwifery care to support and empower the mother and to protect the natural process of birth. NACPM members respect the biological integrity of the processes of pregnancy and birth as aspects of a woman's sexuality.

NACPM members recognize the inseparable and interdependent nature of the mother-baby pair.

NACPM members believe that responsible and ethical midwifery care respects the life of the baby by nurturing and respecting the mother, and, when necessary, counseling and educating her in ways to improve fetal/infant well-being.

NACPM members work as autonomous practitioners, recognizing that this autonomy makes possible a true partnership with the women they serve, and enables them to bring a broad range of skills to the partnership.

NACPM members recognize that decision-making involves a synthesis of knowledge, skills, intuition and clinical judgment.

NACPM members know that the best research demonstrates that out-of-hospital birth is a safe and rational choice for healthy women, and that the out-of-hospital setting provides optimal opportunity for the empowerment of the mother and the support and protection of the normal process of birth.

NACPM members recognize that the mother or baby may on occasion require medical consultation or collaboration.

NACPM members recognize that optimal care of women and babies during pregnancy and birth takes place within a net- work of relationships with other care providers who can provide service outside the scope of midwifery practice when needed.

**III. Scope of Practice for the National Association of Certified Professional Midwives**

The NACPM Scope of Practice is founded on the NACPM Philosophy. NACPM members offer expert care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. NACPM members work with women and families to identify their unique physical, social and emotional needs. They inform, educate and support women in making choices about their care through informed consent. NACPM members provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period. NACPM members are trained to recognize abnormal or dangerous conditions needing expert help outside their scope. NACPM members each have a plan for consultation and referral when these conditions arise. When needed, they provide emergency care and support for mothers and babies until additional assistance is available. NACPM members may practice and serve women in all settings and have particular expertise in out-of-hospital settings.

**IV. The Standards of Practice for NACPM Members**

The NACPM member is accountable to the women she serves, to herself, and to the midwifery profession. The NACPM Philosophy and the NACPM Scope of Practice are the foundation for the midwifery practice of the NACPM member. The NACPM Standards of Practice provide a tool for measuring actual practice and appropriate usage of the body of knowledge of midwifery.

Standard One: The NACPM member works in partnership with each woman she serves. The NACPM member:

- Offers her experience, care, respect, counsel and support to each woman she serves
- Freely shares her midwifery philosophy, professional standards, personal scope of practice and expertise, as well as any limitations imposed upon her practice by local regulatory agencies and state law
- Recognizes that each woman she cares for is responsible for her own health and well-being
- Accepts the right of each woman to make decisions about her general health care and her pregnancy and birthing experience
- Negotiates her role as caregiver with the woman and clearly identifies mutual and individual responsibilities, as well as fees for her services

- Communicates openly and interactively with each woman she serves
- Provides for the social, psychological, physical, emotional, spiritual and cultural needs of each woman
- Does not impose her value system on the woman
- Solicits and respects the woman's input regarding her own state of health
- Respects the importance of others in the woman's life.

Standard Two: Midwifery actions are prioritized to optimize well-being and minimize risk, with attention to the individual needs of each woman and baby.
The NACPM member:

- Supports the natural process of pregnancy and childbirth
- Provides continuous care, when possible, to protect the integrity of the woman's experience and the birth and to bring a broad range of skills and services into each woman's care
- Bases her choices of interventions on empirical and/or research evidence, verifying that the probable benefits outweigh the risks
- Strives to minimize technological interventions
- Demonstrates competency in emergencies and gives priority to potentially life-threatening situations
- Refers the woman or baby to appropriate professionals when either needs care outside her scope of practice or expertise
- Works collaboratively with other health professionals
- Continues to provide supportive care when care is transferred to another provider, if possible, unless the mother declines
- Maintains her own health and well-being to optimize her ability to provide care.

Standard Three: The midwife supports each woman's right to plan her care according to her needs and desires. The NACPM member:

- Shares all relevant information in language that is understandable to the woman
- Supports the woman in seeking information from a variety of sources to facilitate informed decision-making
- Reviews options with the woman and addresses her questions and concerns
- Respects the woman's right to decline treatments or procedures and properly documents her choices
- Develops and documents a plan for midwifery care together with the woman
- Clearly states and documents when her professional judgment is in conflict with the decision or plans of the woman
- Clearly states and documents when a woman's choices fall outside the NACPM member's legal scope of practice or expertise
- Helps the woman access the type of care she has chosen
- May refuse to provide or continue care and refers the woman to other professionals if she deems the situation or the care requested to be unsafe or unacceptable
- Has the right and responsibility to transfer care in critical situations that she deems to be unsafe. She refers the woman to other professionals and remains with the woman until the transfer is complete.

Standard Four: The midwife concludes the caregiving partnership with each woman responsibly. The NACPM member:

- Continues her partnership with the woman until that partnership is ended at the final postnatal visit or until she or the woman ends the partnership and the midwife documents same
- Ensures that the woman is educated to care for herself and her baby prior to discharge from midwifery care
- Ensures that the woman has had an opportunity to reflect on and discuss her childbirth experience
- Informs the woman and her family of available community support networks and refers appropriately.

Standard Five: The NACPM member collects and records the woman's and baby's health data, problems, decisions and plans comprehensively throughout the caregiving partnership. The NACPM member:

- Keeps legible records for each woman, beginning at the first formal contact and continuing throughout the caregiving relationship
- Does not share the woman's medical and midwifery records without her permission, except as legally required
- Reviews and updates records at each professional contact with the woman
- Includes the individual nature of each woman's pregnancy in her assessments and documentation
- Uses her assessments as the basis for on-going midwifery care
- Clearly documents her objective findings, decisions and professional actions
- Documents the woman's decisions regarding choices for care, including informed consent or refusal of care
- Makes records and other relevant information accessible and available at all times to the woman and other appropriate persons with the woman's knowledge and consent
- Files legal documents appropriately.

Standard Six: The midwife continuously evaluates and improves her knowledge, skills and practice in her endeavor to provide the best possible care. The NACPM member:

- Continuously involves the women for whom she provides care in the evaluation of her practice
- Uses feedback from the women she serves to improve her practice
- Collects her practice statistics and uses the data to improve her practice
- Informs each woman she serves of mechanisms for complaints and review, including the NARM peer review and grievance process
- Participates in continuing midwifery education and peer review
- May identify areas for research and may conduct and/or collaborate in research
- Shares research findings and incorporates these into midwifery practice as appropriate
- Knows and understands the history of midwifery in the United States
- Acknowledges that social policies can influence the health of mothers, babies and families; therefore, she acts to influence such policies, as appropriate.

**V. Endorsement of Supportive Statements**

NACPM members endorse the Midwives Model of Care ({ 1996-2004 Midwifery Task Force), the Mother Friendly Childbirth Initiative ({ 1996 Coalition for Improving Maternity Services) and the Rights of Childbearing Women ({ 1999 Maternity Center Association, Revised 2004). For the full text of each of these statements, please refer to the following web pages.

Midwives Model of Care (MMOC)-http://www.cfmidwifery.org/Citizens/mmoc/define.aspx

Mother Friendly Childbirth Initiative (MFIC) -http://www.motherfriendly.org/MFCI/

Rights of Childbearing Women - http://www.maternitywise.org/mw/rights.html

# Information

regarding

# PLANNED OUT-OF-HOSPITAL BIRTH OF TWINS

## *Twins: a really brief overview*

There are two main types of twins - fraternal and identical. Approximately 70% of twins are fraternal, meaning two separate eggs were released at the same time and fertilized by two separate sperm. The other approximately 30% are identical, meaning that one fertilized egg managed to split into two separate babies.

The babies' living accommodations inside the uterus can be different from one set of twins to the next.

- Dichorionic-diamniotic twins ('di-di'): Approximately 70% of twin pregnancies are such that each baby has their own amniotic sac and their own placenta. Imagine a building with two completely separate apartments inside. This is the least-risky type of twins, as the babies don't yet have to be good at sharing resources.
- Monochorionic-diamniotic (mono-di'): About 25-30% of twins have their own separate amniotic sacs, but share a placenta - like having two separate apartments BUT they share a kitchen and bathroom area. This pregnancy requires significantly increased monitoring to make sure that both babies are getting what they need and one isn't hogging all of the groceries in the fridge.
- Monochorionic-monoamniotic ('mono-mono'): Less than 1% of twins share both an amniotic sac and a placenta - like two people living in the same apartment, having to share both the space AND resources. This is the highest-risk type of twin pregnancy and doctors must keep a very close eye on the babies. (For this reason, mono-mono twins are not a candidate for OOH birth.)

Giving birth to twins comes with considerations that go above and beyond those of a singleton pregnancy. In this document, we'll discuss the risks, benefits, and alternatives to planning an out-of-hospital (OOH) birth of twins. Please read this carefully and ask questions about anything that you don't understand. You are encouraged to research all of your birthing options so that you're able to make the best decision for your growing family.

*WHM appreciates your thorough consideration and thoughtful decision-making.*

## *Guidelines for Licensed Midwives in Wisconsin*

Licensed, Certified Professional Midwives commit to taking care of families who are undergoing healthy, low-risk pregnancies. In the state of Wisconsin, licensed midwives may also care for folks in some moderate-risk brackets in tandem with appropriate physician-consultation and/or collaborative care - the birth of twins falls into this category. We operate inside of the parameters set forth by Chapter SPS 180 to 183 - Standards of Practice for Licensed Midwives, and you're encouraged to familiarize yourself with those. You can ask your midwife for a printed copy of those administrative rules, or you may view them online at: https://docs.legis.wisconsin.gov/code/admin_code/sps/professional_services/180.

WHM midwives ask that you respect our license parameters. Please realize that our determination not to breach those boundaries is an effort to keep our clients and their babies safe, as well as to protect the integrity of midwifery care in the state of Wisconsin.

## *Twin pregnancy considerations*

Growing two babies at once creates an elevated challenge for the body and requires a significant commitment in the prenatal period.

- Nutritional dedication: Concentrating on nutrient-dense food, cutting out junk/fast food, and just generally understanding and appreciating how nutritional decisions factor into pregnancy health & well-being becomes doubly important when you're growing TWO small people. Beginning that journey at the onset of pregnancy is important and has the best impact on outcomes!

- Lifestyle commitments: Moving and staying active is obviously part of a healthy pregnancy. This becomes more important with a twin pregnancy (but can also be much more difficult!). Sleep can be another challenge, though an important piece of the puzzle. Work with your care team if you need help finding ways to stay healthy, active, and well-slept even when the logistics of pregnancy start to become challenging!

- Preeclampsia risk: There is an increased risk of developing a severe complication called preeclampsia during a twin pregnancy. Your pregnancy may require increased monitoring (ultrasound, blood pressure, blood, and urine testing) and your care team may recommend some prevention strategies based on your individual situation. Please take this seriously and understand that preeclampsia that goes undiagnosed can be a very serious, even deadly, threat to mother and babies.

- Blood sugar challenges: During even a singleton pregnancy, the body can sometimes struggle to regulate its own blood sugar. This challenge can be compounded by a twin pregnancy. Your care team will work with you to identify and/or help lower your risk of blood sugar problems. Nutritional and lifestyle commitments will be pivotal!

- Getting to full-term: Preterm labor (labor before 37 weeks of pregnancy) is an inherent risk of twin pregnancies. Giving birth to preterm babies in an OOH setting is risky because the babies may well need more resuscitative therapies than your care team is able to provide, so your birth would need to happen in the hospital. By concentrating on good nutrition and following the individualized recommendations of your care team, you will increase your likelihood of making it to 37 weeks.

- Fetal well-being assessments: Twin pregnancies require more baby check-ins than a typical singleton pregnancy. Some of these assessments can be conducted at WHM's office, but there will be times that you'll have to travel to your collaborative physician or Maternal Fetal Medicine provider depending on the level of ultrasound that's required. Please understand that this monitoring is necessary to continually understand risk level and is an important key to both parent(s) and midwifery team being able to assess if OOH birth is still the preferred care plan. The interval of these assessments will be on an individualized schedule based on your and your babies' particular needs.

  Because di-di twins have their own separate placentas, they require the least amount of oversight of all the twins. Twins that share a placenta, however, have an up to 15% chance of developing a condition called Twin-Twin Transfusion Syndrome (TTTS). If there would be any evidence of this condition, your pregnancy would automatically become too high-risk for midwifery care.

## *Birthing considerations*

When TWO babies are jostling for position to make their exit, and then TWO placentas need to follow soon after, there are additional factors to consider about the whole birthing process. Regardless of where and with whom you end up giving birth, here are some considerations regarding the birth of twins:

- Malpresentation: There is an increased possibility of one or both babies getting themselves into a position that's simply not conducive to vaginal birth and a cesarean section might be needed. For this reason, an ultrasound position-check near the onset of labor may be necessary. It's also distinctly possible that, after Baby A is born, Baby B's position changes dramatically. The possibilities of a breech birth, an extraction procedure, or both, are things that the parent(s) should be aware of and prepared for. It's also possible for Baby A to be born vaginally, and due to malpresentation, for Baby B to require a cesarean birth.

- Postpartum hemorrhage: There are increased risk factors for elevated blood loss (postpartum hemorrhage - PPH) after the birth of twins. The two most prevalent reasons are: 1) the increased surface area of two placentas releasing, and 2) the uterus failing to contract effectively after having been so distended. Realize that postpartum hemorrhage can be a time-sensitive emergency and can threaten the life of the mother if not addressed in an efficient and effective manner.

- Umbilical cord prolapse: When the water breaks, it's rare, but statistically possible for a baby's umbilical cord to slip ahead of the baby and into the birth canal - when that happens, the downward pressure of the baby can compress the cord. This is a time-sensitive emergency, as baby's oxygen supply can become acutely compromised. If vaginal birth is not imminent, emergency cesarean is required. Cord prolapse is most commonly associated with the birth of Baby B (the literature reports between 1.3 and 1.8% chance).

- Placental abruption: The placenta(s) is the organ that attaches to the wall of the uterus and provides the babies with oxygen and nutrients. It is designed to release only after the birth of the babies, however, uterine distention of a twin pregnancy can create a situation where the placenta starts to detach before the birth. This can be a time-sensitive emergency for mother and baby. The likelihood of this occurring during a twin pregnancy is up to 3.2% (versus a singleton pregnancy where the published rates range from 0.4% to 1.0%)

- Cesarean following vaginal birth: Of all the conditions on this list, this is the only one that is exclusive to a twin birth: the birth of Baby A occurs vaginally, but Baby B experiences a challenge (i.e. malpresentation, fetal heart tone concerns, cord prolapse, etc.) and must be born via cesarean birth. This is less than ideal because the risks associated with that unplanned surgical birth are higher than for a planned, non-urgent cesarean and maternal healing can can obviously be more challenging.

- Lower APGAR Scores: APGAR scoring is the tool used to asses how well babies are making their transition to life on the outside. It requires a brief, physical assessment of the babies at 1, 5, and 10 minutes of age. Twins experience slightly lower 1 and 5 minute APGAR scores than their singleton counterparts, Baby B being most susceptible to challenges. The other main predictors of twins with depressed APGAR scores are: gestational age of <37 wks, being mono-di or mono-mono twins, low birth weight, mode of delivery (vaginal vs cesarean birth), and presentation at birth.

## ***Risks* of birthing twins in an out-of-hospital (OOH) setting:**

ACOG (The American College of Obstetricians and Gynecologists) has taken a very firm stance regarding the idea of twins being born at home Their Committee Opinion is that a twin pregnancy is an absolute contraindication to home birth, citing increased neonatal risk as the primary concern. That is obviously something which should be given thoughtful consideration. The increased risks of birthing twins outside of a hospital setting really boil down to four main points:

- Increased 'decision to incision time': There are multiple reasons for which a cesarean section may be needed over the course of the birthing process. The term, "decision to incision time" refers to the amount of time that elapses between, 1) the decision that a cesarean section is necessary, and 2) the first incision to get the baby out. The primary reasons an unplanned cesarean may become necessary are:

  - Fetal distress (primarily indicated by fetal heart tones)
  - Umbilical cord prolapse (usually relating to second twin)
  - Presentation of one or more babies that's incompatible with vaginal birth
  - Failure of the labor to progress in an appropriate or predictable way.

  Our goal, as attentive care providers, is to pay attention to yellow flags, using them to predict a problem before it becomes a time-sensitive emergency so we can get you to higher-level care in a timely manner. It's possible, however, for the need for cesarean section to arise quickly. In an emergency situation, it's obviously the case that not already being INSIDE OF the hospital will delay your cesarean. Delay of a needed cesarean can result in severe complications for baby(ies). Worst-case scenarios include: Hypoxic-ischemic Encephalopathy *(brain damage due to lack of oxygen which can result in cerebral palsy, cognitive delays or disorders, seizures, etc.), s*tillbirth, or even neonatal death.

- Challenges listening to babies in labor: Listening to fetal heart tones is the only real tool that we have to understand how a baby is tolerating the rigors of labor. One challenge of listening to twins is making sure that we're listening to each baby and not simply hearing the same baby in two different places. (This same challenge exists in a hospital setting, though if a challenge is encountered, a quick cesarean section would obviously be more accessible.)

- Delay of advanced hemorrhage management: In the event of postpartum hemorrhage (losing too much blood after the birth), there is quite a bit that we can do at home, but the hospital has additional treatments/therapies that are not available in a home setting and requires transport.

  ***Available at home & hospital***
  - *Pitocin*
  - *Methergine*
  - *Misoprostol*
  - *IV Fluids*
  - *Tranexamic Acid*
  - *Bimanual uterine compression*
  - *Manual removal of placenta*

  **Only available in hospital**
  - Hemabate
  - Transfusion of blood products
  - Intrauterine devices (i.e. Jada system & Bakri balloon)
  - Operative procedures (i.e. vessel ligation & hysterectomy)

- Delay in advanced respiratory help for a newborn: 10% of babies need a little bit of help breathing right after birth. 1% of babies need a little more extensive help. With twins, those percentages are a bit higher. WHM midwives are all trained to stabilize and transport babies who need help, but we do not have the tools to do prolonged respiratory therapies that would be available in the NICU. We also do not intubate babies; rather we carry a supraglottic airway in the event that an ongoing ventilatory effort is needed while en route to higher level care.

## ***Benefits* of birthing twins in an out-of-hospital (OOH) setting:**

The benefits of birthing twins in an out of hospital setting can be distilled down to the same benefits of birthing ANY baby out of hospital: you are picking a modality of care which generally promotes a more physiologic approach to birth, avoids routine interventions, and attempts to facilitate as gentle of a birth as possible.

- Maintaining client autonomy: Midwifery care is often able to preserve the highest amount of autonomy for the birthing family. As covered in the broader 'Informed Consent for Care' document, our goal is to keep as many decisions as possible in the hands of the people who will be most affected by them. This comes with the increased burden of client responsibility and ownership for one's own decision-making.

- Respecting Physiology: In labor, you're not just allowed, but encouraged to move around freely, eat and drink as your body requests, have support people of your choosing, and generally follow your own instincts. This compliments and strengthens your body's innate ability to do the strong work of birth and is a major part of keeping the intervention rate to a minimum.

- Increased time for client education: Significant portions of your prenatal care will be dedicated to education. We will cover topics including upcoming decisions in the prenatal period, aspects of care regarding birth, and preparation for life after your birth (postpartum). We want you to have time to research these topics and make informed decisions. We also use this as an opportunity to discuss possible complications and their fixes. By discussing these things ahead of time, we hope to reduce the possible distress/trauma of an intervention or deviation from the desired care plan.

- Personalized birth plan: As with singleton births, at WHM, we will spend your prenatal period getting to know your individual birth plan and preferences so that we can best support you through this intimate and pivotal event. For example, we have the ability to be patient if/when that's what your birth process needs, we standardize delayed cord-clamping and skin-on-skin care with your newborns. Our goal is for you NOT to have to advocate for yourself and your babies while in labor.

- Breech trained providers: Twin births involve a higher likelihood of a breech birth. VERY few hospital based providers are trained in breech birth, which will mean either a breech extraction or cesarean will be implemented. At WHM, we keep current with physiologic breech birth training.

- Increased likelihood of achieving a vaginal birth: By picking a care provider who puts a high emphasis on facilitating natural birth, you lower your chances of cesarean section. A surgical birth puts you at higher risk of:

    - Elevated blood loss
    - Infection of uterus, bladder, or incision (20x greater risk than following vaginal birth)
    - Hematoma, which is a burst blood vessel inside your body
    - Blood clots (Double the risk compared to natural birth)
    - Accidental injury to internal organs or to the baby (Most likely during an emergency C/S)
    - Anesthesia complications (More likely during an emergency C/S)
    - Allergic reaction to medications
    - Delayed/impaired bowel function
    - Extended hospital stay
    - Microbiome implications for baby
    - Downstream maternal consequences of a uterine incision for future pregnancies and births

## *WHM's Twin Protocol:*

- Ongoing/Collaborative care with a physician: Due to the dynamic nature of twin pregnancies, we at Windy Hill Midwifery require ongoing collaborative care (versus a single consultation appointment) with a hospital-based physician. If a hospital transfer becomes necessary at any point, a pre-established physician relationship eases the burden for the receiving provider and the midwife, while also streamlining the transition for the family.

- Birth attendants: A minimum of four birth attendants will be at your birth: 2 licensed midwives, and 2 trained attendants (or qualified students). This is so that everyone involved, Client, Baby A, and Baby B, has a dedicated attendant. The fourth attendant is there as a scribe to record the timing of all events. (The birthing family is, of course, welcome to have whomever they choose in attendance at their birth, but we ask that support people remain willing to give space to the birth team when/if needed.)

- Ongoing risk assessment: A continual evaluation of risk status is an important part of prenatal care regardless of the number of babies, but this is even more important in a twin pregnancy because things can change quickly. Please understand that this is by no means an exhaustive list, but due to the elevated risks associated with the following, WHM will not attend twins that are:

    - Monochorionic, monoamniotic ('mono-mono')
    - Conceived via IVF
    - Exhibiting concerningly asymmetric growth
    - In any way unfit for vaginal birth (I.E. fetal positioning, congenital anomaly, etc.)

- Strong PPH prevention/management strategies: Due to the increased risk of postpartum hemorrhage, WHM prefers to have an IV "saline lock" established in labor. This means IV access will be established, but only hooked up to fluids and/or medication in the event it becomes necessary. This allows us the most flexibility to provide effective, timely treatment if there's elevated blood loss after the birth.

  We also encourage a more 'active management' approach to the immediate postpartum, likely including an IM injection of pitocin as soon as the second baby is born. This preventative approach to blood loss is preferred (versus reacting only once someone has already lost a significant amount of blood).

- Fetal monitoring in labor: As touched on earlier, the only way to understand how well the babies are tolerating the rigors of labor is to regularly check fetal heart tones (FHTs) and listen for any signs of fetal stress. We use a hand-held doppler for this monitoring. FHTs will be monitored more frequently in active labor than in early labor, and more frequently yet in the pushing stage and the time between births of babies A and B.

  Please realize that, depending on the position of the babies, it can be difficult to know with certainty that we're actually listening to both of them individually. If that problem persists and we're uncertain of our ability to keep tabs on both babies, transport may become necessary, even in the absence of noted decels. This is in the spirit of erring to the side of caution.

- Conservative interpretation of concerning findings: Because twin pregnancies and labor/births are in an elevated risk category, WHM will interpret concerns more conservatively than with a singleton situation. Again, this is in the interest of safety and the health/wellbeing of mother and babies. We are proponents of home birth, but not at all costs.

## *Transfer of care / Transport Plan*

- Non-time-sensitive: A non-urgent transfer of care will be to the hospital with whom the family has established co-care. A few examples of this would be: uncontrolled high blood pressure, uncontrolled blood sugar concerns, and positioning of babies in a way that prevents vaginal birth.

- Time-sensitive: In the event of an emergency situation, the destination and method of transport will be determined by: the midwife, the receiving physician, and the transport team. Transport will be to the closest facility that's able to provide the needed medical services. Please realize that availability of obstetrical resources in northern, rural Wisconsin can be dynamic due to hospital system closures of their birthing centers or understaffing of even the open facilities.

  Declaration of a time-sensitive emergency and implementation of the client's Emergency Transport Plan will be at the discretion of the midwifery team and the decision rooted in safety.

  In the case of a time-sensitive emergency, we may have to take action without the time to guide the client through our regular process of informed decision-making. We will do our best to discuss possible interventions ahead of time so that, should they become necessary, those actions don't feel like a surprise or a betrayal. We also make every attempt to communicate with the client/partner throughout the unfolding of the situation so that everyone is as informed as possible.

- Elective transfer or transport: If a client would simply prefer to change their birthing location/provider decision, that is always an option available to them. The WHM care team will support and facilitate an elective transfer because we will always prioritize client autonomy.

## *Postpartum with twins - some considerations:*

- Arrange for help!: Simply being postpartum is a physical challenge - and that's if the birth was straightforward. Throw in a few plot-twists, and you might find that you really need someone *in your home* for the first couple of weeks just to help with logistics so you can heal. Arranging for someone to come daily for the next month or two can be pivotal. You want to set your growing family up not just to survive, but to thrive. Pick a helper who:

  - Isn't just there to hold a baby (but is willing to do so when needed!). You want someone who can help out in other ways so that the *parent(s)* can hold the babies.
  - Can look around and see what needs to be done, versus needing to be told.
  - Has some experience with babies
  - Can take occasional night-time duties
  - Will support your infant feeding decisions

- Nourish yourself: Your body will heal best if you put nourishing food in and keep inflammatory foods out. That's not to say there's never a time and/or place for take-out or frozen pizzas, but keep junk food & sweets to a minimum and you'll recover much faster!

- Hydrate well: This is especially important if you're breastfeeding, but is important for physical recovery, regardless.

- Consider a Lactation specialist: Having a pre-established relationship with a lactation specialist can be key for getting breastfeeding established with a minimum amount of drama and stress.

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# Informed Consent

for

## PLANNED OUT-OF-HOSPITAL BIRTH OF TWINS

*I, _____ understand and appreciate that a major tenet of midwifery care is the ability to retain my own decision making. I also understand that it means I bear an increased burden to inform myself and take responsibility for my care decisions. By initialing next to each of the statements that follow, I affirm that:*

*(Print full name)*

- I have read and given careful consideration to the information and options given to me by Windy Hill Midwifery, LLC (WHM)
- I have had time to research the topic from different sources and ask questions
- I am making a fully-informed decision

### Regarding my intended out-of-hospital birth of twins:

_____ *(Initials)* I understand that a component of risk reduction involves implementing healthy diet and lifestyle choices throughout pregnancy, but that this does not guarantee that I will remain eligible for an OOH birth. Risk assessment will be on-going and I agree to transfer to a hospital-based option if that becomes necessary.

_____ *(Initials)* I understand that my care team will monitor my labor, birth, and postpartum more frequently and will interpret findings more conservatively than a singleton birth. I agree to give prompt and serious consideration to any concern that develops over the course of labor, as well as to subesquent recommendations from my care team.

_____ *(Initials)* I understand the risks and benefits of out-of-hospital birth of twins. I realize that the provision of emergency interventions such as cesarean section, transfusions of blood products, advanced neonatal resuscitation, etc, will be delayed compared to birthing in a hospital.

_____ *(Initials)* I realize that in a time-sensitive situation, transport will be to the closest location that provides birthing services, which in my situation, is:

_____
*(Hospital)*

In the event of a non-emergent transport or transfer of care, my preferred provider and location are:

_____ _____
*(Provider Name)* *(Provider Location)*

Client Signature: _____ Date: ___/___/_____

**IN THE BEGINNING MIDWIVES**
**VAGINAL BREECH BIRTH INFORMED CHOICE AND CONSENT AGREEMENT**

At term, breech position is found to occur at 3-4%. Approximately 1-2% of babies remain breech at labor onset. Due to increased risks to the baby, the midwives of In the Beginning ensure their skills and knowledge of breech birth are current and all midwives have participated in the Breech Without Borders training. However, we attend very few breech deliveries in the home setting, typically less than one per year. We take care to ensure that the client is fully informed of the risks. Not all midwives and clients may want to have a vaginal breech birth out of the hospital.

The American College of Obstetrics and Gynecologists (ACOG) recommends that every client with a term baby presenting breech should be offered an “external cephalic version in a setting in which cesarean delivery services are readily available.”

Furthermore, ACOG states that "planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management" only. This is due to a higher risk of perinatal death. 2 in 1000 for a planned vaginal breech birth, vs 1 in 1000 for vaginal head-down birth, or 1 in 2000 for planned C-section**. Although there are increased risks to the baby born by vaginal breech, there are also risks to both the client and the baby associated with surgical birth.

When your baby is breech, you have three (3) options for delivery:

1. A planned hospital birth with a physician. This may mean a planned c-section.
2. An external cephalic version, which means attempting to manually turn the baby to a head down position to increase the chance for a vaginal delivery.
3. A planned home birth with risks as described below.

**It is important to be aware of the following risks:**

- Babies with genetic anomalies have a higher rate of presenting breech
- Trauma and injury could occur to baby during labor and birth
- Cord prolapse (where the cord presents before the baby through a dilated cervix), which could interrupt the flow of oxygen to the baby resulting in brain damage and/or death
- Increased need for resuscitation of the newborn
- Perineal lacerations, episiotomy (injury to the area between the vagina and the anus, surgical cut to the area between the vagina and the anus)
- Postpartum hemorrhage which may require blood transfusion or possible hysterectomy
- Overall, vaginal delivery of a breech baby may increase the risk of fetal death and/or short-term serious neonatal morbidity
- These risks may be higher in first time mothers
- The distance from a NICU and pediatrician may increase risk of morbidity and mortality to the infant

**These risks may be minimized by some of the following techniques:**

- Early detection of presentation
- Close observation and monitoring throughout the labor process
- Maintain intact membranes as long as possible
- Delay pushing until completely dilated
- Client's commitment to cooperate fully with midwife's instructions
- Good communication between client and midwife
- Midwife experienced with breech deliveries present at birth and assistant present at birth

I have read and understand all of the above. My midwife has answered all of my questions related to breech birth at home. _____ (initial)

CLIENT ACKNOWLEDGEMENTS
Client must read each item and initial each in the space provided below.

_____1. I understand that transfer to a hospital for further evaluation of possible birth injuries to myself or newborn may be necessary.

_____2. Transfer of care can be initiated at any time at the discretion of the midwife or the client.

_____3. I have been informed that my midwives' experience of breech birth is: less than one breech birth per year for the past five years.

_____4. I understand the importance of promptly notifying my midwife of labor symptoms.

_____5. My midwife has offered me the option of a physician consult or transfer of care

_____6. I understand that during the course of care, it may be necessary or appropriate to perform additional testing and procedures outside the standard of care, for which informed consent will be offered at that time.

_____7. I have been offered an ultrasound to rule out genetic anomalies in the third trimester, and I **permit/decline** (circle one and initial).

After careful consideration of the above information:
_____I am choosing a vaginal breech out-of-hospital birth under the care of my midwife.

_____I am choosing to transfer care to a physician.

Client's signature and date_____

Spouse's signature and date_____

Midwife's signature and date_____

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Oklahoma State Department of Health Vaginal Breech Informed Consent Document 2021

**From:** Holmes-Drammeh, Emelle S
**To:** Hardin, Nilajah - DSPS
**Cc:** Parton, Renee M - DSPS; Johnson, William H - DSPS; Cohen-Plata, Audra - DSPS
**Subject:** Re: Licensed Midwives and PAs
**Date:** Tuesday, December 2, 2025 3:37:10 PM

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Hey Nilajah,

It depends on the practice and what they are referring the patient for. For example, Midwives at UW may see a patient for abnormal bleeding and the patient needs to follow up. Because we are in the same department doesn't necessarily mean a formal referral needs to be placed, but that follow up may end up being with me. However, I have had midwives specifically ask me to see bleeders before because they don't know what to do. When it comes to OB patients that too depends on the practice setting. I know there are PAs in northern Wisconsin who are more involved with inpatient OB care than here in Madison so I could see the referrals happening. I would honestly ask them to look at their practices, if they are referring pts to PAs, it makes sense to include it, especially because practices across the state vary so much.
Sorry for the delayed response. I thought I sent this and am just realizing I never did.
E
Get Outlook for iOS

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**From:** Hardin, Nilajah - DSPS <Nilajah.Hardin@wisconsin.gov>
**Sent:** Friday, October 31, 2025 12:21:42 PM
**To:** Holmes-Drammeh, Emelle S
**Cc:** Parton, Renee M - DSPS <reneem.parton@wisconsin.gov>; Johnson, William H - DSPS <william.johnson@wisconsin.gov>; Cohen-Plata, Audra - DSPS <audra.cohenplata@wisconsin.gov>
**Subject:** Licensed Midwives and PAs



Good Afternoon Emelle,

The Licensed Midwives Advisory Committee is currently working on making recommendations to the Department to update their part of the Administrative Code. The discussion came up at their last meeting of whether it would be appropriate for a licensed

midwife to refer a client to a PA. As you are a member of the Physician Assistant Affiliated Credentialing Board who also practices as a PA in gynecology, I am wondering if you have had any consultations or referrals with midwives or are aware of any PAs who have?

The Committee is reviewing the following Sections of their rules to see if it would be appropriate to add the highlighted text:

**(4)** consultation and referral. **(a)** A licensed midwife shall consult with a licensed physician, licensed physician assistant, certified advanced practice nurse prescriber, or a licensed nurse-midwife who has current working knowledge and experience in providing obstetrical care, whenever there are significant deviations, including abnormal laboratory results, relative to a client's pregnancy or to a neonate. If a referral to a physician is needed, the licensed midwife shall refer the client to a physician and, if possible, remain in consultation with the physician until resolution of the concern.

**Note:** Consultation does not preclude the possibility of an out-of-hospital birth. It is appropriate for the licensed midwife to maintain care of the client to the greatest degree possible, in accordance with the client's wishes, during the pregnancy and, if possible, during labor, birth and the postpartum period.

**(b)**A licensed midwife shall consult with a licensed physician, licensed physician assistant, certified advanced practice nurse prescriber, or licensed nurse-midwife who has current working knowledge and experience in providing obstetrical care, with regard to any mother who presents with or develops the following risk factors or presents with or develops other risk factors that in the judgment of the licensed midwife warrant consultation:

These sections as they are currently written are located here: Wisconsin Legislature: SPS 182.03(4)

Any insight you could provide, would be greatly appreciated.

Regards,

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Proposed rule changes by midwifery membership:

- consider changing language throughout the rules and regulations to **pregnant person** - mother opens a door for saying the rules do not apply to a pregnant father
- 182.03 Practice: (i): Instruct the mother, father and other support persons, both verbally and in writing, of the special care and precautions for both mother and newborn in the immediate postpartum period. *Consider getting rid of the in-writing piece - this seems entirely unnecessary and cannot possibly include everything or be individualized to every family*
- (j) Reevaluate maternal and newborn wellbeing within 36 hours of delivery. - *consider adding in-person visit*
- (o) Within one week of delivery, offer a newborn hearing screening to every newborn or refer the parents to a facility with a newborn hearing screening program. - *consider changing to 2 weeks, as we all share hearing screeners and there is no reason it has to be in the first week*
- meds - clarifying language around whether carrying these meds is required of LMs or just allowable
- oxygen for fetal distress is not an evidence based intrauterine resuscitative measure - not suggesting get rid of it but perhaps our greatest need for oxygen is for NRP and maternal shock- *change the indication on the formulary*
- Intrapartum: (e): Ruptured membranes without onset of established labor after 18 hours. *Consider changing to 24 hours*.
- Postpartum: (h) Observe mother and newborn postpartum until stable condition is achieved, but in no event for less than 2 hours. - *consider changing this to 2 hours after birth of placenta*
- e. Rupture of membranes prior to the 37th week gestation.
- s. Labor prior to the 37th week of gestation. - consider clarifying these consult requirements. 37th week of gestation to me means 36 completed weeks and in their 37th week of pregnancy. Some people may interpret this to mean 37 completed weeks and in their 38th week. *Consider using the language of completed weeks*.
- m. Thick meconium or frank bleeding with birth not imminent. - *consider changing to thick mec in the absence of breech presentation or frank bleeding…*
- Add consult for hypertensive blood pressures or symptoms of Postpartum Preeclampsia to postpartum consult section
- 13. Confirmed AIDS status. - *consider changing to HIV*
- Transfer: (19) Failure to deliver placenta after on hour of there is no bleeding and fundus is firm. *Consider moving this to Intrapartum consult*.
- Consider adding language the supports and directs the work of an intentional birth assistant. Consider the detail about the birth assistant not having to be a temporary permit holder