PROPOSED NEW RULE

A midwife may continue care for a midwifery client with a "postpartum hemorrhage of greater than 500 milliliters in the current pregnancy" as stated in R9-16-111 B 25 if the following criteria are met in the postpartum period:

a. The hemorrhage responds to treatments available in the out of hospital setting and is well controlled
    i. The client is alert and oriented
    ii. The client is not experiencing syncope greater than one occurrence
    iii. The client's blood pressure remains within normal limits of between 90/60 and 140/90; or,
b. The client has been discharged from physician care following a transfer of care for hemorrhage

JUSTIFICATION

Currently available prevention and treatment options for postpartum hemorrhage have been found to be effective at improving maternal outcomes. Midwives undergo rigorous training in assessing risk factors for postpartum hemorrhage. Midwives regularly implement prenatal care plans that reduce identified risks. Midwives in out of hospital birth practices do not provide care to clients with known risk factors for postpartum hemorrhage such as those with: multiple gestation, preeclampsia, chorioamnionitis, and polyhydramnios. Similarly, patients planning an out of hospital birth do not undergo interventive procedures known to increase rates of hemorrhage such as: medical labor augmentation, assisted delivery techniques (vacuum or forceps), and cesarean delivery. Postpartum hemorrhage affects 1-3% of postpartum patients. The most common cause of postpartum hemorrhage is uterine atony which respond well to current standards of practice for a licensed midwife.

There is no single accepted definition of postpartum hemorrhage in the United States. A blood loss of 500mL following vaginal birth and 1000mL following cesarean birth are commonly used for diagnosis even though current research suggests average blood loss may be greater. Visual estimation of blood loss is notoriously inaccurate, often over-estimating total blood loss, and has been found to be of little clinical use. It is important to note that a blood loss volume of 500mL is somewhat arbitrary and fails to take into consideration the individual's starting blood volume and may be irrelevant to the client's hemodynamic state. Likewise, a decrease in hematocrit levels by 10% has also been used for diagnosis, but similarly may not represent the current hematological state of the client and some individuals may suffer a postpartum hemorrhage with lower blood losses.

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

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

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